

Lancashire Care NHS Foundation Trust

RW5

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)
RW5RP	The Minerva Centre	Diabetes, dietetic, podiatry, tissue viability, rheumatology, and phlebotomy clinics	PR1 6SB
RW5RG	Barbara Castle Way Health Centre	Treatment room services and podiatry clinic.	BB2 1AX
RW5NN	Ashton Health Centre	District nursing team, and podiatry clinic	PR2 1HR
RW5HQ	Sceptre Point	A range of clinics and services listed below	PR25 2TN





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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

Some staff used an electronic records system called 'ECR' where as others used a paper based system. The ECR system required more time to complete details and entries made had to be transferred to other systems which increased the risk of errors and extra work for staff. Incorrect entries made on the ECR system could not be amended by the author and had to be amended by the information technology staff which complicated the process and could explain why trust figures for reporting documentation issues was high. Staff used computerised 'tablets' enabling them to source or store information when visiting patients which although useful and speeded up processes when connectivity was poor patient visit lists could not always be accessed. This issue had been added to the trust's risk register which showed it had been identified as problem.

Staffing levels were managed with low levels of sickness and few vacancies however, the managers had not taken a systematic approach to quantify the staffing levels and acuity of caseloads and neither had been reviewed for some time. Despite good practice we found that some teams had been recently reconfigured and there appeared to be limited integration. There were limitations with staffing in some areas which meant that services stopped if staff were on leave. Despite this, longer term staffing issues had been identified in some areas and recruitment plans were in place to address future challenges.

Patients with minor injuries were triaged by staff who were not clinically trained. It was noted that no staff had

advanced paediatric life support despite offering services to children over 1 year however this requirement would be dependent on the number of children seen. These concerns were raised with the trust before the inspection was completed and the trust responded with a full review of the service.

We found extended waiting times for the Chronic Fatigue Service and podiatry and there was not always good use of available space or adequate wheelchair access in clinics.

The community services for adults were delivered by staff who were committed and enthusiastic about their roles. We saw evidence that staff took the time to familiarise themselves with patients and were welcoming and helpful. They were also supportive to each other.

In most of the services provided, people received appointments in a timely way. Clinics were visibly clean, tidy and organised. People expressed that whilst sometimes they had to wait to be seen in clinic, they felt the standard of care was good and the staff were friendly. This was reflected by the low levels of complaints received.

Staff were familiar with reporting procedures despite few having reported an incident recently. Most staff were up to date with mandatory training and felt proud to work for the Trust. Records and medicines were stored correctly in most areas and audits were completed at intervals.

Summary of findings

Background to the service

Lancashire Care NHS Foundation Trust provides community-based services for adults across 145 sites for people in Lancashire. These include the provision of community nursing, and community therapy to people in their own homes such as domiciliary physiotherapy, specialist falls services, community rehabilitation, intermediate care and rapid assessment. Ambulatory care such as treatment rooms, phlebotomy, minor injuries, podiatry, dermatology, diabetes nursing and education, and care for people with respiratory disease is provided as well as specialist tissue viability nursing and a health outreach service for the homeless population and asylum seekers in Blackburn with Darwen.

The service provides more specialist services including dietetics, speech and language therapy, stroke rehabilitation, healthy lifestyles and weight management and stop smoking support. Dental services are provided but were not reviewed during this inspection.

A community equipment loans service was in place for patients. The service loaned and maintained a range of equipment such as beds, nebulisers, commodes and wheelchairs.

The services were led by two directors based within the trust. During our inspection we visited 19 clinics and the equipment storage facility. We spoke to 101 staff and 23 patients and we viewed 31 medical records.

Our inspection team

Our inspection team was led by:

Chair: Peter Molyneux, Chief Executive Officer, South West London and St George's Mental Health NHS Trust

Head of Inspection: Jenny Wilkes, Care Quality Commission

Team Leader: Lorraine Bolam, Care Quality Commission

The team included CQC inspectors and a variety of specialists: A physiotherapist, a dietician, a podiatrist and an expert by experience who had been a carer for people using services for a number of years.

Why we carried out this inspection

We inspected this core service as part of our comprehensive mental health 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?

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 visit on .

We visited a number of clinics and services which were registered under one location 'Sceptre Point'. These included, Leyland Clinic, Clayton Brook Clinic, Fulwood Clinic, The Health Port, Leyland House, Croston House, The Royal Preston Hospital, The Innovation Centre and the Darwen Health Centre.

Summary of findings

During the visit we talked with a range of staff who worked within the service, such as district nurses and allied health practitioners. We talked with people

who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services.

What people who use the provider say

All of the people we spoke to said that staff were efficient, kind and very helpful. Many of the people we spoke to said that there was nothing that could be done to improve the services they received, and that they felt well looked after. They reported that they never feel rushed during their appointments. People using the podiatry service had difficulty getting timely appointments.

People spoke about the Minerva Centre which housed a café that had been closed for some time. They were keen for this to be reinstated. Some felt this was particularly important when patients had to undergo a fasting blood test.

Good practice

The Minerva Centre displayed excellent community links with diabetes patients and strived to maintain these through education and care.

