Wirral Community NHS Trust

RY7

Community health services for adults

Quality Report

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

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

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

Summary of findings

Ratings

Overall rating for Community health services for adults	Good
Are Community health services for adults safe?	Requires Improvement
Are Community health services for adults effective?	Good
Are Community health services for adults caring?	Good
Are Community health services for adults responsive?	Good
Are Community health services for adults well-led?	Good

Summary of findings

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Summary of findings

Overall summary

The trust was first registered with CQC on 01 April 2011. The trust delivered a variety of community services within Wirral and some areas of Cheshire and Liverpool. It provided a range of services including nursing and therapy services as well as unplanned care, lifestyle support and primary care services.

We spoke with approximately 120 patients and their carers or relatives and 125 staff across a range of roles within the trust.

Our key findings were as follows;

Patients were safe and told us that they felt safe using the services provided by the trust. Staff said the trust had an 'open culture' where poor practice could be challenged. Although the trust had mechanisms in place to; report and record safety incidents, concerns, near misses, allegations of abuse and to audit the quality of treatment, some improvement was required to manage potentially emerging risk. There was a risk of 'less serious' incidents being under reported and trends being missed.

The trust had a strategic plan in place for integrated discharge planning with the local acute hospitals and social services. It worked with local partner providers to improve its services. This meant that services were working together to provide what people needed.

Community nursing caseloads in the trust varied in different areas. There were high levels of sickness absence in the teams with the most patients at Birkenhead and Wallasey. The trust was addressing this. Patients with complex needs were supported by community matrons but there was less effective support for young people moving from children's to adult services.

Community nursing teams, therapists and staff in clinics were well functioning, highly skilled and appropriately qualified. They followed up to date nationally agreed guidelines and procedures for treating patients and within trust policy. Patient's needs were thoroughly assessed; they were involved in their care planning and provided with the equipment they needed to support their care and independence.

Staff received the support and training they needed to carry out their role and had good professional development opportunities. Patients told us that the staff were kind and caring supporting them with their needs. They were pleased with the care and treatment provided. A lack of facilities to occupy children at the clinics however, added to the strain of attending for their own appointments.

The trust had some work to do to catch up with its own targets for checking if there were any groups of people that services might be failing to reach, such as minority ethnic groups and addressing barriers to care. Some services were working to improve access such as running clinics on Saturday mornings so that working age people could more easily attend. There were formal agreements between trusts locally to ensure that patients could access the services they needed.

Most patients did not have to wait long once they arrived for their appointments but waiting times for first and follow up appointments varied between clinics. Patients being discharged from hospitals were picked up by the community nursing service either on the same day or the next day.

The trust had a complaints procedure and collected feedback from patients in order to improve services. Patient experience cards were very visible in most clinics but some staff were not clear about the difference between a complaint and a concern. This affected the way that complaints were managed locally.

There was an annual programme of 'walk arounds' by different members of the trust board. This gave staff and patients direct access to board members. At a local level staff felt involved in developing and improving their services including achieving better value for money.

Summary of findings

Background to the service

Nursing and therapy services and lifestyle support were provided from a large purpose built health centre in Birkenhead run by the trust, Victoria Central Hospital at Wallasey and a number of local clinics carried on by the trust in medical centres and GP's practices around The Wirral. The Livewell service was also run from a shared community facility as a one stop shop on the main street in Birkenhead. Fourteen community nursing teams including community matrons, operated out of local area offices across Wirral.

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

- Community nurses including out of hours services
- Podiatrists
- Cardiac rehabilitation
- Leg ulcer care
- Wheelchair therapy
- Health and wellbeing services such as weight management and smoking cessation.
- Equipment supplies
- Physiotherapy services

Our inspection team

Our inspection team was led by:

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

Team Leader: Debbie Widdowson, Care Quality Commission

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

Why we carried out this inspection

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

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the Trust and asked other organisations to share what they knew. We also received comments from people who had attended a listening event prior to the inspection. We carried out announced visits on 2, 3 and 4 September 2014. We also visited the trust unannounced

Summary of findings

out of hours on 3 September 2014. We visited health centres, dental clinics and walk in centres. We went on home visits with district nursing, health visitors and palliative care specialist nurses. During the visits we held focus groups with a range of staff who worked within the service, including nurses, therapists and healthcare assistants. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records.

