

5 Boroughs Partnership NHS Foundation Trust

RTV

Community health services for adults

Quality Report

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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)
RTV06	Warrington	Nutgrove Villa	L36 6GA
RTV06	Warrington	St Chad's Centre	L32 8RE
RTV02	St Helens Hospital	St Helens Walk in Centre	WA10 1HJ
RTV06	Warrington	St Helens Hospital	WA9 3DA
RTV06	Warrington	The Blue Bell Centre	L36 7XY
RTV06	Warrington	North Huyton Primary Care Resource Centre	L36 3TN
RTV06	Warrington	Kirkby Walk in Centre	L32 8RW
RTV06	Warrington	The Centre for Independent Living	L36 6HY
RTV06	Warrington	Lowe House Health Centre	WA10 2DJ
RTV06	Warrington	The Anita Samuels Centre	L36 9GA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs 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 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Community services for adults were delivered by staff who were committed and enthusiastic about their roles, and who felt proud to work for the trust. Staffing levels were managed and there were low levels of sickness and few vacancies.

Patient experiences were positively reported and although data was captured relating to patient outcomes, there was sometimes a lack of feedback to staff about the results of data analysis, or learning from incidents.

An new IT system was being implemented in planned phases to improve the overall experience for patients and make services more streamlined. The implementation inevitably caused some delays and reduced the number of some clinic appointments which lengthened the time taken to be seen.

Referral and discharge processes worked effectively except in one area, where the cessation of a Clinical

Assessment and Treatment service in June 2015 had lengthened the process of referral because patients had to be referred via their GP rather than being directly referred from the service.

There was a system in place to monitor mandatory training levels and staff showed us evidence that they completed training regularly. In some small teams there were deficits in the uptake of particular training such as infection control, the Mental Capacity Act, and moving and handling in specific teams. Medicines management training was also poor across district nursing teams, two of which reported that no one was up to date.

In most of the services provided, people received appointments in a timely way. Clinics were visibly clean, tidy and organised. Patients said the standard of care was good and that the staff were friendly. This was reflected by the low levels of complaints received.

Summary of findings

Background to the service

The 5 Boroughs Partnership NHS Foundation Trust provides community-based health services for adults, predominantly in the Knowsley area but extending to St Helens. Services include district nursing, continence, podiatry and orthotics, phlebotomy, physiotherapy, dietetics, tissue viability, occupational therapy and specialist equipment provision.

The Centre for Independent Living works in partnership with voluntary, council and housing organisations, providing a multi-disciplinary approach to helping patients requiring equipment. The centre also provides wheelchair and advocacy services, and disabled facilities grants, and it has a falls and wellbeing team.

The service runs walk-in centres in Huyton, Kirkby and Halewood in buildings shared with GP surgeries. Additionally, the service runs treatment rooms at five sites in Knowsley. The district nurses are split into three teams covering north, south and central areas.

Some services use sites managed by other NHS trusts but the staff working in services are employed by 5 Boroughs NHS Foundation Trust. Administration staff are based in three sites providing support for all areas.

During our inspection we visited eight clinic buildings, including two walk-in centres. We spoke with 60 patients and 67 staff. We also reviewed 18 patient care records.

Our inspection team

Our inspection team was led by:

Chair: Kevin Cleary, Medical Director

Head of Inspection: Nicholas Smith, Care Quality Commission

Team Leader: Lorraine Bolam, Care Quality Commission

The team for community health services for adults comprised of:

- Two CQC inspectors
- a district nurse
- a podiatrist
- a dietician
- an expert by experience.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

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 team inspecting this core service included two CQC Inspectors, a podiatrist, a dietician, a district nurse and an Expert by Experience; a person with personal experience of using or caring for someone who has used the type of service we were inspecting.

Summary of findings

As part of the inspection we carried out announced visits between 21 and 23 July 2015 and visited The Millennium Centre, St Helens Hospital, Nutgrove Villa, Blue Bell Lane, St Chad's Centre, The Centre for Independent Living and Lowe House Health Centre.

During the visit we held focus groups with a range of staff working within the service, such as nurses, allied health professionals, health visitors and support staff. In total, we spoke to 67 staff working in a range of disciplines such as dietetics, podiatry and walk in centres.

Additionally we spoke to 60 patients who were attending various clinics. We also reviewed 18 patient medical records.

Finally, we looked at a range of policies, procedures and other documents relating to the running of services.

What people who use the provider say

People who used adult community services told us they received excellent care. They told us that walk-in centres offered good, quick and friendly services in good locations. People accompanying patients said they were made to feel welcome.

People also told us that whilst clinical staff were caring and helpful, so were reception staff who were very obliging.

Good practice

The Centre for Independent Living provided equipment for patients in the community. There were areas for

people to try equipment before ordering as well as designated cleaning areas. There were systems in place to ensure equipment was delivered to people and training and support in place to help them use it.

Areas for improvement

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

Action the provider **SHOULD** take to improve;

The provider should;

- Improve the uptake of mandatory training where there are pockets of low compliance.

- Ensure outcomes of patient surveys and internal audit results are fed to staff within teams and used to monitor and improve services.
- Ensure all staff who may be required to offer support during major incidents are aware of their roles.
- Continue to review the incidents relating to missed insulin doses to ensure that action plans to address this are effective in reducing the risk of recurrence.

