Cheshire and Wirral Partnership NHS Foundation Trust

RXAX2

Community health services for adults

Quality Report

Redesmere
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Date of inspection visit: 23 - 26 June and 1 July 2015
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXAX2	Countess of Chester Health Park	Community health services for adults	CH2 1BQ

This report describes our judgement of the quality of care provided within this core service by Cheshire and Wirral Partnership NHS Foundation 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 Cheshire and Wirral Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Cheshire and Wirral Partnership NHS Foundation Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
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

Whilst staff were able to articulate the process for reporting incidents, staff did not always receive timely feedback about them or details of any lessons to be learned when things went wrong.

Staffing incidents were not reported via the electronic incident reporting system in line with trust policy. Instead, staff were encouraged to report staffing issues via the management escalation process which meant that not all staffing related incidents were recorded on the electronic system, potentially giving an inaccurate picture of staffing concerns.

The level of staffing and mix of skills in the integrated teams did not match patient needs. Although the trust had been monitoring staffing and capacity, it used its own tool to determine nursing caseloads, which did not take into account the acuity (the level of severity of illness or level of need) and complexity of patients. The trust acknowledged that further work was required to enhance the capacity tool to fully assess the acuity of patients. There were also a number of vacancies within the community nursing service. Following our visit, we were told of measures taken by the service to provide support for staffing levels and to ensure the appropriate skill mix to match the needs of patients more effectively.

Care and treatment was evidence-based and was provided in line with best practice guidance. The implementation of the integrated therapy service promoted multidisciplinary and multiprofessional approach to therapies, which enabled patients and families to avoid duplication of services and receive therapy support nearer to their homes.

Patients and their families were cared for by staff who were kind and compassionate. Patients were involved in the assessment, planning and delivery of their care, and were kept informed of changes and developments by members of the multidisciplinary team.

Data provided by the trust indicated that the services were provided within the national 18 week target but staff told us they were struggling to maintain that. There was also a delay of five months in the non-urgent review of venous flow conditions clinic due to long-term sickness.

Referrals to the district nursing service were being managed and records showed that in the month prior to our visit, patient assessments and visits had been deferred to help manage the delays. We found that this could have an adverse effect on patients' care and treatment.

There were examples of good local leadership across the individual services. However, there were a lot of staff in temporary and 'acting' roles across the integrated community teams and a lack of professional nursing and therapy leadership was commented on by staff. The lack of nursing leadership had been acknowledged by the trust as part of an incident investigation and the trust had plans to provide more robust clinical leadership.

Summary of findings

Background to the service

Community health services for adults are provided by Cheshire and Wirral Partnership NHS Foundation Trust and are known as West Physical Health Services. West Physical Health Services are provided for people in Cheshire. Within the West Physical Health Services there are nine multidisciplinary community teams. The teams include nurses, therapy staff and social workers who work collaboratively with local GPs to provide care and support to people in their homes and local areas. The services are run jointly by Cheshire and Wirral Partnership NHS Foundation Trust and Cheshire West and Chester Council. The Western Cheshire area is home to approximately 300,000 residents, across a mix of urban centres, smaller towns and rural communities.

Services we inspected were provided in people's own homes, nursing homes, clinics and GP practices. They included:

- Community nursing (also known as district nursing), including out-of-hours services
- Community matron services
- Leg ulcer care
- Respiratory Service
- Home intravenous therapy
- Podiatry
- Occupational therapy
- Physiotherapy services
- Adult musculoskeletal assessment and management service
- Adult musculoskeletal service
- Community neuro therapy physiotherapy
- Choose and book
- Inpatient therapy
- Tissue viability
- Heart failure
- Cardiac rehabilitation
- Early supported discharge for stroke
- Community pain service
- Hospital alcohol liaison service
- Smoking cessation
- Continence and tier 2 urology service

The community nursing service is large and is the main provider of nursing care at home for adults who have complex and palliative care needs. It works in collaboration with key partners within primary care and social care. The service also provides leg ulcer clinics in a number of health centres. Community matrons provide care for patients with multiple, complex long-term conditions who are at a high risk of hospital admissions and readmissions. The service provides assessment, diagnosis and treatment for this group of patients in their own homes, when they might otherwise have been admitted to hospital.

The occupational therapy service treats patients with physical illness or disability through specific activities that will enable them to reach their maximum level of function and independence. The physiotherapy service provides a musculoskeletal service. Respiratory specialist nurses and physiotherapists work together at the trust in treating patients with chronic lung conditions. They see patients in hospital, in the community, in hospital clinics and in their own homes.

The podiatry service offers specialist service provision such as wound care, nail surgery, biomechanical assessment and orthotics manufacturing and supply. The service treats adults and children with foot and lower limb problems. West physical health services provide a discreet community continence service to individuals (adults, children and young people) who suffer with bladder or bowel problems.

The community pain service accepts referrals from any Western Cheshire GP, the secondary care pain service, adult musculoskeletal assessment and management service and MSK physiotherapy for those patients living with chronic spinal pain. The heart failure team works closely with the Cardiologists across the Northwest.

The trust also provides a single point of access service for health professionals to seek advice to avoid hospital admission.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Bruce Calderwood, Director of Mental Health, Department of Health (retired)

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leaders: Sharon Marston, Inspection Manager (Mental Health), Care Quality Commission; Simon Regan, Inspection Manager (Community Physical Health), Care Quality Commission.

The team that inspected this core service comprised: Two CQC inspectors, a district nurse and an allied health professional.

Why we carried out this inspection

We inspected the community health service for adults as part of our comprehensive inspection of Cheshire and Wirral Partnership NHS Foundation Trust.

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew.

We carried out an announced inspection from 23 June to 26 June 2015 and an unannounced inspection on 1 July 2015. During the visit we met with 95 staff including physiotherapists, occupational therapists, health care support workers, therapy assistants, nurses of different grades and specialisms, administrative staff, doctors, team leaders and community service managers. We also spoke with 21 patients and six carers. We reviewed records, observed direct care both in clinics and in people's own homes, attended handovers and multidisciplinary meetings. We also offered special meetings for staff called focus groups and reviewed patient feedback forms.