Areas for improvement

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

Safety

- The provider must review the triage process for nurse led treatment rooms (formally minor injury units)
- The provider must ensure that staff at all levels are aware of statutory duties relating to Duty of Candour legislation.
- The provider should review current district nurse staffing and caseload levels using a recognised acuity tool
- The provider should ensure that all clinics offer appropriate access for wheelchair users and that safety measures are adhered to.

Effective

- The provider must ensure that appropriate fall back systems are in place should electronic systems fail.
- The provider should ensure that electronic systems used by staff are streamlined and working in tandem with other systems

- The provider should ensure that effective line management is in place for the Health Outreach Team and that appraisals are up to date.
- The provider should review the requirement for conditions referred to Pulmonary Rehabilitation Clinics
- The provider should review the requirements for life support skills in treatment rooms and ensure staff are adequately trained to deliver care.

Responsive

- The provider should review the time taken to recruit staff
- The provider should improve the time taken to send letters to GPs following rheumatology appointments
- The provider must improve the waiting time for patients attending the Chronic Fatigue Clinic.
- The provider should consider a more uniform approach to nonattendance at clinic appointments.

Well Led

Summary of findings

- The provider should review the culture of feeling 'supplementary' to mental healthcare provision. In particular, ensure all relevant documentation reflects 'community services' rather than 'mental healthcare' where applicable.

Lancashire Care NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

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

Requires improvement 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Some staff used an electronic records system called 'ECR' where as others used a paper based system. The ECR system was in good working order but it could take 2 hours to complete ECR details and entries made on the ECR had to be transferred to other systems which increased the risk of errors. It also created extra work for staff. Incorrect entries made on the ECR system could not be amended by the author and had amended by the information technology staff which complicated the process for record completion and could explain why Trust figures for reporting documentation issues was high. Staff used computerised 'tablets' enabling them to source or store information when visiting patients which although useful and speeded up processes when connectivity was poor visiting lists could not always be accessed. This issue had been added to the trust's risk register which showed it had been identified as problem.

Across the adult community teams staffing levels were managed with low levels of sickness and few vacancies due

to recent recruitment however, managers had not taken a systematic approach to quantify the staffing levels and acuity of caseloads. Staffing level, demand and acuity requirements within district nursing teams had not been reviewed for some time. There were limitations with staffing in some areas which meant that services stopped if staff were on leave. Despite this, longer term staffing issues had been identified in some areas and recruitment plans were in place to address future challenges.

Staff were familiar with reporting procedures and there was an open, honest culture of learning, however not all staff were aware of Duty of Candour regulation requirements but they told us that they demonstrated they open in their approach to patient incidents.. We found evidence of good hand hygiene practice in both staff and patient areas. Patient records were of a good standard and stored correctly in most of the locations we visited. Medicines and clinical waste were stored correctly in most of the locations we visited and actions to rectify issues raised were taken

during the inspection. There were effective safeguarding policies in place and staff had received mandatory training. We visited minor injuries units as described on the trust website where low level urgent care could be accessed.

Safety performance

- The Trust used the NHS Safety Thermometer to record and measure patient harm. This tool, designed for the NHS, monitors the frequency of pressure ulcers, falls, blood clots and catheter related urinary infections each month. Figures for this service in the last year were analysed in relation to pressure ulcers, falls and catheter and urinary infections. At times, the number of patients acquiring pressure ulcers and suffering falls were above the national average. The service generally had below the national average number of catheter urinary tract infections.

Incident reporting, learning and improvement

- Staff were familiar with the Trust's incident reporting system (Datix) and knew how to report incidents. There was adequate access to the system in community, however many staff had not reported an incident for a long time. Whilst this could indicate that incidents were not being reported when they should be, our intelligence showed that the Trust reported incidents well.
- We were told that errors made within district nursing teams were shared with colleagues in other areas, to allow lesson learning and improvement to take place. For example, a competency framework was developed by staff following administration errors for Insulin, a drug to treat diabetes.
- Staff identified trends in incidents and took action to reduce them. For example, the Planning and Discharge Coordination Team monitored the frequency of referrals which were not made to the team when indicated. This was found to occur more frequently on a particular ward due to one staff member being unclear about the procedure. This allowed the team to rectify the issue.

Duty of Candour

- Managers were aware of the requirements of the Duty of Candour regulation however other staff were not aware. When the regulation was explained to them, they told us that they felt they were already open in their approach to patient incidents.

- Duty of Candour did not form part of the mandatory training schedule for staff.

Safeguarding

- Staff underwent mandatory safeguarding training and knew where to find information and guidance about reporting these issues. However, none of the staff we spoke to had reported a safeguarding concern recently.
- Some staff acted as 'safeguarding champions'. This was the case at the Clayton Brook Clinic where the lead offered advice to other staff.
- Some staff used electronic records but others used paper records. Only staff using the electronic records system were able to access safeguarding details remotely using a computerised 'tablet'. Measures were in place to ensure that when recording safeguarding issues, all the necessary details were obtained. The system would not allow staff to progress through the form without certain answers.