5 Boroughs Partnership NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

The locations where care was provided were visibly fit for purpose, clean and tidy. Staff were aware of current risks within their teams and these were documented, acted upon and monitored. There was a system for recording and investigating incidents. Monthly team meetings were held to ensure information was shared.

Arrangements were in place to monitor hand hygiene and clinical competency however the results of these were not routinely shared with staff which limited their learning. Equipment used by staff was visibly clean, and equipment provision was organised and delivered by the Centre for Independent Living. However, not all equipment had undergone Portable Appliance Testing recently and managers acknowledged that some equipment being used in people's homes had potentially not been checked to ensure it was working safely and effectively since 2008.

Patient records were clear and easy to understand, and the patient's consent to treatment was documented where required. Staff were aware of and responsive to identified patient risks.

Staff were aware that major incident plans existed but were not aware of what their role would be should a major incident be declared.

Overall, staff compliance with mandatory training was below the trust's target of 90%. In June 2015 87% of staff had completed core training and 84% had completed statutory training. However figures for district nursing teams showed particularly low compliance in areas like infection control training, where only 58% of the central team were up to date. Only 23% of the night team were up to date with Mental Capacity Act training. Medicines management training was poor across all district nursing teams, two of which reported that no one was up to date. The north team had the highest number of staff trained in medicine management but that was only 15% of the team

Safety performance

- The trust used the NHS Safety Thermometer to measure and record patient harm. This tool shows the frequency of pressure ulcers, falls, blood clots and catheter-related urinary infections each month. Figures for this service

Are services safe?

were collected monthly in line with national requirements. Between March 2014 and March 2015, between 95% and 100% of patients were recorded as being 'free from harm'.

- Managers were aware of risk and told us what areas of risk had been identified and placed on local risk registers. For example, the implementation of new software had reduced the availability of podiatry appointments by approximately 50% but data around this was not robust. Actions were being taken to address this and podiatry services were awaiting further feedback at the time of our inspection.

Incident reporting, learning and improvement

- The trust used an electronic system called 'Datix' for reporting incidents, concerns or near misses.
- Staff knew the procedure for reporting and were clear about what to report. They gave examples of incidents they had reported.
- District nursing teams and walk-in centre staff reported that most of the incidents they recorded related to complaints or pressure ulcers.
- We saw some evidence that lessons were learned following incidents. For example, a storage area for needles was changed after a child accessed these in a phlebotomy clinic.
- Monthly meetings were held by district nursing, podiatry and tissue viability teams where feedback from incidents was provided. For those unable to attend, minutes were circulated by email. When we asked for these, staff struggled to locate them. Those we were able to review contained limited information about findings.
- District nursing staff reported attending quarterly national network meetings where best practice could be shared.
- Team meetings at the Kirkby Walk-in Centre were held when the opportunity arose. We saw evidence of the last meeting held in July 2015. Whilst staff told us that lesson learning was shared via the management team, there was no available documentation to support this.
- The trust had a strategy in place to deal with Duty of Candour requirements. The Duty of Candour is a legal duty to inform and apologise to patients if there have been mistakes in their care that have led to significant harm.

- Managers were aware of Duty of Candour legislation but only some staff (mainly district nursing staff) providing care for patients were able to tell us what this meant. Despite this, staff were open in their approach to patients when errors were made.

Safeguarding

- Staff were familiar with safeguarding and understood their responsibilities to protect vulnerable children and adults. Staff were able to provide us with examples of recent referrals.
- The process for making safeguarding referrals was up to date and displayed in a number of locations we visited.
- We saw two examples of appropriate safeguarding referrals being made by staff.

Medicines

- The district nursing teams were involved in four incidents whereby insulin doses were missed for diabetic patients between January 2015 and July 2015. These had been correctly recorded as incidents and pharmacy leads had action plans in place to try to ensure the errors did not occur again. When further incidents occurred, the actions were reviewed. As these had only been reviewed recently we were unable to assess how successful they had been.
- Patient Group Directives (PGDs) were held by the physiotherapy service. PGDs are written instructions which allow specified healthcare professionals to supply or administer particular medicines when prescriptions are not available. We checked a sample of these and found that they were up to date and authorised appropriately.
- In the physiotherapy department at St Helens Hospital medicines were stored in a locked cupboard with the key to the cupboard stored securely in a separate location. There was documentation for people to record each time the cupboard was opened.
- At the Millennium Centre, wound dressings were stored securely. Whilst the temperature of this storage unit was monitored regularly (some wound dressings can be damaged by excessive temperatures), staff had only recently begun to record this.

Environment and equipment

- The Centre for Independent Living worked with other agencies in the voluntary, council and housing sectors to ensure patients received equipment.

Are services safe?