What people who use the provider say

Overall, people were very positive about the community health services for adults provided by Cheshire and Wirral NHS Foundation Trust.

Feedback from people who use the service, their families and stakeholders was continually positive about the way staff treated people. Patients and families said that staff went the extra mile and that the care they received exceeded their expectations.

Patients told us, "I feel much happier now and know how to manage my condition in the future" and "at all times, the service was delivered in order to meet my rehabilitation goals, and I was encouraged to state what my rehabilitation objectives were. The professionals who worked with me and my partner were unfailingly warm and empathetic, giving every sense of taking tremendous personal satisfaction in the progress we achieved together."

Summary of findings

Some services asked patients to complete satisfaction surveys. The majority of patients expressed satisfaction with the service they had received. Comments included, "I cannot thank you enough for showing me how to live a healthier lifestyle. You have been my guardian angel".

Good practice

- The cardiac rehabilitation service had gained national accreditation for the quality of its services and the early supported discharge service for stroke had won the trust's six Cs award for delivering an outstanding service to patients who had experienced a stroke.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The provider must ensure that:

- There are sufficient numbers of suitably qualified skilled and experienced nursing and other staff working in adult community services to meet the needs of the service.
- There are appropriate timely systems in place for incident reporting and investigation.
- Systems to identify, mitigate and manage risk allow all local risks to be clearly identified and managed by staff at service level whilst clearly linking with trust-wide governance processes to ensure that all risks are captured and monitored.

The provider should ensure that:

- There are robust medicines stock control and management systems in all physical health services in line with best practice requirements.
- All staff are adhering to the patient group directives for administration of medicines in line with trust policy.
- Line management and professional leadership across the adult physical health services is reviewed to maximise the role of the professional advisors and clinical leadership.
- All areas of service participate in record documentation audits to ensure best practice in line with trust policies.
- Appropriate testing is carried out on equipment in a timely manner to ensure that it is safe and fit for purpose.
- The process for the provision of pressure-relieving cushions is fair and equitable and in line with clinical need and assessment.
- The strategic approach to services is reviewed to ensure that there is an overall approach to service development and initiatives.
- Learning across the different teams is encouraged to share best practice and closer working in line with the principles of integrated working.
- The management of the dressings clinic is reviewed to provide maximum privacy and dignity for people using the service, particularly for mixed-sex patients' appointments.
- All staff receive an appraisal.

Cheshire and Wirral Partnership NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The level of staffing and mix of skills in the integrated teams did not match patient needs. Although the trust had been monitoring staffing and capacity, it used its own tool to determine nursing caseloads, this did not take into account the acuity (the level of severity of illness or level of need) and complexity of patients. There were also a number of vacancies within the community nursing service. Following our visit, we were told of measures taken by the service to provide support for staffing levels and to ensure the appropriate skill mix to match the needs of patients more effectively.

Whilst staff were able to articulate the process for reporting incidents, staff did not always receive timely feedback about them or details of lessons to be learned when things went wrong.

Staffing incidents were not reported via the electronic incident reporting system in line with trust policy. Instead, staff were encouraged to report staffing issues via the management escalation process. This meant that not all staffing related incidents were recorded on the electronic system, potentially giving an inaccurate picture of staffing concerns.

Medicines stock control and the use of patient group directives were not always in line with the trust's policy. Electrical medical equipment had not been routinely tested in one of the community areas we visited. Staff followed appropriate infection control practices and care and treatment was provided in visibly clean and well maintained premises. All staff knew how to report the signs and symptoms of potential abuse. Staff were aware of the relevant safety policies for lone workers.

Safety performance

- The service had reported ten grade three or four pressure ulcers for the period 1/5/2014-30/4/2015. This level of ulcer indicates a significant impact on the patient's quality of life. A senior manager confirmed that

the service had reduced the number of pressure sores but acknowledged there was further work they would like to do in order to further reduce the number of incidents.

- The service held a monthly "zero harm" meeting attended by the safety team, clinical leads and audit team members. Minutes of these meetings confirmed that incidents were discussed. We were also shown a copy of the "sharelearning" publication, which highlighted the management of pressure ulcers.

Incident reporting, learning and improvement

- Incidents were reported using the electronic reporting system. Staff could describe the process for reporting accidents, incidents or "near misses" that occurred.
- Staffing incidents were not always reported through the electronic system but through a separate escalation process via email. We found that two staffing related incidents had been reported in the two weeks prior to our visit but staff had been encouraged to use the escalation process instead of the electronic reporting system. The trust's incident policy indicated that they should have been reported via the incident reporting system as well. The use of a separate process meant that not all staffing related incidents were recorded on the electronic system, potentially giving an inaccurate picture of staffing issues.
- Senior managers from several clinical teams told us they investigated all incidents and held team meetings to learn from them. However, we found that not all serious incidents were investigated and acted upon in a timely manner. We reviewed the root cause analysis (RCA) for two grade 4 pressure ulcer incidents and found that they had been thoroughly investigated and an action plan was in place. However, the incidents had occurred in December 2014 and the RCAs had not been completed until two months after the incidents had occurred. At the time of our inspection, the action plan and relevant feedback for one incident had not been cascaded to the key staff involved in the incident.The lack of timely response and action did not assure us that the systems for managing incidents were being managed effectively to protect patients from harm.
- Managers gave us examples of learning from incidents. For example, discrepancies in the electronic booking system for outpatient therapy appointments (choose and book) had been identified and the appropriate actions were taken by the informatics service to address the concerns at the earliest opportunity. We were told that a pressure ulcer assurance tool had been introduced following a number of reported pressure ulcer incidents. This had been shared through the zero harm group.
- Although staff said that they got feedback following incidents, they did not routinely have access to an overview of incidents for their services. This meant that they were not always able to identify possible trends. Locality data packs had been introduced across services in the last couple of months. These had not been seen widely by staff and were not yet embedded.
- Allied health professionals and specialist nurses told us that they were reporting all incidents.