Medicines

- There were policies and procedures covering all aspects of medicine management. These were accessible to staff via the Trust's intranet system.
- Medicine management training was completed by staff where their role required it.
- Nursing staff told us that they had access to pharmacist advice if required.
- Audits were carried out on a quarterly basis to assess the safety and security of medicine handling in community and district nursing teams. These were completed by pharmacist technicians. The audits included areas for improvement. At one site we saw evidence that action had been taken as a result.
- An audit of antimicrobial use in some staff was carried out in November 2014. This showed that staff complied with Trust policy which was one of the Trust's aims in reducing the antibiotic resistance.
- Medicines were stored securely alongside records of fridge temperatures. Room temperatures were also recorded in most locations where these medicines were stored.
- Arrangements were in place to enable reporting of incidents involving medicines. We found that there was an open culture about reporting medicine errors.
- Patient Group Directives (PGD's) were used across the sites we visited. PGD's 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.

- Blank prescriptions forms were handled in accordance with national guidance. They were tracked and kept secure at all times.
- A system was in place for managing national alerts about medicines such as safety issues. Records showed that these alerts were distributed to community teams by the Trust via email and discussed during meetings. Team co-ordinators implemented any necessary actions to protect people from harm.
- In one clinic (Leyland Clinic) we found sputum and smear specimen samples in the same fridge as medicines. This is not good practice because it poses a risk of contamination. Staff told us there were no other fridges available.

Environment and equipment

- At Clayton Brook Clinic a gate was used to prevent children from accessing first floor stairs. Staff told us this gate was often left open and that young children regularly walked unsupervised in the area when mother and baby clinics were being held. We visited the community equipment storage and loan facility. This service was in the process of applying for accreditation to the 'Community Equipment Code of Practice'. It was praised by staff who said the ordering process was simple, equipment could be supplied within an hour of being requested, and was in working order. The service operated seven days per week. There was a dedicated phone line for the planning and discharge coordination team to make contact quickly.
- Staff told us that despite there being written criteria for equipment provision, there was no limit on the types of equipment that could be ordered from a catalogue. Whilst staff were trained to use all equipment in the catalogue and manufacturer instructions were provided to patients upon delivery, this raised questions about how competent staff could be in the use of a large range of equipment.
- Under some circumstances such as high value equipment purchase requests, a panel (chaired by someone outside the organisation) was involved which could slow down the process.

- Equipment was checked and appropriate Portable Appliance Tests were carried out by maintenance staff, however there was a back log of items requiring service in the community.
- The Trust had purchased special beds which could be changed into bariatric beds by the addition of extra components. This meant the patients using them did not need to be moved when parts needed replacing and only one bed was required.
- Weekly fire alarm testing was in place and staff were able to explain the local procedure should the alarm sound unexpectedly.
- Medical equipment was stored out of site and out of reach in all the locations we visited, except for Fulwood Clinic. Here we found a cupboard accessible to children with equipment relating to sexual health, tubes of lubrication, and tubs of antiseptic cream that were all out of date by several years. When we asked staff about this they said they had been unaware of the contents and would take action to ensure it was removed.[RM1]
- We checked automatic electronic defibrillators in a number of locations. These were in good working order and records showed that batteries and pads were checked daily.

Quality of records

- Some staff used an electronic records system called 'ECR' where as others used a paper based system. The ECR system was in good working order and we were told issues rarely arose. However, staff told us it could take 2 hours to complete ECR details and entries made on the ECR had to be transferred to other systems which increases the risk of errors. It also created extra work for staff.
- We were told that incorrect entries made on the ECR system could not be amended by the author. Instead, the issue had to be reported so that Information Technology staff could amend the record. This complicated the process for record completion and could explain why Trust figures for reporting documentation issues was high.
- Staff used personally issued computerised 'tablets' enabling them to source or store information when visiting patients. Staff told us these were useful and speeded up processes. However the technology did not

always work. On one occasion, patient visit lists could not be accessed. This issue had been added to the trust's risk register which showed it had been identified as problem.

- Phlebotomy staff reported that the Information Technology team made regular visits to check that new systems were working. However this was not reported by any other teams, some of whom felt they had not received adequate training. They reported building up knowledge through experience and with colleague support.
- Records were stored in people's homes or in clinics.
- We looked at 31 patient records held in clinics. These were mostly completed to a good standard. The majority were legible, signed and dated with a clear explanation of the care and medicines prescribed. However care plans were not always evident in the records we saw.
- Records were stored in line with data protection except for one location (The Health Port), where records could be seen by cleaning staff. Apart from this, storage areas for records were organised, tidy and secure. Storage of records at the Minerva Centre was excellent. All records were readily available with only one set of records lost in 6 years.
- Staff told us that samples of records were audited and were able to tell us when the next audit was due. However this was not always done regularly. In the continence clinic the audit of records had not been done for approximately 12 months. District nurses audited their records annually.
- A tracking system was used to record the movement of records across locations. This meant that the number of lost records was minimal.
- Some staff used electronic records but others used paper records. This presents a risk by having two systems complicates the process of record keeping and could lead to confusion or recording errors.

Cleanliness, infection control and hygiene

- The locations we visited were visibly clean and tidy.
- Hand hygiene instructions and alcohol gel dispensers were readily available in most clinics except for the Clayton Brook Clinic where there were no gel dispensers in the waiting area.