What people who use the provider say

People told us they felt safe using the services provided by the trust in the community and at clinics. They told us that staff were friendly, went out of their way to help their patients and seemed happy in their work.

Few people we asked knew about the trust complaint procedures but many said they would complain to a manager if they needed to.

Some people said they never had to wait when they arrived for clinic appointments, others said they had waited on occasions. Some people said that community nurses always arrived on time, others said they never knew what time to expect them but they usually turned up.

Some people commented on long waiting times for a first appointment at a clinic or appointments being changed at short notice by staff. Some said they had been able to refer themselves to clinics. People were generally positive about the facilities provided by the trust.

People generally felt listened to by trust staff, respected and involved in their care planning and treatment.

They commented positively on the attitude of staff and their competence and professionalism.

Good practice

There was good multi-disciplinary working in most services and the trust worked with other services to improve and innovate practice.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must review systems to report incidents across the community teams. The frequency of use of the incident reporting procedure varied and staff access to the electronic reporting system was inconsistent across the services.
- The trust must review its policies and procedures for safeguarding vulnerable adults to ensure it is fit for purpose and provides staff with clear information to support them when reporting issues.
- Different record keeping systems were in place across services while a new IT system was being rolled out. There was some time consuming duplication of records. Together these may present emerging risk of under reporting of some types of incidents and trends being missed. This must be addressed by the trust.
- The trust must review staffing levels in community teams to ensure they are safe, especially at times of high staff sickness.
- The impact of the Mental Capacity Act 2005 code of practice and Deprivation of Liberty safeguards was not well understood by most staff. This has an impact of staff ability to support patient's giving informed consent to treatment. The training that was provided should be reviewed.

Summary of findings

Action the provider SHOULD take to improve

- The effectiveness of transition arrangements for children and young people to adult services should be reviewed as community nursing staff had no confidence in current arrangements, including liaison with mental health teams.
- The trust should ensure that community nursing teams are able to monitor and articulate outcomes for patients.
- Staff were not clear about how the trust was defining the difference between a 'complaint' and a 'concern'. This affected the way issues raised by patients were dealt with locally and could result in trends being missed by the trust. The trust should review the clarity of its message about complaints.
- The trust should address the issue of no facilities being available in clinic waiting areas to occupy children. Patients told us this added to the strain of attending for their children's and their own appointments.

Wirral Community NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Requires Improvement

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

Summary

Patients were safe and told us that they felt safe using the services provided by the trust. The trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. This included the on line reporting tools, policies, procedures and clinical audits. However there was a risk of 'less serious' incidents being under reported and trends being missed.

Clinics and health centres were clean, tidy and uncluttered. Staff practiced good hand hygiene and infection prevention practice within the therapy and community nursing clinics and in patient's own homes. There were no significant concerns raised about the maintenance of the environment and general equipment.

The safeguarding vulnerable adults policy document was not fit for purpose as it was not clear enough to support staff to respond consistently. However all staff said they felt confident about speaking up if they had any concern about the welfare of a patient and this indicated the trust had an 'open culture'.

The trust was in the process of moving from a written records system to an electronic one. This meant there was some duplication of record keeping. Staff in some parts of the service, had to compete for access to computers and expressed frustration with the length of time this transition was taking.

Community nursing caseloads were 'open ended' and heavier in some parts of the trust area, such as Birkenhead, than in others. Some staff told us they did not feel safe at times, they talked to us about high sickness levels and the impact this had on the quality of patient care.

We found varying levels of understanding amongst staff with regards to deprivation of liberty safeguardings and the application of the Mental Capacity Act.

Requires Improvement

Are Community health services for adults safe?

Community nursing teams were well functioning and highly skilled. Staff in clinics were appropriately qualified and functioned well together and in their teams.