- Equipment for patients was stored in the Integrated Community Equipment Store (ICES), which was accessible seven days a week and was commissioned by Knowsley Council.
- Equipment included wheelchairs, hoists and mobility aids. Specialist equipment was also available including sensory devices for autistic patients and visual impaired patients.
- Some equipment was available for people to try before ordering or installation, including a bathroom with mobility aids, a stair lift and a vertical ceiling lift. There were also two rooms where wheelchair assessments using weighing scales and hoists took place.
- The Centre for Independent Living distributed wheelchairs. They provided specialist training for children requiring manual or powered wheelchairs. The information was also provided in DVD format.
- Equipment was maintained by external contractors but the trust kept their own maintenance and risk assessment records.
- Some electronic equipment such as wheelchair scales had no portable appliance testing (PAT) stickers, which would identify when it was last checked. Managers told us not all equipment had been PAT tested within the last year and details were recorded on the local risk register. This meant there was a potential that unchecked equipment may be in use in the community.
- There was a clear 'single point of access' process in place for storing, ordering and delivering equipment that worked well. Orders were prioritised for patients requiring equipment urgently. This could be done within a day if required.
- Staff delivering equipment also trained people how to use it safely. Leaflets with supporting information were also provided.
- Delivery staff worked on an 'on-call' basis out of hours.
- There was a telephone number for people to contact the ICES or district nurses for advice, should they have any queries.
- District nurses carried standard medical equipment in line with trust policy and reported that their electrical equipment underwent annual PAT to ensure it was safe to use.
- At walk-in centres we checked two utility rooms which stored refrigerated samples and medication separately. The rooms were secure which prevented unauthorised access. The fridge temperatures were checked and

recorded twice daily. An escalation process was in place for occasions when temperatures rose (which can affect the efficacy of drugs or the quality of samples). We observed similar processes at the Bluebell Centre.

- Equipment at The Kirkby Walk in Centre had been PAT tested within the last 12 months except for one suction machine. However another machine was also available which was within date.
- We found evidence in the podiatry service that disposable, single use equipment was used where appropriate and stock was rotated to ensure that older stock was used first.
- The locations we visited had adequate seating for patients waiting. In particular, the Kirkby Walk-in Centre provided a range of different seats and a pram storage area.

Quality of records

- Some patient records were held on paper but the majority were electronic.
- We reviewed 18 records which were concise and included clear instructions for staff to request patient signatures confirming their understanding of treatment plans. A list of defined and acceptable medical abbreviations was also included to maintain consistency.
- Senior staff in the ambulatory care service acknowledged that although they checked some records to ensure standards were maintained, the outcomes of these checks were not recorded. This could lead to difficulty identifying trends in the standard of record keeping amongst staff.
- Templates were used to record patient details in walk-in centres. These required details of clinical observations, clinical history, risk assessment and a plan to share with the patient. There was also a 'safety net' section where changes to plans were documented and agreed.
- Staff providing care at the Walk in Centres told us the information was shared with other relevant agencies including the patient's GP when patients provided consent to do so.

Cleanliness, infection control and hygiene

- All of the clinics we visited were visibly clean and tidy.
- The trust had an Infection Prevention and Control policy in place which was accessible to staff via the intranet.

Are services safe?

- Equipment was also visibly clean. The ICES service had a process in place to decontaminate equipment. This involved equipment being cleaned in a separate area by trained staff before being quality checked, after which it would be refurbished, repaired or condemned.
- We saw staff washing their hands between seeing patients and using gloves when required.
- Hand hygiene audits were completed by observation and recorded using a checklist. The checklist was comprehensive, covering aspects such as information displayed in clinic, swab scores for testing surfaces and staff awareness of good hygiene practice such as being 'bare below the elbows'. Scores were marked by percentage with actions for improvement also recorded. We reviewed ten records and found seven with scores of 90% or above.
- There was no process in place to ensure staff were informed of hand hygiene audit findings which limited knowledge of their performance.

Mandatory training

- Staff completed mandatory training, which was delivered either face to face or via the trust intranet system. Training included topics such as safeguarding, infection prevention and control, and basic life support. District nursing teams completed training in the Mental Capacity Act and the Six Item Cognitive Impairment Test (6CIT) which is used to screen for dementia.
- Staff used the Electronic Staff Record (ESR) system (a national system used across the NHS to track mandatory training). This recorded what training staff had been done, what was outstanding and deadlines for training.
- A 'red, amber, green' (RAG) rating system was in place showing training status, which was monitored through the trust's personal development review (PDR) process.
- The majority of staff we spoke to were up to date with mandatory training except for administration staff who were not fully up to date following an influx of new starters, and some staff in district nursing teams. The trust reported that in June 2015, 86% of staff were up to date with training against a target of 90%. Despite this, district nursing teams showed low compliance in some areas. For example, only 58% of the central team were up to date with infection control training and only 23% of the night team were up to date with mental capacity act training. Medicines management training

was poor across all district nursing teams, two of which reported that no staff were up to date. The north team produced the highest number of staff trained in medicine management, but this was still only 15% of the team.

Assessing and responding to patient risk

- District nursing staff told us there was a process in place for occasions when patients with high risk conditions did not answer the door when visited at home. The process involved making contact with the GP or next of kin as well as with local hospitals.
- Risk assessments were completed for patients attending clinics. Treatment plans incorporated these assessments. For example, a podiatry patient with neuropathy was advised to attend twice annually instead of annually so that the issue could be monitored more frequently.
- Staff knew what the process was for patients whose condition worsened in clinic and a clear process was visible on notice boards to remind staff of the emergency protocol.
- The walk-in centres had a clear pathway in place for triaging patients using an established tool called the Manchester Triage System.