- Disposable cubicle curtains were used across all of the sites. In most locations these were clean and correctly dated except for the Health Port where curtains were not dated. Marking the dates on curtains helps to remind staff when to replace them.
- We found that recognised audits (Essential Steps to Safe, Clean Care) were in place to ensure that staff adhered to good hand hygiene practice.
- A healthcare assistant at the Minerva Centre told us that regular cleanliness and infection control meetings took place. Meeting notes were held on file and disseminated to other healthcare assistants.
- Clinical waste bins were clearly labelled across sites and there was evidence of weekly collection of waste.
- However in the Leyland Clinic we found an unsecured open clinical waste storage area close to where children were playing. This was highlighted to staff who then secured the area.
- We found evidence of Ebola awareness promotion in a number of locations with leaflets displayed on walls. District nursing teams had flow charts to follow if they suspected anyone as suffering with Ebola.

Mandatory training

- A mandatory staff training programme was in place across the Trust.
- This was mostly delivered via the trust's eLearning system which was internet based and therefore accessible for staff 24 hours a day.
- Trust figures showed that uptake of training in fire safety, equality and diversity, basic life support and infection control were below the trust target. However when we asked staff about their training, they were able to show us local figures which suggested most of them were up to date. They told us training was monitored and they were notified when further training was due. This demonstrated that the central monitoring system did not provide a true reflection of the levels of training.
- District nursing management told us that training was cancelled if patients required care instead. They advised that patient care commitments meant they had been unable to complete some on line training.
- We found evidence that challenges in completing training were recognised. For example the planning and discharge team had the issue identified on their local risk register.

Assessing and responding to patient risk

- Staff showed an understanding of risk and what it meant for patients and staff.
- We found evidence that risk assessments were carried out on people's homes dependent upon needs.
- District nursing teams prioritised visits based on condition and immediate needs and had their own patient risk register.
- Pressure sores were graded according to severity and this supported staff in providing appropriate care, treatment and equipment for these patients.
- Staff from the podiatry service confirmed that people with wounds or infections could be graded as high risk to ensure they were prioritised.
- Despite evidence of good practice, not all staff at the Minerva Centre were aware of procedures relating to patients who become unwell in clinic.
- The planning and discharge coordination team monitored 'adverse discharge issues'. These occurred when patients requiring district nurse care on discharge were not referred. Practical risks were also managed within the areas we inspected. Fire and risk assessments were completed in peoples' homes by district nursing teams to safeguard patients and the staff visiting them. Issues identified were communicated amongst teams.

Staffing levels and caseload

- There was no tool used to quantify the staffing levels and acuity of caseloads in nursing. Staffing level, demand and acuity requirements within district nursing teams had not been reviewed for some time. No agency staff were being used.
- Many of the staff we spoke to felt that their departments were short staffed. However staff rotas showed full complements of staff to establishment. Staff vacancy rates and staff sickness rates were low.
- District nurses told us that action was taken to maintain staffing levels but the process of recruitment could take several months.

- Nursing staff told us that they provided assessments for residents of nursing homes when required, to assist the management of pressures across the local health economy. The aim was to provide this within 28 days but this was not always possible.
- The community discharge planning co-ordinator advised that the sickness rate for this team was 'very good' at 3.6 against the trust figure of 6.9%.
- Nursing staff spoke of a national shortage of specialist community practitioners and explained that the Trust had opted to recruit staff and then provide them with this training, rather than waiting for qualified staff to apply.
- We were told that in the Buckshaw Village Surgery, there were no Community Matron cover for annual leave. This meant that if staff were on holiday, people reverted to seeing their GP or other members of the team.

Managing anticipated risks

- Additional resources had been provided to ease winter pressures or when staffing was low. For example two extra staff were sourced to assist with discharge planning and coordination and a weekend treatment room service had been implemented.
- Local managers had risk registers in place which showed that clear actions to reduce the risks were in place. For example, the planning and coordination discharge team were concerned that not all staff had received mandatory training in some areas. This was placed on the risk register with a plan to increase staffing.

Major incident awareness and training

Community staff were included in the Trust's major incident plan. The plan covered clinical response and business continuity arrangements and cited the use of community service staff to help with this..

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

Staff were patient focused and worked towards achieving good outcomes for the people they cared for and had access to and followed national guidelines. Multi-disciplinary care was being provided and links were supportive with good communication between disciplines. Roles and responsibilities were clear and management structures were in place and clearly understood. We observed good practice by teams although some had been recently merged and their integration was still embedding.

Staff were suitably qualified to perform their roles and in some areas had the opportunity to gain experience through observation and extra training which was offered to enhance skills. Others had the opportunity to lead on issues such as Dementia and Safeguarding. Most staff received timely appraisals with managers.

Evidence based care and treatment

- Staff cared for patients with a holistic approach including disciplines such as physiotherapy, continence, nursing, rheumatology and phlebotomy. We were told that meetings took place regularly to assess how effective care was.
- Clinical staff had access to and followed national guidelines.