Incidents, reporting and learning

- There were 19 serious incidents reported at The Wirral Community NHS Trust between June 2013 and June 2014. A total of 18 of the 19 incidents related to a grade 3 or grade 4 pressure ulcer**.** The trust had identified that incident reporting has decreased in the last three months and the trust scored below average for the % of staff reporting errors, near misses or incidents witnessed in the 2013 NHS Staff Survey. CQC received 311 notifications via NRLS between June 2013 and June 2014. Of these, 300 were of the type 'moderate', four were for 'abuse', four were 'severe' and three were 'death'.
- Registered providers must notify CQC about a number of changes, events and incidents affecting their service or the people who use it. CQC received one notification directly in the last six months from Wirral Community NHS Trust in May 2014; this was about a change of telephone number.
- Patients that we spoke with told us that they felt safe using the services provided by the trust.
- We found that the trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. This included the on line reporting tools, policies, procedures and audits.
- Information regarding incidents were fed through to a representative of the appropriate governance team and serious reportable incidents were reported at the trust committee.
- Staff told us that managers follow up investigations, service leads' managers reviewed incidents and discussed at service lead's meetings if actions needed to be taken. Team briefings and staff meetings were used for feedback and learning from incidents so the service could improve. Staff working in one service provided us with an example of how they were involved with improving patient safety after one recent incident that we tracked through the reporting system.
- The incident reporting system allowed for the reviewing manager to make changes to assessments made by the reporter of the incident. For example, staff in ulcer clinics told us that pressure sores were downgraded if found to be unavoidable after the investigation. Staff were not entirely confident how accurately this reflected the incident.
- We found that while some managers could recall the level and nature of the incidents reported from their part of the service, others could not. Community Matrons, for example felt confident that they reacted to issues raised from the Datix reporting system and they kept on top of them.
- Some staff, including band five community nurses and clinic receptionists, were very clear about what 'an incident' was and what type of incident was their responsibility to report. Other staff were less clear. At the heart failure clinic in Victoria Central Health Centre and the Eastham clinic we found some staff indicated a reluctance to report 'problems' to managers, and a reluctance to access the computer systems that were used to report, assess and escalate incidents.
- The vast majority of the staff that we spoke with told us that they knew how to report incidents and that any member of staff was authorised to do so.
- The frequency of use of the incident reporting procedure varied. Some staff told us that they had never used the incident reporting procedure. Other staff told us that they reported incidents 'on a daily basis' and completed the Datix electronic recording system 'routinely'.
- Access to the electronic reporting system was inconsistent across the services. Staff based in clinics on trust premises told us that they had easy access to the electronic reporting system. Community nurses providing care in patient's homes told us that any incident reporting they made had to be done when they returned to their base, often at the end of a long shift of visits. They said although incident reporting was 'drilled into staff', it was not a seamless part of their working routine as it could be time consuming and they often had to compete for computer access. This meant there was a risk of 'less serious' incidents being under reported and trends being missed.
- Community nurses we spoke with confirmed they undertook regular clinical audits including of pressure ulcers and also completed the monthly safety thermometer. Clinic staff told us they received regular 'Front Line Focus Visits' where specialist staff observed the practice of clinic staff and therapists.

Requires Improvement

Are Community health services for adults safe?

Cleanliness, infection control and hygiene

- The 2013/14 quality account states that the trust had no avoidable healthcare acquired infections in their services.
- The trust had up to date infection control policies and procedures in place. The director of infection prevention and control was a member of and was responsible for the Infection prevention and control Service (IPCS) and reported directly to the chief executive officer and the board.
- There was a hand hygiene policy including one for practitioners performing healthcare in a patient's home or non-NHS premises.
- The trusts' catheter and new urinary tract infection rate for all patients and patients over 70 shows considerable fluctuation during the 12 month period between June 2013 and June 2014. However both rates were below the England Average for almost the entire period.
- Staff confirmed that they received infection team inspections and managers were required to submit quarterly reports on infection control issues.
- During our inspection we observed good hand hygiene and infection prevention practice within the therapy and community nursing clinics and by staff in patients own homes. Staff we spoke with were aware of procedures and had access to them on the trusts intranet site and paper copies.
- We saw that hand gel was available in clinics and the gym; decontamination systems were in place for vehicles; hoists were cleaned and labelled as such and there was a cleaning schedule in clinic areas.
- However we noted that no hand gel was available/ signposted at most reception areas or for use by touch screen facilities by patients and visitors. Except for at the wheelchair service, we saw no indication if wheelchairs had been cleaned between use.