Safeguarding

- Data provided by the trust showed that the majority (90%) of staff in the service had received safeguarding training at Level 2 or Level 3, dependent on their role.
- Staff demonstrated that they knew and understood how to identify potential abuse and would report any concerns to their manager.
- Staff told us about a safeguarding concern they had raised concerning the nutritional requirements of an elderly person in a local nursing home. The staff member told us they had been supported by their line manager to raise their concerns to the trust safeguarding lead. This demonstrated that staff were aware of the correct policy to follow and that the provider had appropriate systems in place for reporting potential abuse.

Medicines

- The musculosketal (MSK) physiotherapy service had patient group directives (PGDs) in place for the administration of anti-inflammatory injections in the physiotherapy department at Ellesmere Port Hospital. Patient group directions give authority to a nurse to supply and/or administer prescription-only medicines to patients using their own assessment of patient need, without necessarily referring back to a doctor for an individual prescription. Individual PGD forms completed by each member of the MSK service who administered medicines should have been available at the service but were not. This was not in line with the trust's policy for the safe management of medicines.
- All drugs were stored in a locked cupboard but there was no evidence of stock control in the MSK

department. We were not able to access clear documentation relating to the management of medicines stock. There was a record of medications ordered, receipted and individual patient records demonstrated the medications used. The 'medicines management procedure' identified the stock control arrangements that should have been in place for the service.

- The community nurses administered controlled drugs through syringe drivers in line with the trust policy and National Institute for Health and Care Excellence (NICE) Guidelines.
- We reviewed 18 patient records and noted that the appropriate consent for treatment had been obtained and that documentation of the medicines administered was correct and legible.
- Nurse practitioners and senior nurses in the heart failure and cardiac rehabilitation services had undertaken training to become non-medical prescribers.

Environment and equipment

- At one clinic we found a range of medical equipment that had not been routinely tested in line with requirements (portable appliance testing). For example, a fan heater was last tested in 2012. There was no evidence of urology battery charger testing, and extension leads and IT equipment had not been tested since 2013. We brought this to the attention of the senior manager, who gave us an assurance that immediate action would be taken and that an audit would be carried out urgently for other centres to ensure that appropriate servicing had been carried out.
- The community clinics were appropriate to deliver care and treatment. Staff who had moved into a new building within the last month could articulate the induction processes they had been through to work in the premises.
- Daily equipment checks were undertaken and recorded in the cardiac rehabilitation service. Suitable resuscitation equipment was in place. For example, a defibrillator. Portable appliance testing of equipment had been undertaken in 2014. This showed emergency equipment had been appropriately tested and maintained and was deemed fit for purpose.

Quality of records

- Community nurses maintained a full paper case file in patients' homes and also completed an electronic record using the online system. Staff said they were due to change to full electronic systems using portable devices in the next few weeks.
- Patient records were in the main electronically based across the rest of the community health services for adults. We reviewed 23 sets of electronic patient records. Each professional had recorded their entries appropriately; documentation was accurate, complete, legible and up to date. There was a plan of care for each patient.
- All the records we reviewed contained the necessary information, such as risk assessments, to allow staff to carry out their required clinical activities. Staff told us: "It is very helpful to my patients to be able to share information about their condition wherever you are based in the community."
- There were no care plans in the electronic records for the chronic obstructive pulmonary disease (COPD) service. However, there were patient self-management plans, which demonstrated the care and support identified by the patient and the COPD specialist nurses to help the patient to self-manage their condition. The specialist nurse told us there was a problem with accessing the electronic records system due to connectivity issues when in the community. This could impact on the information available about patients on the COPD caseload. COPD is the name for a collection of lung diseases, including chronic bronchitis, emphysema and chronic obstructive airways disease.
- Case records for the adult brain injury service were paper-based. We reviewed seven case records for this service. All notes were complete, accurate and legible and included outcome measures around people's care and indicated where consent had been given for treatment. However, feedback from community rehabilitation teams was not evident despite referrals having been made.
- Some teams could not provide evidence of record audits to provide assurance of how they monitored the quality of their record-keeping.

Requires improvement

Are services safe?

Cleanliness, infection control and hygiene

- No methicillin resistant staphylococcus aureus (MRSA) or clostridium difficile related infections had occurred across the services in the last 12 months.
- Staff showed us how they accessed trust policies from the trust policy database. We saw the policies for infection control and hand hygiene had current review dates for 31 December 2016.
- Staff had access to appropriate personal protective equipment, such as gloves and aprons, and used hand hygiene techniques. We saw the majority of staff in a variety of community settings using good hand washing and use of hand gel practices when caring for people.
- Patients told us staff washed their hands regularly.
- The Podiatry service used an external company to decontaminate instruments. There was evidence of quality control checks and regular quality audits to minimise the risk of cross contamination.
- The clinic rooms, hospital corridors, wards and treatment areas we visited were visibly clean and free from clutter and bad odours.
- All staff had attended infection control training either as part of staff induction or as part of their on-going mandatory training.

Mandatory training

- Staff received mandatory training in a variety of subjects, including manual handling, fire, infection control and safeguarding. The levels of completion of mandatory training varied across the community health services for adults. For example, 99% had completed training in fire safety, 87% had completed basic life support training and only 50% had completed training in safeguarding children. Overall, the community health services for adults achieved the trust target of 85% completion in 16 out of 18 subjects.
- Many of the individual departments we visited were able to demonstrate that they were achieving 90% plus compliance.