Nutrition and hydration

- Staff across a number of disciplines (district nursing, continence, dietetics) knew when to assess patients for possible malnutrition. A nutritional screening tool was devised by the Trust which triggered further assessment using the Malnutrition Universal Screening Tool (MUST) if required. The success of this system had not yet been reviewed because it was in the process of being implemented.
- Staff in the discharge planning and coordination team had completed focused work about acting in the best interests of patients regarding nutrition and hydration needs.
- In November 2014 the trust's 'DESMOND' team, who provide education for people living with diabetes won a national award for community diabetes education.

- Specially trained dietetic staff helped people with Irritable Bowel Syndrome, and one staff member worked part time to focus on helping people manage weight problems.
- An Eating Disorders Team worked within the trust but dietetic staff told us that contact with the team was limited.

Patient outcomes

- Local audits were undertaken including environmental, infection prevention and control and pressure ulcers. Results in all were positive.
- There was limited monitoring of patient outcomes however, some patient outcomes were reviewed in relation to diabetes and weight management. However we were unable to review whether the information was used to improve services.
- The trust participated in the National Intermediate Care Audit for 2014.

Competent staff

- Staff were suitably qualified to perform their roles.
- Staff had the opportunity to enhance their knowledge through learning and observation
- Staff within the Continence Service were members of the Association for Continence Advice allowing them to access areas of knowledge and share good practice with colleagues. Time was allocated at the end of monthly team meetings for them to discuss their work with colleagues.
- Some staff underwent specialist training to become 'Dementia Champions'. This enabled them to advise their colleagues. Training was also provided for specific staff to provide them with specialist knowledge of the dietary management of Irritable Bowel Syndrome.
- Podiatry staff at the Minerva Centre benefitted from extra training, such as observation of treatment. This enabled them to give a better diagnostic service to people.
- Staff were up to date with appraisals except staff in the Health Outreach Team who advised their appraisals had lapsed after the manager left the service in June 2014.

Are services effective?

Nursing staff told us that appraisals were booked but had not yet been completed because patient care had been prioritised. Where this was a problem it was recorded on the risk register.

- Shared training with the local hospital was also in place for staff to benefit from opportunities across both trusts, often at no extra cost.

Multi-disciplinary working and coordinated care pathways

- Multi-disciplinary work was evident at the locations we visited. Staff reported that this worked well except at the Buckshaw Village surgery where communication between the teams was poor. Despite telling us that multi-disciplinary work was good, some staff were not able to recall the names of those staff from other disciplines. This raised questions about how familiar the teams were with each other.
- Rheumatology teams reported having monthly team meetings involving different disciplines and were part of a regional clinical effectiveness group. District nurses worked within Integrated Neighbourhood Teams and demonstrated links with a range of different disciplines such as GP's, occupational therapists, lymphedema teams and physiotherapists. They felt part of a multi-disciplinary team where the aim was a coordinated approach, working to care for people at home where possible.
- There were links between the Planning and Discharge Coordination Team and a local hospital trust for people being discharged from hospital. The manager shared an office with hospital staff and social services staff were situated next door which encouraged communication. Nursing staff reported having good communication links with the team and that the service implemented plans within a few hours when nurses requested crisis care for patients.
- Whilst some nursing staff reported very good links with Social Services, those in other areas advised there was poor integration.
- Nurses showed us a list of care pathways which were in place for them to use when caring for patients.
- There were communication links between the local clinics. For example staff at the Healthport reported regular contact with the Minerva Centre (which housed more specialist services) to ensure people's needs were met.

- Clinic staff described a reconfiguration within community services where two teams had merged into one. At times this caused cross boundary issues which could lead people to feeling confused about which clinics they could attend.
- In some clinics care such as dermatology had been awarded to private providers. However administrative duties still lay with the Trust. At times there appeared to be a disconnect in the running of that service. For example, when a clinician did not arrive for clinic, reception staff had no way of making enquiries and patients were sent home without being seen.

Referral, transfer, discharge and transition

- Community services staff used a central point for making referrals called the Main Access Point (MAP). This service operated 24 hours a day, seven days a week. Staff reported that the process worked quickly and effectively.
- Referrals to the MAP were made via facsimile. Whilst this automatically generated an email response confirming receipt some staff reported receiving no confirmation of receipt and felt anxious about whether referrals were always received.
- Staff from the Planning and Discharge Team spoke passionately about ensuring people being discharged had appropriate nursing care and support in Lancashire. Case managers were employed on some hospital wards which maintained good links. A process was in place for referring the patients requiring care after discharge and planning commenced at the earliest opportunity. Whilst this service only operated for people living in Lancashire, case managers were still able to assist people living further away.
- The podiatry service at the Minerva Centre provided transport for patients with limited mobility. Additionally, the service made home visits for some people if necessary.
- We were told that it took six weeks to send referral letters to GPs following rheumatology clinics. This far exceeded the expected time of 5 days; however a long term recovery plan was in place to address this.