Staffing levels and caseload

- District nursing staff told us that appropriate new patient referrals were never declined and any increase in patient numbers was managed by prioritising visits.
- Staff identified occasions when they felt that patients were inappropriately discharged home to receive community care, and used the trust's incident reporting system to ensure this was recorded.
- The central district nursing team reported having no vacancies. When the team was short staffed, one team would cover another. Where this was not possible, bank staff were called in to assist. Bank staff provide cover for planned and unplanned shortfalls in staffing. However, a manager told us it was difficult to source bank staff with enough experience to work alone in the community.
- A five year review of administrative and management staff had resulted in staffing adjustments and changes in responsibility. Further changes were expected but it was not possible to review the potential impact of this at the time of our inspection.

Are services safe?

Managing anticipated risks

- The trust was changing the IT system which handled patient details. The new system, called RiO, had a facility to alert staff about potential weather changes. Weather changes can cause increases in demand for care and treatment, for example chilblains in the winter, or swollen feet in the summer as well as causing difficulties reaching patients in their homes.
- Specific actions were in place for winter periods such as staff carrying shovels and blankets.
- Senior staff in ambulatory care were aware of current risks within their department which were recorded on a risk register.
- Processes were in place to take action during a staffing crisis, for example all non-essential visits could be cut back in the short-term.

- The trust Lone Worker policy was adhered to by staff which aimed to reduce the risks associated with working alone

Major incident awareness and training (only include at core service level if variation or specific concerns)

- Staff were aware that the trust had a Major Incident Plan. However, they were not able to tell us what their role would be if a major incident was declared by this trust or by another agency.
- The Centre for Independent Living had a business continuity plan in place for major incidents within that service, such as a failure in the supply chain or fire within the warehouse.

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

The care and treatment provided for patients was based on evidence and through the use of a range of care pathways. Multi-disciplinary care was being provided in a range of services by competent and caring staff. District nurses felt that working within a mental health trust had brought about closer links with specialist dementia nurses. This and close links with the later life and memory services supported their view that dementia care had improved. Patient experience surveys completed by the chronic pain service in March 2015, showed that 100% of patients surveyed reported that their needs had been met, 93% stated that they were treated with dignity and respect and 100% of patients felt that their treatment had been properly explained.

Appropriate tools were used to measure levels of pain and pain relief was offered to patients. Measures were in place for occasions when stronger pain relief was needed. Staff understood patient consent requirements and how to document these. They knew how to help patients with a learning disability to understand medical procedures such as taking blood samples.

Although data was captured relating to patient outcomes, there was often a lack of feedback to staff about the results of this and what it meant for services providing care. Consequently, managers did not consistently steer change in response to findings.

Referral and discharge processes worked effectively however it was felt that the Clinical Assessment and Treatment service being decommissioned in June 2015 had lengthened the process of referral, as patients had to go back through their GP if they needed referring to services.

Staff were able to access patient information when needed, although the process was more complex given that the trust was undergoing change to its IT system at the time of inspection. It was noted that the walk in centres could not access GP held information and there were also difficulties when services were being run from premises looked after by other providers. Some services used more than one IT

system to access information and the implementation of RiO had changed the responsibilities assigned to clinical and administration staff but there was awareness of this and actions were being taken to manage it.

Documents we saw displayed the logo of the predecessor trust. This raised concerns that the documents were not up to date and lacked professionalism.

Evidence based care and treatment

- National guidance was used to support the delivery of care to patients. For example, the continence service used Good Practice Guidelines, and other services used National Institute for Health and Care Excellence (NICE) guidelines.
- The trust worked with commissioning bodies under a payment framework called 'Commissioning for Quality and Innovation' (CQUIN). This framework enabled commissioners to financially reward providers who achieved agreed quality standards of care. Staff in the Centre for Independent Living demonstrated knowledge of the indicators they had to meet to attain this such as improved referral to treatment times. A range of data was recorded which provided information to trust executives and commissioners.
- The centre also used a 'portfolio' covering a range of services such as adult speech and language therapy, the wheelchair service and falls and wellbeing services. The portfolio was populated with details of incidents, complaints, compliments, items on the risk register and staffing sickness levels, which was reviewed at monthly meetings. This was up to date and allowed reviewers to gain an overview of the service quickly and effectively.

Pain relief

- Patients attending walk-in centres had access to pain relief if required. If patients required stronger pain relief, an ambulance was arranged.
- Standardised pain charts were used to assess the level of pain patients were experiencing and pain relief was administered in line with this. Pictorial pain charts were available for patients who had difficulty understanding the standard chart.

Are services effective?

- The Kirkby Walk-in Centre team were sourcing evidence to support their idea to introduce the pain-relieving drug Entonox into practice. This was done by recording the frequency of patients who would benefit from the drug. Staff also told us that an audit was being done to evaluate how well pain scores were recorded but the details could not be accessed by staff at the time of our visit.

Nutrition and hydration

- Dieticians ran a Community Nutrition and Dietetic service as well as a Weight Management and Nutritional Support Service for community patients.
- These services catered for people by offering support and advice and were based on the needs of the local population.
- Figures from April to July 2015 showed that approximately 75% of people accessing the Weight Management and Nutritional Support Service lost weight and felt positive about the changes they had made to their lifestyle.