Assessing and responding to patient risk

- In patient records there was evidence of risk assessments being completed, relating to issues around safety or the patients' general living environment. Risk assessments for venous thromboembolism, pressure ulcers, nutritional needs, falls and infection control risks were conducted by the community teams.
- The integrated care teams, both nursing and therapy staff, were not always able to see every patient due to staffing and time pressures. In order to ensure that urgent patients were seen, the staff told us they had worked overtime or delayed non-urgent patients to the caseload for the next day. The staff had access to a priority caseload tool, which identified how to prioritise different clinical conditions. Staff we spoke with in a number of teams told us that the tool did not adequately account for the complexity of the patients to be seen and that further work was required to make the tool more robust.
- Patients and their families were advised that if they became unwell or their condition suddenly deteriorated to contact their GP or to attend the emergency services department. Staff could articulate what to do if a patient deteriorated and were aware of the escalation processes for senior manager support and what they would do in an emergency.
- The Acquired Brain Injury (ABI) service undertook a range of risk assessments with patients and would aim to see patients in an environment that was safe for the patient and the member of staff. The first visit to a patient was undertaken by two staff members to ensure staff safety, which was in line with the lone worker policy.
- Where required, for example, for patients with complex or long-term conditions, the ABI team would forward the completed risk assessments, with a full screening assessment, to the patient's GP and social worker to enable a plan for the future care of the patient to be agreed.
- The tissue viability service undertook risk assessments to support the planning of patients care. For example, they assessed nutrition and hydration and pressure ulcer risk.
- There were delays of up to five months in the non-urgent review of venous flow conditions clinic. The tissue viability nurse expressed concerns about the length of the delays but said every attempt was made to ensure patients who were at risk were seen at the earliest opportunity.
- The podiatry service carried out nail surgery for certain clinical conditions. Clear processes were completed, such as the World Health Organization surgical safety

checklist and local anaesthetic batch number checking for minor surgery. Information leaflets and advice on what to do if a patient felt unwell after a procedure were also available.
- The MSK service had clear injection checklists to follow when doing joint injections. Records confirmed that staff were compliant with this.

Staffing levels and caseload

- The trust had taken steps to monitor staffing and capacity in the integrated teams .However we found the vacancy rate for community nurses was 7%.
- We looked at vacancies across all the teams and found staff vacancies across three of the community teams.
- Records showed and staff confirmed that the north team had 14.6 whole time equivalent (wte) members in the team out of 18.2 wte. We asked the trust to provide us with assurance as to the provision of safe staffing levels and skill mix for the teams. Senior managers told us they had appointed to several temporary posts using winter pressure monies and that they had to move staff from their own areas to support staff in other teams.
- Staff in other areas confirmed that they had to move to other areas to support staff shortages in their teams. Nurses worked overtime on a regular basis in one of the teams we visited. Staff told us they were always reprioritising and the lack of senior staff meant that junior staff were being asked to see more complex patients.
- The service used its own tool to determine nursing caseloads but this did not take into account the acuity (the level of severity of illness or level of need) and complexity of patients.
- We requested further information from the trust regarding the nursing caseload tool and prioritisation of patients. We found that there were criteria for prioritising patients but it was not clear how staff assessed level of risk (for example, red, amber or green) as there was no formal assessment framework or metrics. Senior managers confirmed that further work was needed to make the caseload tool robust. The trust reported that each of the clinical leads reported acuity to the team managers, which was then escalated to the locality senior leadership team. However, not all staff we spoke with were aware of the process and did not fully understand the system.
- Following our visit we received confirmation of measures taken by the service to provide support for staffing levels and ensure the appropriate skill mix.
- The tissue viability service was staffed by a band 7 and a band 6 nurse and also a band three support worker. An agency nurse was supporting the service to try to reduce delays.
- The heart failure service was staffed by two band 7 nurses and one band 6. The two band 7 nurses were nurse practitioners, who undertook clinical examinations and non-medical prescribing. There was a vacant post in the service. This had been changed into a development post to attract more applications. The staff told us they were managing the demand of the current service by assessing the more urgent patients first.

Managing anticipated risks

- Policies and procedures were in place for maintaining staff safety when they were working alone. If they had concerns regarding any of the areas they were visiting overnight, staff would visit in pairs to ensure their safety. The staff had mobile phones to maintain communication and the service was in the process of implementing the introduction of mobile tablet devices.
- Staff were able to use the electronic records system to flag alerts if a patient had specific risks or had a history of being abusive to staff.

Major incident awareness and training

- The physical health service was included in the emergency planning and business continuity planning arrangements at the trust. This meant they had a significant role to play in the event of unexpected incidents and emergencies occurring.
- Staff in clinical and therapy services – for example, physiotherapists, occupational therapists, care support staff nurses and specialist nurses – were aware of the emergency arrangements in place within their teams.
- Staff at various locations – for example, the 1829 building used by the early supported discharge for stroke and therapy services – told us they attended emergency planning training every two years as part of their mandatory training requirements.
- We saw evidence of weather warnings distributed to individual teams for action and escalation in line with trust policies.

Requires improvement

Are services safe?

- Staff were able to report how they managed a recent flooding incident in one the centres and what systems had been in place to manage the incident.

Good

Are services effective?

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

Summary

Care and treatment was evidence-based and was provided in line with best practice guidance. Both the podiatry and continence services were able to show clear evidence of benchmarking themselves against national standards and the podiatry service was taking steps to ensure that they carried out a service redesign in order to ensure compliance with NICE Guidance (CG10 foot health for type 2 diabetes).

The implementation of the integrated therapy service promoted multidisciplinary and multiprofessional approach to therapies, which enabled patients and families to avoid duplication of services and receive therapy support nearer to their homes. Staff worked together to make multidisciplinary decisions for the next steps in joint care planning, based on discussion, evaluation of outcomes and patients' own goals.

Nursing staff had recently reviewed care bundles to ensure that best practice was being followed for pressure ulcer care and catheter care. A bundle is a selected set of elements of care that, when implemented as a group, have an effect on outcomes beyond implementing the individual elements alone.

Evidence based care and treatment

- Patients received care according to national guidelines. Clinical audits included monitoring of National Institute for Health and Care Excellence (NICE) and other professional guidelines. There was a clinical governance system in place and findings from clinical audits were reviewed at all levels of the trust.
- We saw relevant NICE guidance was in place across the community services – for example, in relation to stroke, heart failure and specific physiotherapy treatments (shoulder impingement). A physiotherapist spoke with confidence about the national guidance and how it had helped to support and inform the development of teaching packages for physiotherapists.
- Bi-monthly safety metric audits were completed by the community teams to assess if set clinical care bundles were being followed – for example, for skin care, catheter care and pressure area care.