Access to information

- In most of the clinics we visited, there were leaflets available for people to take away. These provided

Are services effective?

information about common conditions, organisations that could offer support and details about how to make a complaint. However these were mostly only provided in English.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We found evidence that staff understood patient consent and when it should be obtained.
- Staff worked under implied consent principles, except in circumstances where written consent to treatment was required. For example, for physical examination or invasive procedures such as fitting catheters.
- Evidence of consent was seen in podiatry notes.
- There were Safeguarding and Mental Capacity Champions within clinic settings. This worked well at the Clayton Brook Clinic where we saw a checklist for assessing capacity which staff carried.
- Where required, nursing staff used a template to complete details about mental capacity. They told us that best interest decisions were made in consultation with other healthcare professionals and family members. They knew who to ask if they had queries about this element of care.

Are services caring?

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

Summary

Staff provided a caring service and people told us that they felt safe and happy. Interactions between staff and people demonstrated a respectful, kind and compassionate approach. The experiences of patients impacted on staff in a positive way. They took time to interact with the people using their service and knew where to find additional support for people if required.

They were sensitive to the needs of patients who were seriously ill and recognised the impact this had on those close to them.

Compassionate care

- Whilst we did not observe consultations with patients, we spoke with patients and clinical staff separately, and observed interactions between reception staff and people using services.
- Reception staff working in clinics were familiar with peoples' circumstances and were friendly and welcoming when they arrived at clinic.
- Patients felt 'reassured' by nursing staff.
- On one occasion, we saw that staff were visibly moved by the death of a terminally ill patient. This demonstrated that they cared about this patient. This depth of feeling was evident across a number of sites and staff spoke warmly of their patients.
- Nursing staff told us it was a privilege to provide care and saw their role as vocational.

- Patients described reception staff at the Leyland Clinic as 'fantastic' and were 'very happy' with the podiatry service at the Minerva Centre.
- Staff providing specialist care for people with diabetes at the Minerva Centre had recently won an internal award for displaying compassion.

Understanding and involvement of patients and those close to them

- District nurses told us that they worked with patients and those close to them, ensuring that they understood the care being provided and how to use equipment.
- Meetings were held for patients being discharged home from hospital with a requirement for nursing care. Those close to the patient were invited to attend these meetings.
- Staff were able to tell us where they would access additional support such as language interpreters but reported this was rarely required.
- Following the death of a patient, nursing staff told us that bereavement visits were organised with those close to them.
- Reception staff addressed peoples' needs quickly and effectively with a friendly and welcoming approach.

Emotional support

- Staff provided emotional support to patients and their carers however we did not find consistently provided information for carers.
- Following the death of a patient, condolence cards were sent to those close to them.

Are services responsive to people's needs?

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

Summary

We visited minor injuries units as described on the trust website where low level urgent care could be accessed. It was found that patients were triaged by reception staff rather than clinically trained staff and not all clinical staff had received basic life support for adults and children as per Resuscitation Council (UK) guidelines which states that training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation (CPR) in Primary Care. It was noted that no staff had advanced paediatric life support despite offering services to children over 1 year however this requirement would be dependent on the number of children seen. These concerns were raised with the trust before the inspection was completed and the trust responded with a full review of the service.

In some areas such as Rheumatology, patients had access to advice within 24 hours and plans were in place to increase the availability of other services. Podiatry and Leg Ulcer patients at the Minerva Centre and Fulwood Clinic benefitted from immediate referrals where required and same day appointments were offered. However, some patients reported that they could not get appointments as often as they would like and staff confirmed the waiting list for re-assessments was long.

However the waiting time for Chronic Fatigue Service appointments was much worse than the expected 6 weeks with an average wait of 60 weeks. In a podiatry clinic at Leyland Clinic, demand for follow up appointments exceeded the number available due to a number of vacancies in recruitment. This impacted on waiting times for follow up appointments. This meant that on occasions reception staff were unable to provide follow up appointments and patients would be asked to contact the clinic to rebook at a later date. One patient reported waiting five months for a podiatry appointment. Despite this, our intelligence showed that patients were usually seen within 6 weeks which was better than the target of 18 weeks.

Missed appointments were monitored and efforts were made to limit their frequency. Cancelled appointments were dealt with proactively with efforts made to reallocate to patients waiting to be seen.

Assistance for patients from minority backgrounds varied amongst services. There was an example of excellent links with communities via one link worker, but other staff reported rarely being faced with issues of this nature.

Staff showed an awareness of people in vulnerable circumstances and gave examples of how to make care more accessible to them. Most of the locations were accessible to wheelchair users.

People had the opportunity to comment on the service they received. Complaints were dealt with primarily at local level. There was a risk that these complaints were not recorded formally.

Planning and delivering services which meet people's needs

- Evidence of planning and service delivery was found in all of the locations we visited. For example managers in the continence and district nursing services were aware of an ageing local population who were becoming less able to attend clinics, leading to increased home visits.
- Staff in the Planning and Discharge Coordination Team were due to retire. Plans were in place to recruit new staff who would gain experience prior to colleagues retiring.
- Phlebotomy staff told us that nurses were proactive, making telephone contact with managers and travelling to other clinics to assist if required. We also witnessed staff offering to work past their finish time to accommodate patients still waiting to be seen in clinic.
- We were told that plans were in place to offer a 7 day service with increased hours of working (8am until 8pm) for the Chronic Obstructive Pulmonary Disease clinic.
- An advice line was available for people to contact specialist rheumatology nurses within 24 hours. This was audited to ensure people were being contacted within the time scale and that the advice given was appropriate.
- Staff in the continence service dealt with cancellations proactively by offering the appointment to other patients.
- All of the locations we visited were wheelchair accessible. However at Clayton Brook Clinic we found