Maintenance of environment and equipment

- Patients were seen in a wide variety of locations throughout the trust ranging from GP surgeries, community hospitals, the new purpose built St Catherines Health Centre, clinics and in their own homes. There were no concerns raised about the maintenance of the environment and equipment.
- All of the clinic facilities we saw were clean, well-organised and uncluttered. This meant that they could be easily cleaned.
- Some clinics held in buildings that were not controlled by the trust such the leg ulcer clinic at Whetstone Lane Medical Centre had waiting room spaces that were cramped or unsuitable environments for children visiting with patients. At the Livewell One Stop Shop, one patient expressed concern about other users of the building and people told us parts of the Catherines Health Centre, where the open plan galleried layout above ground floor, was a possible hazard for children in the waiting areas. We found that the trust had taken action to assess the atrium layout at St Catherine's and planned for additional safety measures to be put in place during September 2014.
- The trust managed safety in all of the buildings that it used and had systems of checks and audits in place. Faults could be reported by any of the trust's staff directly into the maintenance provider's electronic system and progress of managing a fault could be followed by members of the trust. The trust estates manager told us that staff use the Datix system to report any health and safety issues including near misses and potential hazards.
- We noted some faults and hazards across the locations that we visited for example; no risk assessment for staff use of hot water boiler dispensers and where a drip tray was available it was faulty. We brought these to the attention of the estates manager during the inspection. We also noted a lack of consistency with testing of portable electrical appliances across locations. The estates manager told us that the board were considering a proposal to vary the regime of testing, within the boundaries of legal requirements.

Medicines management

- We noted when we accompanied them on visits to patient's homes that community nurses performed the administration of controlled drugs through syringe driver in line with trust policy and NICE guidelines.
- Some health care assistants that we spoke with said they felt frightened when they were asked to take on the role of 'second checker' for intravenous medication in community services to people's homes.

Safeguarding

- Since registration, no safeguarding records have been raised for the trust.

Requires Improvement

Are Community health services for adults safe?

- The trust had in place policies and procedures to safeguard vulnerable adults. Those that we saw were in draft form only and we noted a lack of connectivity between the policies. The safeguarding policy document was not fit for purpose as it did not provide staff with sufficient clarity to support them to respond consistently to suspicions or allegations of abuse of vulnerable patients.
- Safeguarding adults and safeguarding children training was mandatory at level one for all trust staff as a one hour e learning course every two years. For clinical staff there was an additional level two e learning course requirement every two years. Staff that we spoke with in a range of roles confirmed they were up to date with their required safeguarding training or had updates planned for the 2014/16 training cycle.
- All of the staff that we spoke with were aware of their responsibility to report any safeguarding concerns that they had.
- We found that staff across the clinics were aware of the need to follow up non-attendance at appointments of vulnerable patients, but some, such as chiropody clinics did not have a system in place for doing this. Reception staff in St Catherine's leg ulcer clinic, told us that they knew the regular patients, noted if they had not attended or a pattern of absence had developed and raised this with the therapist to make an assessment of the risk.
- Staff told us that non-attendance at clinics could be a significant pattern for patients living in care homes locally where appointments were postponed due to shortage of staff to escort the patient to their clinic. Trust staff did not seem to be aware of a clear route through which they could raise such a pattern of risk to patient's welfare observed from the quality of other local services.
- We did see an example of where trust staff had acted to raise safeguarding alerts about two patients living in care services locally, who arrived for their appointments in a condition that raised concern.
- All staff that we spoke with told us they felt confident about reporting any concern about the welfare of a patient.

Records systems and management

- We noted the trust provided a weekly bulletin to all staff that included notice of and links to policies and procedures that had been updated or changed.
- Staff understood the important role that good record keeping played in providing safe care.
- Staff in some roles told us that there was a duplication of record keeping systems where some records were hand written and others were made electronically.
- Community nurses and health care assistants expressed frustration with the length of time the planned transition from paper to electronic records was taking.
- Training was provided to staff in using the electronic systems. Community nursing teams told us they were satisfied the training was sufficient. Some community health care assistants however, said they found SystmOne difficult to understand and did not receive the same level as training to use it as the 'qualified' staff did. This could create a risk of incidents being unreported.
- We saw electronic systems being used effectively by therapy staff at clinics, and comprehensive care plans and detailed treatment plans in place throughout the services we visited.
- Some staff delivering clinics in local GP surgeries and small health centres were duplicating records by making paper notes and then copying them into the electronic system later when they had access to it. Staff said they had been told they would be issued with electronic tablets in January 2015 to avoid this time consuming repetition of work.
- We noted in clinics that staff had printed lists of the patients that were expected and had their details and notes available.