Pain relief

- The community pain service was provided by a multidisciplinary team including an advanced spinal practitioner, a community mental health nurse, a consultant pain specialist and other health care practitioners, including a pharmacist and dietician. The service used a range of national audit tools to assess patients' pain – for example, a pain tool and depression score. Patients were supported to attend an active life programme following an initial assessment of their clinical condition.
- Pain relief was reviewed regularly for efficacy and changes were made as appropriate to meet the needs of individual patients.

Nutrition and hydration

- Patients who were at risk of developing pressure ulcers and attended the tissue viability service were assessed by the specialist nurse and their nutrition and hydration status were incorporated into their risk assessment and included in their care plan.
- Risk assessments were also carried out by the community nursing staff to identify those at risk of malnutrition or dehydration.

Technology and telemedicine

- There were on-going issues with patient and staff information computer systems. This was across the organisation and impacted on care services. The choose and book service had experienced problems with the booking system, which had resulted in complaints from service users and had contributed to the delays in patients accessing the musculoskeletal service. The team leader had raised this as a concern through the incident reporting process.
- One patient who was receiving care and support from the chronic obstructive pulmonary disease service was using assistive technology (tele health) in their home. The patient was managed by a "Hub" who oversaw the service and alerts were sent to them if the patient's physical recordings were outside of their normal parameters.

Good

Are services effective?

- We observed the use of a system in administration offices to ensure that telephone calls were given a priority to stop people from having to wait for a phone to be answered.

Patient outcomes

- The chronic obstructive pulmonary disease (COPD) service had key performance indicators for the number of patients discharged from the service and the number of patients involved in the quality of care they received. The COPD specialist nurse had developed a self-management plan for the service, which was monitored at each home visit. A respiratory dashboard was completed every six months through the respiratory network, which had been set up18 months ago to provide a co-ordinated service for COPD patients.
- Staff in the tissue viability service said they had no key performance indicators to monitor the quality of the service and people's outcomes. The community pain service had a key performance indicator for the number of referrals to the service and had achieved 95% of their target within nine months of establishing the service.
- The heart failure service monitored their own service through patient questionnaires, exercise tolerance tests and non-medical prescribing. The service had also developed an "end of life" pathway for heart failure patients. The nurse practitioner told us that many of their patients would prefer to see the heart failure nurses than go to their GP and the GPs had agreed with this.
- To improve patient outcomes, the podiatry service had reviewed 21 diabetes screening assessment forms for diabetes patients to streamline care and ensure that the most effective care and outcomes were achieved.
- The podiatry service had implemented rapid access clinics to ensure patients were on the appropriate pathways.

Competent staff

- Staff told us they received an annual appraisal, clinical supervision (every six weeks) and were meeting their mandatory training requirements.
- Data provided by the trust showed a variable picture relating to staff who had received an appraisal in the last twelve months. In some areas this was 100% while in others it was as low as 27% in one integrated community team. The use of appraisals is important to ensure that staff have the opportunity to discuss their development needs or support required to help them carry out their job role.
- Staff in the cardiac rehabilitation (CR) service were able to support patients who required a specific programme of rehabilitation based on their clinical condition following a period of in-depth assessment. The CR team of specialists, nurses, physiotherapists and exercise physiologists were skilled in providing exercise programmes, education and symptom control and lifestyle advice.
- Community matrons had advanced clinical skills to support care in the home to maximise patients' health and reduce the risk of ill health. They used a case management approach to anticipate, coordinate and join up health and social care.
- Patients and their relatives told us they were cared for by caring staff who were confident and well trained to undertake their roles. One patient said, "The expertise of the heart failure staff is excellent and I always know I can ask them about my condition".

Multi-disciplinary working and coordinated care pathways

- Monthly multidisciplinary team (MDT) meetings were held across the various services. The integrated community teams held MDT meetings with each GP practice to discuss complex patients requiring input from all disciplines. We considered this to be good practice. Staff told us the integrated teams approach was working well for both patients and the teams as they were able to routinely complete joint case reviews and not just in an emergency, which improved patient outcomes.
- Relatives told us the acquired brain injury (ABI) service provided an excellent multidisciplinary and multi-agency service to patients who had suffered an ABI as an adult over 18.
- We observed a multidisciplinary team meeting for the ABI service attended by the lead manager, clinical lead, vocational occupational therapists, neuropsychologists, case manager and administrative support. The meetings were held weekly and a review of all the patients on the ABI caseload was undertaken.

Good

Are services effective?

- The staff were able to outline joint working between the mental health teams, GP practices and smoking cessation services to provide service users with information on stopping smoking and how to review any circulation issues.

Referral, transfer, discharge and transition

- The early supported discharge (ESD) service for stroke patients ensured an effective discharge from hospital by providing a coordinated programme of home-based personal care, intensive physiotherapy and occupational therapy. Patients were referred from the hospital and an assessment was undertaken by the ESD team. Following the assessment and discharge to home there was a period of up to six weeks' intensive physical therapy and support. We were shown a letter from a patient which said "throughout the ESD programme, professionals have stressed positively the likelihood of post- stroke recovery and the opportunity for me and my partner to take an active role in planning activities and goals. This sense of partnership between patient and therapist, with the patient as an active player in rehabilitation design, is a major benefit in terms of promoting the success of home-based rehabilitation".
- The care coordinator in the community teams was able to arrange visits for multidisciplinary professionals to reduce the need for repeated assessments, improving patients' experience.
- Patients were referred via the single point of access service.