Are services responsive to people's needs?

that wheelchair access was less than ideal. Access led directly into a treatment room. This meant that staff would need to ensure the treatment room was not in use whilst being used as a thoroughfare

Equality and diversity

- Staff received training to enhance their understanding of personal, cultural, or religious beliefs.
- There was some, but not much information available for people in different languages at many clinics where staff told us most patients could speak and read English. Despite this, they knew that advice about language needs was available via the Trust intranet. One exception to this was the Fulwood Clinic who displayed posters which people could use to identify their language.
- The Minerva Centre employed a diabetes link worker to engage with Muslim and Hindu communities and there was greater evidence for engagement with the communities here. Regular contact took place in mosques, community centres, schools and health melas. Patients were encouraged to attend clinic and classes were offered using translators.
- Specialist outreach work was being done in preparation of Ramadan at the Minerva Centre, however we found further evidence that written information was limited. Here we found one leaflet giving information to people fasting during Ramadan. The leaflet was written in English despite the fact that for many people fasting this may not be their first language.
- There were visibly few leaflets available in other languages.
- We saw an example of equality in care towards a patient escorted by prison guards who staff treated with dignity and a helpful and caring nature.

Meeting the needs of people in vulnerable circumstances

- Care was provided for people in vulnerable circumstances. Staff received training in how to safeguard children and adults which was monitored.
- Staff explained how they worked in the best interests patients where necessary and consulted with those close to them.
- On one clinic (Minerva) we found that special pain assessments using pictures were available. These assessments are more suitable for some people because they are easier to understand.

- The Minerva Centre also ran a transport service to allow patients with poor mobility to attend clinic. Home visits were organised for podiatry patients to be seen at home if required.
- District nursing teams at Leyland House told us that none of their patients had disabilities that they were aware of.

Access to the right care at the right time

- We visited minor injuries units as described on the trust website where low level urgent care could be accessed. It was found that patients were triaged by reception staff rather than clinically trained staff. However clinical staff had received basic life support for adults and children as per Resuscitation Council (UK) guidelines which states that training must be in place to ensure that clinical staff can undertake cardiopulmonary resuscitation (CPR) in Primary Care.
- Podiatry and Leg Ulcer patients at the Minerva Centre and Fulwood Clinic benefitted from immediate referrals where required and same day appointments were offered. However, some patients reported that they could not get appointments as often as they would like. Podiatry staff confirmed that the waiting list for re-assessments was long. Staff in the Fulwood clinic told us that extra podiatrists had been recruited. In a podiatry clinic (Leyland Clinic), staff reported that demand for appointments exceeded the number available and that waiting times for appointments was long. This meant having to refer or turn away several patients on a daily basis. One patient reported waiting five months for a podiatry appointment. Staff were concerned that people would be forced to seek private healthcare to meet their needs. Despite this, our intelligence showed that patients were usually seen within 6 weeks which was better than the target of 18 weeks.
- Staff told us that nonattendance was monitored regularly and plans were in place to limit this. For example, reminder letters were sent to patients attending dietetic clinics. In the pulmonary rehabilitation service patient appointments were booked by telephone rather than by letter which improved the rate of non-attendance. This information was shared in monthly meetings
- Podiatry patients being discharged from care were provided with a telephone number for any concerns in the future.

Are services responsive to people's needs?

- Patients reported never feeling rushed despite knowing that staff were busy.
- Parking was available for people at all of the clinics we visited.
- In January 2015, trust data showed a significant average waiting time of 60 weeks for appointments to attend the Chronic Fatigue Service. This breached the target of 18 weeks.
- A patient attending the Health Port for a blood test had taken the day off work because services were not available out of office hours. Despite this, other patients described being pleased with services.
- The Pulmonary Rehabilitation clinics saw people living with a range of respiratory conditions such as Chronic Obstructive Pulmonary Disease and Bronchiectasis.
- We saw opportunities in a number of clinics for people to comment on their experience of services.
- Leaflets were available explaining how people could make a complaint about the service if required but these were not routinely given out. This issue was on the trust's risk register with plans to include information about complaining on general leaflets.
- Clinic reception staff often dealt with complaints at a local level. Fulwood Clinic reception staff dealt with complaints at the time by facilitating telephone contact for a patient to speak with relevant staff about their complaint. Alternatively they provided a leaflet or website address. Staff confirmed that if the issue is resolved no further action was taken. This meant that verbal complaints may not always be recorded.

Learning from complaints and concerns

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 trust values were clearly displayed and although there was no vision or strategy for Community Services for Adults, the service had adopted the SEEL quality improvement system which was a mandatory self assessment and improvement tool used across the trust. Local teams liaised well with immediate line managers and staff of other disciplines to ensure patients' needs were met. They felt supported but we found the Health Outreach Team (providing care for homeless people or those seeking asylum) operated with only remote supervision.