Lone and remote working

- The trust had a policy and procedures for maintaining staff safety when they were working alone. All staff that we spoke with about it safety considered important and looked out for each other.
- Community staff carry personal alarms and none of the staff that we spoke with raised any concerns about the arrangements for their safety at work. A GPS tracking system was planned but as yet there was no date for its implementation.
- We saw security staff present in trust buildings in the evenings.

Assessing and responding to patient risk

- Staff in podiatry clinics told us that the waiting time for appointments had increased by 100% and there was an

Are Community health services for adults safe?

increase in the number of patients who did not attend for booked appointments, since new commissioning arrangements were put in place. They saw this as a risk to patients.

- We found that equipment patients needed to manage their conditions and support their independence was delivered to them promptly by the trust. Community nursing staff had access to controlled drugs for night service when necessary and staff did not have to wait for dressings and products they needed for treating pressure ulcers.

Staffing levels and caseload

- The trust had fourteen community nursing teams and fourteen whole time equivalent community matrons in post across Wirral.
- Community matrons did not manage other staff but held a case load of patients at high risk with multiple, complex and deteriorating conditions. They could prescribe medication which took some pressure off GP's and they saw their role as preventing people being admitted to hospital. They said they worked closely with the local acute hospital trust to manage the discharge of patients effectively and coordinate their care.
- We were told they covered a large demographic area and were 'thin on the ground' in the Birkenhead area which was an area of higher social deprivation and ill health than other parts of the Wirral.
- Community matrons told us that staffing deficits were reported through the Datix system and the director of nursing reacted to those reports and regularly asked for feedback on staffing level management plans.
- Community nurses told us that their rosters were planned with the skill mix and experience of each staff member in mind. Band 2 health care assistants (HCA's) had been further developed within their role and they did 'a lot of band 3 type work'. They said there were only a few staff employed at band 4 level as this post required foundation degree qualification. They told us that all HCA's had national vocational qualifications at level 2 or 3 but there was no further career progression available to them and this caused some frustration. Staff believed that band 2 workers carrying out band 3 tasks presented a risk to patient and staff safety and that sickness absence had a big impact on the tasks being taken on by HCA's. However, the only example of this that we heard was about HCA's being asked to take on the role of 'second checker' for intravenous medication, as this made them feel nervous.
- Community nursing staff in the Birkenhead area told us that they did not feel safe with the amounts of patients on their case loads and they believed this had raised staff sickness absence levels and impacted on the quality of care delivered to patients. Caseloads were open ended.
- Staff told us there was a high level of long term sickness absence within some community nursing teams, mostly due to back injury. Although staff were very positive about the support in place to return to work from sickness or compassionate leave, they believed the trust should do more to get health appointments quicker for staff so they could return to work sooner. They said that every team member regularly worked more than their contracted hours to cover for absences. They believed that the trust took this level of good will for granted and when staff took their annual leave it really put team under pressure, "weekends are awful at the moment". Staff said that they looked after patients with increasingly complex needs in the Birkenhead area of the trust especially, and the job was too busy and stressful to do now if they felt below par. "This year has been tough but we don't expect that to continue. Phased return from sickness and injury is very good"; "Currently we have two vacancies however it is being addressed, we use bank staff to fill the gaps. It feels like things are finally turning around".
- Community nursing staff in other parts of Wirral did not express the same experience of work load and sickness absence pressure.
- Our observations of the community nursing teams when we accompanied them on visits were that they were well functioning and highly skilled.
- We noted that staff in clinics and at the wheel chair service were appropriately qualified and functioned well together and in their teams. They did not raise with us any concerns about staffing levels or sickness absence. Managers told us they were actively recruiting new staff to deal with increased referrals and we noted a detailed Induction programme for locum staff.

Deprivation of Liberty safeguards

- We found that there was only a sketchy understanding among most staff of the relevance of 'deprivation of

Are Community health services for adults safe?

liberties safeguarding' (DoLS) and the application of the Mental Capacity Act 2005 to their work. It was not well understood by all staff in services in clinics or in the community nursing teams. We had to explain to some staff what DoLS meant. Yet when we accompanied community nurses on home visits we noted in care records that patient's mental capacity was regularly assessed in terms of a their ability to consent to treatment and some community nurses told us they got regular training on this issue.

- We found this conflicting level of understanding across a range of staff roles. There was a view held among some clinic staff that it was unlikely they would come into contact with patients who were living with dementia as the service 'would tend to see them in their own home'. Yet a community manager told us that DoLS was covered as part of safeguarding training; they were aware that it applied to some patients within care homes, but not to patients being treated in their own homes where family members were assuming responsibility. This suggested that training was ineffective and the trust could not confidently assure itself that people were able to consent to their treatment.