Access to information

- We saw examples of where patients moved between services and teams – for example, patients with COPD – but information did not always support their care in a timely way. There were examples of where the electronic patient record management system was unable to link across all the trust's community services. This was a particular problem for the COPD service where poor connectivity limited the specialist nurse's ability to review a patient's self-management plans in the patient's home.
- Access to information about mandatory training was also a problem. We saw that staff in the cardiac rehabilitation service had reported their concerns about limited access to electronic data concerning staff attendance at mandatory training sessions. Records showed that the IT department were planning to provide the service with separate laptop computers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in the West physical health services obtained consent from patients (verbal, implied and written) whenever it was possible to do so. When seeking consent, we observed staff spending time with patients and using terminology the person could understand when explaining what they were going to do.
- In the 23 case records we reviewed, we saw examples of where patients had given consent for treatment. For example, injection therapy in the musculoskeletal physiotherapy clinic, healthcare assessments in the ABI service and treatment of pressure ulcers in the tissue viability service. A patient told us the specialist nurse spent time with them to ensure that they understood the procedure that was about to be undertaken and were happy to give their consent.
- We spoke with staff about their understanding of consent in relation to the Mental Capacity Act (MCA) 2005, particularly people who had a diagnosis of dementia and the use of the best interest checklist. Staff had a basic understanding of the MCA 2005 and had completed basic level training through induction and eLearning programmes.
- We found evidence of staff obtaining consent for photography of wounds to be part of the electronic record.

Good

Are services caring?

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

Summary

Patients and their families were cared for by staff who were kind and compassionate and who ensured that privacy and dignity needs were met. Patients were involved in the assessment, planning and delivery of their care and were kept informed of changes and developments by members of the multidisciplinary team.

People were encouraged to self-care and were supported to achieve their full potential. Feedback from people who used the service, their families and stakeholders was continually positive about the way staff treated people. Patients and families said that staff went the extra mile and the care they received exceeded their expectations.

Compassionate care

- We spoke with 21 patients and six carers and they all told us that staff were caring and that staff treated them with dignity and respect. We observed staff interactions with people and their families as being friendly and welcoming. Staff went out of their way to be sensitive; they were intuitive and developed trusting relationships with the person and their family.
- We observed a patient and their carer being supported by the COPD specialist nurse who needed to undertake a physical examination of the person in their own home. The patient was listened to and treated with respect during the procedure. The person told us they were "confident" in the service and knew how to contact the specialist nurse and how to make a complaint if they had any concerns about the service.
- We observed a patient whose first language was not English receiving treatment. The therapy assistant had arranged for the patient to meet an interpreter before the treatment session to enable the person to understand what was going to happen to them.
- A patient attending a tissue viability clinic was very anxious about the swelling and pain they were experiencing in their leg. The specialist nurse treated them with great kindness and helped to relieve the patient's anxiety by answering their questions and giving them information about the procedure they were about to undergo. The patient's privacy and dignity was respected throughout the procedure by the specialist nurse ensuring the curtain was drawn to protect the patient's dignity. Following the procedure, the patient was given an explanation about the expected outcomes and how to manage their clinical condition before returning to the clinic for a further review. The patient said: "I feel much happier now and know how to manage my condition in the future".

Understanding and involvement of patients and those close to them

- We observed a member of the booking team advising people on the telephone about the choices of treatment available to them through the booking service at the trust. We observed four telephone calls undertaken by the same member of staff. The staff member was kind and patient and provided information to each person in a manner that enabled the person on the telephone to understand the choices that were available to them and to be involved in planning their own care by making appointments that were convenient to them.
- A patient receiving specialist tissue viability treatment discussed the options for their care with the specialist nurse and the plan of care was agreed and recorded on their care plan. Their relative was also provided with supporting information.
- A patient who attended the early supported discharge service for stroke showed us a letter that said "at all times, the service was delivered in order to meet my rehabilitation goals, and I was encouraged to state what my rehabilitation objectives were."

Emotional support

- Families who had received emotional support from the acquired brain injury (ABI) service wrote in glowing terms about the service. One person said, "excellent explanations about the service and the ongoing emotional support to the family has been wonderful. As a family it has helped us to come to terms with the changes in our lives". Another person said: "the service staff have always been polite and responsive and helped us to feel involved and have provided us with support".

Good

Are services caring?

- With regard to the heart failure service, one patient said: “I know that without their help and kindness I could not have coped well with my illness and I will always be grateful for that”. Another patient said: “the service has been a considerable comfort to me as I know I can contact them if I need to”.

Promotion of self-care

- We observed a patient receiving treatment from a physiotherapist in the inpatient therapy ward. The patient was supported to walk using a walking aid and the physiotherapist was kind and supportive but continued to encourage the person to self- care.
- We observed an occupational therapist supporting a person who had sustained an acquired brain injury in planning their return to work through a phased return to work programme.
- The smoking cessation service and podiatry services were working closely together to promote self-care and provide service users with information on their condition and lifestyle management.
- Patients told us the rehabilitation team for stroke and the integrated therapy service were enabling them and their families to live full and active lives within the constraints of their clinical condition. Patients told us, “The support from the staff (ABI) is wonderful and I am able to lead a more normal and happy life”.

Good

Are services responsive to people's needs?

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

Summary

Data from the provider indicated that the services were within the national 18-week target but the services were working hard to meet the targets. There was a delay of five months in the non-urgent review of venous flow conditions clinic due to long-term sickness. Referrals from the district nursing service had been deferred for the month before our visit to help manage the delays but could have an adverse effect on patients care and treatment.

The service provided pressure relieving cushions for some service users but we found an inconsistent approach to assessment for the provision of this equipment that might cause a delay in buying a cushion and lead to deterioration in the patient's clinical condition. Following our visit, we were told that the trust had arranged for pressure relieving cushions to be provided to all patients as needed in line with clinical need and assessment.

The service did not always respond to individual needs in relation to privacy and dignity. We found that a dressing clinic had mixed sex patients attending at the same time, with no facility for private conversations and limited curtaining to ensure privacy for patients having clinical assessments.