A tool was in place to measure quality which helped staff steer the direction of local change. However, staff felt that changes put in place across the trust had been rapid and at times difficult to deal with. Whilst some staff had seen members of the board once or twice, some had never come into contact with any of them which supported the feeling that teams and services were locally driven.

The reports from staff suggested that community services were seen as addition to the main trust focal point of mental health. As a result, they did not always feel as valued as mental health colleagues.

Service vision and strategy

- The values of the trust were clearly displayed in a number of clinics.
- There was no vision or strategy for Community Services for Adults although the service had adopted the SEEL quality improvement system.

Governance, risk management and quality measurement

- We found evidence that risks to services such as staffing issues were identified and recorded on locally held risk registers and there was a process for escalation.
- We found evidence of an internal system used to monitor quality in a number of areas including safety, effectiveness, patient experience and leadership. This

allowed areas for improvement to be identified in local teams. Information was displayed so that staff could see the results. Displays were colour coded using a traffic light system, highlighting areas for improvement.(SEEL)

- Risk to office based staff was managed well with an alert system in place across services. We tested this process and found it to be effective in summoning staff to assist. However, this could introduce risks to colleagues attending to staff who have raised the alarm.
- Loneworker policy and practices were in place.

Leadership of this service

- Staff were happy with line managers and felt supported in their roles. More senior managers were visible to staff, attending meetings regularly and disseminating information to the teams via email.
- However, when we visited the Health Outreach Team (providing care for homeless people or those seeking asylum) we found that the service operated with remote supervision.
- Some staff had never had contact with members of the board. However we were told of two occasions when they sent flowers to staff, one of which was for 'best team of the month'.
- Some staff reported a lack of senior managerial support through recent reconfigurations but had received local support from colleagues.
- Some training took place to cope with change. For example some nurses had attended training about 'roles and responsibilities'. However this was not reported across all services.

Culture within this service

- Staff we spoke to felt part of a wider team. However some staff reported feeling that community services were supplementary to mental healthcare services which were the main focal point of the trust. This was supported by the fact that documentation was geared for mental health staff and had to be amended by community service staff to reflect their roles.
- Despite this the trust made efforts to raise awareness of smaller departments (such as dietetics and smoking cessation) by hosting a 'niche services day'.

Are services well-led?

- Staff spoke about the open and honest culture of the organisation with a view to promoting good, compassionate care.
- Some staff spoke about the reconfiguration involving teams merging. This had been stressful and created challenges such as roles being downgraded. However, staff felt supported by colleagues and we saw evidence of close working relationships.
- Staff spoke of the limits for career progression. One manager reported that nursing staff had been reluctant to complete courses because it would not lead to career progression.
- We were told there was no bullying within the services and our observations supported what staff said. We saw lots of examples of positive interactions amongst staff.

Public engagement

- Regular engagement took place to encourage attendance at diabetic clinics via a link worker but this was only evident at the Minerva Centre.
- Staff ran a forum for people using the sexual health service to attend.
- We were told that patients were involved in reviewing a care pathway for Ankylosing Spondylitis.

Staff engagement

- Many of the staff we spoke to felt that the intranet was a useful form of engagement. For example there were regular podcasts and published messages from board members.
- We found that the annual appraisal system worked well and that most staff were up to date or had received dates for their appraisals. Staff reported that this was useful and gave an opportunity to address any problems.
- Staff reported that despite completing a staff survey, they had not received any findings or results from this or actions to be taken.

Innovation, improvement and sustainability

- The podiatry service showed efforts to learn and improve by facilitating a group of representatives across a number of organisations who met regularly to discuss service provision. Additionally a 'photo web' had been developed, which meant that pictures of various conditions were photographed and available for reference.
- The diabetes education service had received the 'Innovation Award' in the annual Celebrating DESMOND awards for their training model.
- The equipment and community loan storage facility seemed to run with great success, including recycling. Staff were able to source equipment quickly and effectively with few limitations.

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

Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

12(2) (c)

The triaging of patients upon arrival at nurse led clinics was not by suitably qualified staff.

Regulated activity

Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 (2) (c)

The trust used both an electronic records system and a paper based system. In the electronic system it could take 2 hours to complete ECR details. ECR entries had to be transferred to other systems increasing the risk of errors and created extra work for staff. Incorrect entries on the electronic system could not be amended by the author and had to be amended by the information technology staff which complicated the process for record completion. This could explain why Trust figures for reporting documentation issues was high. Staff used computerised 'tablets' enabling them to source or store information when visiting patients which although useful and speeded up processes when connectivity was poor visiting lists could not always be accessed. On one occasion, patient visit lists could not be accessed. This issue had been added to the trust's risk register which showed it had been identified as problem.

Regulated activity

Nursing care
Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Requirement notices

Regulation 9(1) (b)

Care and treatment did not meet service users needs as the waiting time for Chronic Fatigue Service appointments was an average of 60 weeks. In a podiatry clinic at Leyland Clinic, demand for appointments exceeded the number available and waiting times for appointments were long. This had resulted in several patients on a daily basis being referred or turned away. One patient reported waiting five months for a podiatry appointment. Despite this, our intelligence showed that patients were usually seen within 6 weeks which was better than the target of 18 weeks