Technology and telemedicine

- The Centre for Independent Living issued special mats which alerted others if pressure was placed on them. This safeguarded people living with dementia who may be at risk if walking around unsupervised.
- The Centre also provided phones which presented information in pictorial form. This was helpful for patients with cognitive impairment. Other technology was available for patients with autism or visual impairment.

Patient outcomes

- In most of the locations we visited, we found evidence that information relating to patient outcomes was collated and passed to senior staff within teams. However, we saw no evidence that this information was analysed locally or fed back to staff within the teams. If information is not fed back to staff they may be unclear about performance and the effects of their work on patient outcomes.
- The exception to this was in the continence service that monitored the number of days taken to triage a patient, the number of patients who did not attend appointments and the results of quality assessment questionnaires. However, despite staff telling us there was 100% satisfaction, no one was able to tell us how

many patients returned the questionnaire, or why some patients did not complete it at all. Small numbers of completed questionnaires may produce findings that are not representative of all service users.

- The chronic pain service completed quarterly reviews of patient experiences. Results from March 2015 showed that 82% of patients gave information about their experiences. All of them reported that their needs had been met and that their treatment had been properly explained, and 93% stated that they were treated with dignity and respect.
- Information was gathered about patient falls, including the time taken to refer them to a service and the length of time taken to be seen. The service also monitored the results of actions to help improve outcomes for patients. For example, by educating staff, the service noted an increase in confidence which in turn led to a better standard of risk assessment for patients.
- The Centre for Independent living monitored breaches in targets such as equipment provision times. For example, specialist parts may take longer to arrive. All breaches were documented and we saw action plans following analysis.

Competent staff

- Staff reported having had regular appraisals and this was evident in the records we saw. However, trust figures showed that the number of completed appraisals were still below their target of 90% with a rate of 79% in June 2015. Action was being taken to improve this by instructing managers to focus on completing appraisals within the coming month.
- A clear structure for supervision was in place. For example, supervising staff in the phlebotomy service completed regular competency assessments and were present during clinic times.
- There were opportunities for staff to develop themselves professionally and provide enhanced care for patients. For example, podiatrists requested further training in Diabetic Foot Care and nurses were given a range of different modules such as tissue viability care to choose from in order to enhance their skills.
- Nurses had a good relationship with staff in the local acute hospital trusts via a liaison nurse which meant they were able to receive specialist hospital training for tracheostomy care or wound packing to enable them to care for community patients.



Are services effective?

- Staff were given the opportunity to undertake coaching training. This began at senior level but staff told us that it had stopped before lower grade staff had the chance to complete it.
- Physiology staff felt supported by senior colleagues and saw a clear path to progress to more senior roles.
- The phlebotomy service assessed staff on a regular basis. Clinical supervision took place twice yearly and a full competency framework was completed annually for staff employed to take blood samples.
- District nursing teams used a hierarchical clinical supervision structure whereby staff supported the grade below them. Clinical supervision was also in place in the podiatry teams where the aim was to complete three formal supervision sessions annually, in addition to discussion at monthly team meetings. However, this financial year the team had not been able to do this due to service demand.
- The administration team had bi-monthly supervision and personal development reviews (PDRs) every six months. This was actively monitored by supervisors.
- Walk in centre staff rotated across three sites in Huyton, Halewood and Kirkby except for a core group of four staff at Kirkby. These four staff had Accident and Emergency backgrounds and therefore more experience of X-ray provision which was available at the Kirkby site.
- There were a number of training initiatives in place at the Kirkby Walk-in Centre. Senior staff were training in suturing and ring blocking (anaesthetising nerves in fingers or toes). Non-medical prescriber training was being provided for clinical staff of all grades, and an A&E consultant from a local hospital attended the centre each week to provide supervision and training in topics such as head injury, respiratory examination, and X-ray.
- In addition to completing mandatory training, delivery staff at the Centre for Independent Living completed risk assessment training. They were also trained to use each piece of equipment by the manufacturers. This ensured they could safely install equipment and train patients and carers in its safe use.
- Managers at the Centre for Independent Living spoke of a culture of employing staff for their potential rather than their experience, provided they met the essential criteria for their post. For example, Maths and English courses were available through the 'skills for health'

NHS programme, and apprenticeships were available at intermediate and advanced levels in areas such as driving goods vehicles or customer service. One staff member had also completed sign language training.

Multi-disciplinary working and coordinated care pathways

- We saw some evidence of multi-disciplinary working across different services, however sometimes this happened because staff were working in the same building rather than there being a documented process. For example a podiatrist liaised with nurse prescribers who worked along the same corridor in one clinic. If there was no practitioner on site, the patient was referred back to the GP instead. We saw no evidence of a clear process to enable staff to work in this way routinely.
- The weight management service formed a panel consisting of a GP, physiotherapist, occupational therapist, cognitive behavioural therapist, consultant and dietician to discuss patient referrals for surgery.
- At walk-in centres, staff liaised with colleagues at local hospitals when patients required further care. However, we saw no evidence of work between internal teams such as district nurses or podiatrists.
- Care pathways were in place in the musculoskeletal, leg ulcer and tissue viability services to support clinical staff in the delivery of correct care. For example, we reviewed a pathway document for the treatment of a condition called Shoulder Impingement Syndrome, which was up to date.
- Specialist tissue viability nurses worked with local nursing and residential home staff to enhance their knowledge of care provision for residents.
- Partnership working with tissue viability nurses enabled district nursing teams to introduce an early intervention Doppler and leg ulcer clinic, the aim of which was to improve the quality of life for relevant patients who might otherwise not have been treated until their condition was more advanced.
- We also saw internal guidelines for Doppler scanning to measure arterial flow, a pathway for treating leg ulcers and a tissue viability policy. On reviewing these documents we saw they were displaying the predecessor trust logo. This raised concerns that the documents were not up to date and lacked professionalism.