Planning and delivering services which meet people's needs

- Due to pressure on service delivery, the podiatry service had undertaken a consultation exercise with the local commissioners to redesign the service to meet the needs of the local population.
- We found that vanguard pilots were in place, which were responsive to the changing needs of service users. A pilot model had been developed to provide physiotherapy (MSK service) in GP practices to improve access.
- A review of community services had been carried out by commissioners in 2013, which had introduced plans to bring integrated services together to encourage new ways of working that were closer to the local population.
- The service provided pressure relieving cushions for some service users but we found an inconsistent approach to assessment for the provision of this equipment that might cause a delay in buying a cushion and lead to deterioration in the patient's clinical condition. Following our visit, we were told that the trust had arranged for pressure relieving cushions to be provided to all patients as needed in line with clinical need and assessment.
- A dressing clinic we visited had mixed sex patients attending at the same time with no facility for private conversations and limited curtaining to ensure privacy for patients having clinical assessments.

Equality and diversity

- The trust provided services to people who did not have English as their first language. We spoke with two staff who described their experiences in accessing an interpreting service to help them to communicate with patients. They said it helped them to understand the patient's care needs and helped them gain consent before providing any support.
- Physical health services provided a multidisciplinary response to meeting the individual care and support needs of patients and their families. For example, a national audit of cardiac rehabilitation services identified that the cardiac rehabilitation (CR) service was enabling 86% of people in the Western Cheshire area to access cardiac rehabilitation services. This was much better than the national average of 40%. The service lead had developed services that were tailored to the needs of women. The service lead was also aware of the cultural differences relating to patients using the CR programmes. A person who did not attend group activities for cultural reasons took longer to complete the usual six-week programme as the sessions were planned so the person could attend on a one-to-one basis with the therapist.

Meeting the needs of people in vulnerable circumstances

- The hospital alcohol liaison service was based at a local hospital and people from the Cheshire area were able to access the service. The aim of the service was to provide support for people with problems associated with alcohol in a confidential and supportive environment.

Good

Are services responsive to people's needs?

- Staff could articulate examples of supporting people living with learning difficulties. The community matrons service offered specific support for patients with long-term conditions and acted as a specialist support for the community nursing teams.

Access to the right care at the right time

- Data provided by the provider indicated that the services were within the national 18-week target but the services were struggling hard to meet the targets.
- The AMAMs and MSK physiotherapy referrals were received through the choose and book (C&B) service. Four hundred referrals a week were received for both services and they were triaged by specialist physiotherapist staff. The service target was for a five-day turnaround from the date of receipt and this was being achieved. The target for AMAMs was for patient contact within 10 days from receipt of referral and for the first contact and if seen by the AMAMs service for assessment, within 20 days. At the time of our inspection, patients were waiting for five to six weeks for a MSK appointment.
- The AMAMs and MSK service had a plan to manage the delays within the next four weeks. All breaches were monitored by the MSK clinical lead and processed through the patient's choice arm of the C&B service. Extra staff had been deployed to the C&B service to enable referrals to be processed in a more timely way. On the day of our visit the C&B electronic booking system was running slowly, which was impacting on the number of bookings that could be processed. Complaints had been received from service users over the delays to people receiving their outpatient appointments.
- At the time of our inspection we noted there was also a delay of five months in the non-urgent review of venous flow conditions clinic due to long-term sickness as staff were required to cover the tissue viability dressing clinics. Some 105 patients had already received an initial assessment and had been seen at least once by the specialist nurse. Sixty patients were booked for assessments and there were nine inbound referrals. Urgent referrals were still being received from GPs. A patient for whom a referral was received on the day of our visit would not be seen for three weeks, which could impact adversely on their clinical condition. We were told that patients who were at risk were seen at the earliest opportunity. The delays in patient referrals had been reported to the service line manager, who had arranged for an agency nurse to cover staff shortages.
- Referrals to the district nursing service were being managed and records showed that in the month prior to our visit patient assessments and visits had been deferred to help manage the delays. We found that this could have an adverse effect on patients' care and treatment.
- The tissue service also held dressing clinics in community settings to enable people to access services nearer to home.
- Podiatry rapid access clinics held two emergency clinics for people at high risk – for example, through complex needs or diabetes – to ensure that people were seen in a timely manner and in line with clinical need.
- The heart failure service was linked to the local secondary care hospital. Patients remained on an emergency discharge list, which enabled them to access the service in the event of requiring emergency support. We did not see a plan for how the service was going to comply with NICE guidelines (CG108) January 2015, which requires all patients with heart failure to be seen by the service.

Learning from complaints and concerns

- The number of complaints received for the community health services for adults was low, with 18 complaints received across the services in the last 12 months. This demonstrated that patients and their families were satisfied with the level of service they received. The team leader in the choose and book service told us that they were aware of the complaint relating to waiting times for an appointment. Feedback from the complaint had been shared with the team leader and systems in the service had been reviewed to help mitigate further complaints.
- We were told about the trust complaints policy and procedures and staff were able to tell us how they would advise people using the service to make a complaint. Patients attending the MSK service at one local hospital were asked to advise reception if they had waited longer than 20 minutes to see the physiotherapist.

Good

Are services well-led?

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

Summary

The West physical health service had a wider strategic plan for delivering a whole system integrated approach to community services. We noted that individual services had implemented some innovative projects but we did not see joined up strategic operational planning for the services. There were examples of good local leadership across the individual services. However, there were a lot of staff in temporary and 'acting' roles across the integrated community teams and a lack of professional nursing and therapy leadership was commented on by staff. The lack of nursing leadership had been acknowledged by the trust as part of an incident investigation and plans had been put in place to provide more robust clinical leadership.

Staff were aware of the wider vision of the trust and could clearly articulate the six Cs (a framework for care and support for patients and staff). The majority of staff felt that they were a valued part of Cheshire Wirral Partnership NHS Foundation Trust and had no concerns about the culture within the service.