Are services effective?

- Phlebotomy staff attended departmental monthly meetings. For staff unable to attend, details were emailed to them, ensuring they were kept up to date.
- District nurses worked with designated GPs and a discharge liaison nurse was in place to assist with the discharge process. They also had close links with social services and used a single point of access approach.

Referral, transfer, discharge and transition

- A system was in place to manage patients who did not attend appointments but this was not consistent. For example, one staff member in the podiatry service told us that patients who did not attend three appointments were referred back to their GP. Conversely, podiatry staff at the Millennium Centre told us that patients who did not attend on two occasions were referred back.
- District nurses used a checklist to ensure patients were eligible for home visits. Criteria included checking whether patients were housebound, and whether they had conditions such as diabetes or required palliative care.
- District nursing teams visiting patients at home would leave a card if nobody answered the door. However, further actions were completed for high risk patients, including contact with the patient's GP, next of kin or the local hospital.
- District nursing teams planned to improve the way care was delivered to older people by streamlining processes and reducing multiple assessments.
- The phased introduction of the RiO IT system allowed some clinical staff to arrange appointments quickly and effectively, instead of patients having to wait for appointments to be processed by clerical staff. However, this increased the time taken for clinical staff to complete tasks and reduced the time available for other patients. In podiatry services this had led to a reduction in the number of patients being seen and the waiting time had extended as a result.
- A Clinical Assessment and Treatment service which had been stopped in June 2015 had allowed staff to make direct referrals to other clinical services without having to request a referral via the patient's GP. Instead, patients were being referred back to their GP, which staff felt lengthened the time taken for them to receive specialist care.
- District nurses told us that working within a mental health trust had brought about closer links with specialist dementia nurses. This and close links with the later life and memory services supported their view that dementia care had improved.

Access to information

- Systems to manage information were in place to support staff in delivering effective care and treatment; however services were undergoing a period of change with the introduction of RiO.
- The RiO system was replacing paper based patient records but staff felt the change had been stressful. Clinical staff had to enter more details onto the system than they were used to doing which reduced the number of patients they could see each day.
- The system was being rolled out to different services throughout the year in different cohorts. A number of staff were due to migrate to RiO at the end of December 2015. They felt this was an inappropriate time given the Christmas and New Year period and the potential for less support staff to be available if required. The project team were aware of this and it was included on the trust risk register.
- The systems used by walk-in centre staff did not allow access to GP medical records and this was expected to remain the case following full implementation of the RiO system. This meant staff were reliant on information provided by patients and those with them.
- Staff in wheelchair services told us they would not be migrating to the new system because it would not be compatible with other systems they used. This meant that the new system would not be in use across all services.
- Currently some services used different systems to manage appointments. Information about existing and future appointments had been transferred to RiO, but for any queries relating to previous appointments staff still had to access the other systems.
- Staff in the podiatry service told us that technical issues had led to some details being transferred to the wrong teams when moving to the RiO system. This led to administration staff having to re-allocate details to the correct teams, increasing their workload.
- Due to some services being based in locations owned by other NHS trusts, the IT infrastructure was configured

Are services effective?

slightly differently. Staff at these locations told us that they spent a lot of time trying to access system files and resolve IT issues that arose because of this. During our visit to the Millennium Centre we saw this issue occur.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had access to both a trust procedure and a trust policy which guided them through issues relating to consent, mental capacity and deprivation of liberty safeguards. The documents also provided further sources of information for staff if required.
- Staff understood the requirement for obtaining consent. When observing consultations with patients in the Kirkby Walk-in Centre we saw consent being obtained in order for a foot examination to take place.
- We also reviewed a number of medical records that evidenced that staff routinely and appropriately sought consent from patients.

Are services caring?

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

Summary

Services were provided in a caring way. People felt informed and supported by staff who were kind to them. We observed staff being courteous, compassionate and professional when dealing with patients and those with them.

Patients reported feeling encouraged by staff and were able to travel to clinics and locations easily via public transport.

Compassionate care

- Patients felt happy with all of the services provided for them. These included walk-in centres, blood test and leg ulcer clinics. They reported having excellent care and that staff were friendly, caring and helpful.
- People also told us that locations were convenient and easy to reach.
- People accompanying patients felt welcome.
- During consultations, staff were courteous, professional, organised and put patients at ease.
- During one consultation we saw staff alter the speed of conversation with a patient who had speech problems.
- In one walk in centre staff sourced a wheelchair for a patient suffering a knee injury

- We found evidence that privacy and dignity was considered and maintained when a patient collapsed in a walk in centre reception area.

Understanding and involvement of patients and those close to them

- Patients reported feeling fully informed by staff when undergoing treatment.
- Staff took time to fully discuss patient's problems during consultations in walk-in centres.

Emotional support

- During weight management consultations we observed staff actively encouraging patients.
- Patients reported that walk-in centre nurses were supportive during consultations.
- The Integrated Community Equipment store staff ensured patients received the support necessary for them to understand how to use equipment, by physically showing them in addition to supplying instructions.
- Bereavement counselling was provided for patients. One patient told us that this was an excellent service and that she felt very well looked after.

Are services responsive to people's needs?

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

Summary

The services provided were open at various times including some weekends, to ensure people could attend. District nursing teams provided out of hours cover. Walk in centres saw at least 99% of patients within 4 hours and all breaches were investigated and discussed at senior walk-in centre staff meetings. However, staff at the Kirkby walk-in centre explained that procedures were in place for when the service was under pressure which were activated at least once every week. Staff also told us that the trust was considering recruiting more staff due to increased activity following the introduction of X-ray facilities in 2013.

Some services reported that some patients were given appointments, did not attend. For example, the speech and language therapy service reported that 17% of patients did not attend.

The trust had identified on the risk register a reduction in the number of patients that could be seen due to the implementation of RiO. Staff reported that this continued to impact negatively on their activities.

Few staff reported working with ethnic minority groups in the areas where their services were provided however, staff in the continence service described working with the Polish community to ensure they were accessing services. Leaflets were not displayed in any languages other than English but staff had access to a telephone interpreter service if required.

There were a range of services for people based on their needs and equipment could be viewed and tested prior to home delivery. The equipment provision was highly praised both by patients and staff within the service.

Staff were aware of how to handle complaints however the majority of these were managed informally. Levels of complaints were low in the services we inspected.

Planning and delivering services which meet people's needs

- Some services were open outside of routine hours. For example, the walk-in centre at Kirkby opened on bank

holidays for patients to attend if required. This service included an X-ray facility, where results were processed quickly and effectively without the patient having to attend an A&E department.

- Patients attending the physiotherapy clinic at St Helen's Hospital had access to a range of services including acupuncture, pilates, pain management programmes, TENS (transcutaneous electrical nerve stimulation) classes and shoulder and lower limb rehabilitation.
- District nurses also promoted flexibility, choice and continuity of care. For example, following a request from a patient to receive specialist care at home rather than in a hospital, staff obtained specific equipment to facilitate his request. This was the first time that this particular type of care had been provided and staff worked with a specialist team to ensure this was possible. The staff also told us that palliative discharges were accommodated even at very short notice, and overtime was authorised to facilitate this if required.
- The Centre for Independent Living saw people via appointment or a 'drop-in' basis. The reception area displayed equipment that, whilst not included in service provision could be bought over the counter such as cushions and pill boxes.

Equality and diversity

- None of the locations we visited displayed leaflets in any other language except English. Many staff told us this was because there were no ethnic minority groups in the areas where clinics were held.
- Conversely, staff in the continence service described working with the Polish community to ensure they were accessing services.
- Staff across a number of services told us that translation could be arranged via 'Language Line' – a recognised interpreter service.

Meeting the needs of people in vulnerable circumstances

- A member of staff from the Centre for Independent Living was able to use sign language to communicate with deaf patients if required and had won an internal award for this.



Are services responsive to people's needs?

- Continence staff described using pictures to assist patients struggling to read to help them complete fluid charts.

Access to the right care at the right time

- The walk-in centres aimed to triage patients within 15 minutes using the Manchester Triage System, a recognised tool for triaging patients. All the patients we spoke to reported being triaged quickly.
- Funded nursing care and speech and language therapy services experienced the highest rates of patient non-attendance at appointments. The rates were 27% and 17% respectively based on a 6 month average.
- Services took steps to try to reduce the number of patients who did not attend appointments. For example, the musculoskeletal physiotherapy service asked patients to ring to book their own appointments which enabled them to choose a convenient time rather than being allocated a system generated appointment time. Staff reported that this had successfully reduced the frequency of non-attendance.
- The trust had identified on the risk register a reduction in the number of patients that could be seen due to the implementation of RiO. Staff reported that this continued to impact negatively on their activities.
- District nursing teams had a system in place allowing people to contact them at any time if required via a 'duty desk' who forwarded messages to the appropriate teams.
- Out of hours (8pm until 8am) district nurses used an on-call structure to maintain appropriate cover. Routine appointments were not undertaken. Instead certain core services were provided at weekends such as end of life care and insulin administration, and at night time; including Percutaneous Endoscopic Gastroscopy (PEG) feeding, Intravenous (IV) therapy and care for patients requiring three visits per day.
- Walk-in centre staff reported that waiting times were displayed on whiteboards in waiting areas and regularly updated. However, the boards were not updated during our visits.
- The dietetics team offered appointments on Saturdays for patients who found it difficult to attend mid-week.
- The main outcome measurement for the walk-in centres was breaches of the national four-hour waiting time

target. This was reported regularly to the commissioning body. Between April 2014 and March 2015 the trust reported that over 99% of patients were seen within 4 hours.