Service vision and strategy

- All staff were able to tell us about the six Cs (a framework for care and support for patients and staff) and gave us examples of where it was being used to support trust services.
- The West physical health service had a wider strategic plan in regards to delivering a whole system integrated approach to community services. We noted that individual services had implemented some innovative projects but we did not see joined up strategic operational planning for the services. For example, the implementation of new working patterns in the integrated community teams did not have an overarching project plan and the integrated teams did not have shared objectives or development plans. This had led to some confusion and anxiety in different teams.
- Staff from the smoking cessation service and health promotion services were unclear about the future of service contracts that were undergoing a re-tendering process. The uncertainty of future service provision might impact on the service's ability to ensure smooth transition or continuation of service provision.

Governance, risk management and quality measurement

- Incidents, accidents and near misses were recorded and investigated using the trust incident reporting system. Staff were aware of the incident reporting system but not all incidents were being recorded on the system in line with trust policy, particularly staffing incidents. This meant that data and information used to identify themes and trends might not have provided an accurate picture of the issues.
- Managers responsible for the running of the service undertook the root cause analysis (RCA) of incidents. We reviewed the RCA reports for two pressure ulcer incidents. Staff confirmed that lessons had been learnt from the incidents.
- Services did not have individual risk registers, although we noted that the provider had recently reviewed locality data packs which included all clinical safety metrics. There was an overarching risk register for the West physical health services division. Senior managers could articulate the process for completing the risk register and the escalation process to ensure divisional and executive level management oversight. Several staff at different levels had not seen the wider service risk register. Whilst there were systems to ensure key risks were escalated up through the trust, it was not clear how key messages were cascaded back down to staff at service level. Although some staff said there was feedback through operational and governance meetings, we did not find a clear link between local risks and the wider trust assurance processes.
- The community teams had recently reviewed a safety metrics audit, undertaken every two months by a peer team manager from another team. The audits included a review of the quality of care plans, risk assessment, and crisis/contingency plans from a sample of 10 patient records.

Good

Are services well-led?

- Monthly governance meetings were held and we saw minutes of these meetings. Audits, incidents, complaints and performance issues were discussed.
- Concerns with improving data quality had been reviewed as the trust's electronic systems were not compatible with its partner organisation and it was difficult for staff across community teams to download outcome data to support the delivery of care to patients. The service had appointed a designated person to address the issues and this had been highlighted on the divisional risk register.
- The role of lone workers across community teams had been entered on the trust risk register and the trust was in the process of purchasing tracker devices for all lone workers.

Leadership of this service

- All staff told us they were proud of the care they provided to people and felt they were supported by the trust to give high quality care. All staff knew who the chief executive and the director of nursing were but were not aware of other members of the executive team.
- At the time of inspection there were a lot of staff in temporary and 'acting' roles across the integrated community teams and a lack of professional nursing and therapy leadership was commented upon by staff. The lack of nursing leadership had been acknowledged by the provider as part of an incident investigation and plans had been put in place to provide more robust clinical leadership.
- There were examples of good local leadership across the various services. Staff spoke highly of the head of joint therapies and local heads of service and told us they were always approachable and would listen to issues and concerns raised by staff, patients and families. The senior managers told us they were part of the wider locality management structure for West physical health services and frequently liaised with other specialist leads and had regular meetings with their service director.

Culture within this service

- There was a culture of openness, team working and support across the physical health service. All staff told us about the importance of the multidisciplinary approach to the care and support of people and their families and we observed many examples of this throughout our visit. Staff were positive about the amalgamation of physical health services, although the integration process had been challenging over the last 18 months. Staff felt the service offered to patients and their families was more patient-centred and avoided duplication. We did find a small number of staff who due to the increase in referrals to their service were feeling overwhelmed and devalued.
- Staff survey results in 2014 reported 69% of staff would recommend the trust as a place to work. This was in line with the national average; 77% of staff would recommend the trust as a place to receive care. However, we were not able to see a breakdown of this information by individual teams in order to identify specific responses in relation to the community health services for adults.

Public engagement

- We were told that NHS Friends and Family Test (FFT) feedback was reported in each teams as part of a locality data pack issued on a bi monthly basis.
- We noted that individual services had received positive feedback from patients and their families through their own service questionnaires. For example, "I cannot thank you enough for showing me how to live a healthier lifestyle. You have been my guardian angel".

Staff engagement

- Staff told us they were well supported with mandatory training, clinical supervision and staff appraisals. Some staff (about half the staff we spoke with) told us that they were required to support their own professional development and often did not receive time back, particularly for courses they had attended at weekends.
- The percentage of appraisal rates ranged from the lowest at 27% to 100%. There was a lack of consistent participation in the appraisal process between the services.
- The provider had plans to implement a new shift pattern in the Autumn of 2015.
- There was a new professional nurse lead in post and the occupational therapy professional lead had been in post for some time. There was a lack of clarity about the professional lead roles; this was confirmed by senior managers. Professional leads play a key role in implementing the trust's strategy; providing leadership and promoting service innovation and improvement.

Good

Are services well-led?

Innovation, improvement and sustainability

- Staff told us they were encouraged to share ideas about service improvements and spoke positively about how they were involved in service planning. For example, the implementation of Vanguard projects to promote joined up working and person-centred care for patients who were receiving physiotherapy.
- In GP surgeries, physiotherapists were involved in developing a service user questionnaire and were involved in the roll-out of projects across other GP surgeries in West Cheshire.
- We saw examples of outstanding practice that had been recognised by the trust and national bodies, particularly around cardiac rehabilitation and the early supported discharge service for stroke patients. In 2015 the cardiac rehabilitation service had gained national accreditation for the quality of its services and the early supported discharge for stroke patients had won the trust's six Cs award for delivering an outstanding service to patients who had experienced a stroke.
- A staff member told us, "The integration of the therapy service has helped us to place the patient and their family at the centre of everything we do and has ensured we avoid duplication and give the best possible care and support we can".
- The smoking cessation service had introduced a free download "NHS quit smoking" app for patients with mobile phones that could access it.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Risks within the organisation were not always identified and those that had been identified were not always managed effectively. The service did not adequately monitor the quality of service provision to identify or manage risks in order to assure people's welfare and safety. Regulation17 (2) (a) (b) (f)