- The trust also monitored the waiting times for patients to be treated in walk in centres. The target for this was for patients to receive treatment within 60 minutes. The trust took between 16 and 24 minutes to provide treatment for patients between April 2014 and March 2015.
- Procedures were in place for when the service was under pressure for example, during busy periods or poor weather. At these times, care was limited to triaging and signposting patients to other services rather than providing treatment. Staff told us that this happened at least once weekly. In the longer term, the trust was considering recruiting more staff due to increased activity following the introduction of X-ray facilities in 2013.
- Referral to treatment times were mostly within target except that not enough patients received wheelchairs within 18 weeks (90% of patients rather than the trust's target of 95% in May 2015).

Learning from complaints and concerns

- Staff were trained to handle complaints and were able to explain the process. Complaints were dealt with informally where possible.
- The physiology department displayed a noticeboard inviting comments about the service.
- We saw monthly team meeting agendas where compliments and complaints were itemised in order for outcomes to be shared with staff but it was not clear how detailed this information was.
- The wheelchair service gave examples of identified outcomes from complaints where practice was changed. For example, the method for notifying the service when stock arrived was changed to encompass a wider range of staff. This promoted collective responsibility rather than relying on one individual.
- District nurses reported receiving complaints when home visits were declined. They worked with the local hospital to educate about referral criteria and reiterate their role as a service for housebound patients. Complaints were also discussed at monthly team meetings.
- We tracked the process of one complaint which showed evidence of being investigated appropriately. The

Are services responsive to people's needs?

complaint was not upheld by the trust but this outcome had not been recorded. A second complaint was reviewed and we found that all details, including action and the staff member responsible for the action were complete.

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

Services had a clear vision and strategy that was visible during the inspection. Members of the executive team had a presence amongst staff and engaged with them to seek ideas for change. Different services engaged with the public to educate them about what was available.

There were competency frameworks in place for staff in some services but not uniformly across all areas.

Most staff were happy at work despite changes to working practice. IT systems were being replaced which was stressful. Some staff had been affected by administration and management re-structures and felt they had faced challenges, some of which they were still experiencing.

Service vision and strategy

- We saw the trust's vision and values were visible on posters and computer screens in the clinics we visited.
- Staff told us the trust's chief executive made email contact with them to ask for ideas to improve services, and that action was taken to adopt these where appropriate.
- District nurses had an awareness of the 'six Cs'. This is an NHS strategy promoting core values such as compassion, communication and courage. At the time of our inspection it was being incorporated into the trust's recruitment strategy.

Governance, risk management and quality measurement

- The service used a register to record risks which described potential risks to service delivery, what control the trust had in managing the risk, any actions taken, and progress in reducing the risk. Risks could be escalated to the trust's overarching risk register if required.
- The quality of care provision was captured through the use of 'Team Quality Assessments'. The assessments covered 16 different standards for issues such as consent, safeguarding and the care and welfare of

patients. Whilst one manager we spoke to completed these questionnaires, she did not receive feedback unless issues arose, and neither did staff working in her team.

- The phlebotomy team used a Competency Framework to assess staff responsible for taking blood. It covered elements of care such as patient identification, disposal of used needles and explanation of the procedure. The framework used tick boxes and open questions to capture answers. However, despite the framework being useful a manager told us it had only been shared amongst blood taking staff and not in the wider trust.

Leadership of this service

- The staff we spoke to were familiar with and knew who their chief executive was. Staff in the Speech and Language Therapy service said the trust was 'fabulous'.
- Staff in the phlebotomy service told us that members of the board completed 'walkabouts' in clinic every few months. However, staff at other locations reported never being visited by board members.
- Staff felt supported, that there was an open door policy and that managers were visible for all.

Culture within this service

- Most of the staff we spoke to were happy in their roles and passionate about the care they provided.
- Some staff described a lot of change in managerial and clerical structures and felt they had not always been fully informed about the reasons for change.
- Staff described feeling that community services were seen as 'supplementary' to what was predominantly a mental health trust although others acknowledged this had improved over time.
- Measures were taken to protect the safety of staff who worked alone. The trust used a buddy system, diaries, mobile phones and panic alarms to help keep staff safe. A code phrase could be used if required.
- Administrative staff displayed a motivational attitude demonstrated by the processes they introduced. For example they generated a daily tasks checklist and quick reference guides for other staff.

Are services well-led?

Public engagement

- The wheelchair service team attended local events such as a campaign for 'right chair, right time, right now', which allowed them to promote their presence in the community.
- They also facilitated a user group which allowed people using the service to have more input.
- A number of service user and carer forums were organised by the trust, one of which was relevant to adults. Senior managers attended these meetings where people were able to share their views about services.

Staff engagement

- The trust recognised staff achievements and gave monthly awards for team, and employee of the month. They also gave annual awards such as a 'team of the

year 2015' award for the falls and wellbeing team in recognition of integrated working. We saw that the award had also been given to a walk in centre and a district nursing team.

- Staff described an initiative called 'afternoon with the chief executive' where the chief executive was available online for them to put suggestions to him.
- Staff working on the project to implement the new RiO system told us that they sought feedback from staff regarding the RiO system and fed outcomes back to them if issues were raised.

Innovation, improvement and sustainability

- Staff in wheelchair services said they were encouraged to 'strive for excellence' and were in the process of developing an 'app' which used barcode technology to produce details about the piece of equipment being used by service users.