Good

Are Community health services for adults effective?

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

Summary

The trust had a range of policies and clinical guidelines available for staff in clinics and in the community teams and staff used recognised protocols and procedures to treat patients. Service lead managers conducted regular audits of their services to check effectiveness and compare with other services nationally.

The community matron role ensured a smooth transition for patients from hospital to home and prevented hospital re admissions. However community matrons were not satisfied about some aspects of transition, such as the continuing health care (CHC) assessment and arrangements for young people transferring from children's services.

Community nursing teams were well functioning and highly skilled and clinic therapists were qualified to the appropriate level and worked well in their teams or individually with patients.

Staff had regular supervision and support from their manager and most staff were up to date with their essential ongoing training and had good professional development opportunities.

Clinics were clean, tidy and well organised. Clinics situated in local medical centres and GP's facilities and public buildings, although clean and tidy tended to be cramped and some signage was poor. Those provided in the purpose built facilities at St Catherine's Health Centre were also spacious and well equipped and the catering outlet provided fresh, healthy foods and drinks for patients, staff and visitors.

There were good systems in place to respond in a timely way to requests for equipment for patients, including urgent requests.

There was good multi-disciplinary working in the community nursing teams and in clinics. However, access to some clinic services was slower when patients had to be referred through their GP.

Evidence based care and treatment

- The trust had a range of policies and clinical guidelines available for staff. These were held on the trust's intranet and readily accessible for staff in the community. Staff in clinics and in community teams were aware of these and told us that policy changes were updated on staff zone part of the trust's intranet.
- We observed protocols and procedures in use, for example use of International recognised scales at the cardiac rehabilitation clinic.
- We saw Nice (National Institute for Health and Care Excellence) Guidelines in clinics and we heard examples of staff contributing regularly and nationally to conferences, publications and to networking specialist groups such as the tissue viability group.
- In a nurse led heart failure clinic we noted that the guidelines in use were dated 2006. At the nurse led leg ulcer clinic at Whetstone GP medical centre all policies and procedures were kept in file on site for nurses to consult when they ran trust clinics and these were updated as reviews became available. For example we observed the nurse add the new Doppler procedure on the day of our visit. Staff there told us that they knew which the most up to date procedures were because they used the staff zone on SystmOne.
- Service lead managers told us that they conducted regular audits of their services and we noted national audit information was collected to provide a comparison with the performance of other trusts regionally and nationally, for example in the cardiac rehabilitation clinic. We did not see any evidence that community nursing staff were monitoring outcomes for patients so they could use to describe the trusts performance in this area.
- Community matrons saw their role as crucial in ensuring a smooth transition for patients from hospital to home and preventing hospital admissions. They gave us an example of a significant number of people being re admitted to hospital on one occasion, when one Matron

Good

Are Community health services for adults effective?

was on extended leave. This demonstrated the effectiveness of their role but raised questions about the effectiveness of the arrangements for community nurse cover of a matron's case load whilst they were on leave.
- Assessments of patient's needs were made and recorded. Community matrons told us that all patients have to have full assessment documentation completed regardless of the reason for their referral to the service. They expressed a view that a 'short intervention' note system for relevant patients would save time. At the wheelchair service we noted that patient's assessments were thorough and included mobility, usage of their current equipment and pressure area issues.

Pain relief

- We noted when we accompanied community nurses on home visits that all patients had a pain assessment in their notes and these assessments were carried out regularly.
- We observed in clinics staff checking for feedback from patients related to pain and comfort levels during procedures and treatments including removal of dressings in leg ulcer clinics.

Approach to monitoring quality and people's outcomes and

Patient outcomes performance

- We noted in clinics, there was photographic evidence on patient's files of pressure ulcer healing.
- Community matrons told us that they were 'struggling to grapple with' CHC and they believed the process needed to be reviewed especially in fast track, where the assessment took too long and this inhibited the flow of care.
- Community matrons also expressed dissatisfaction with the transition arrangements for young people from children's services. They said although there was an expectation that these patients would be picked up by adult services and cases handed over, there was no strategic view. They believed they did not have the expertise to support these patients and that young people needed their own specialist nurses. They said they had raised this within the trust but it was not being dealt with.
- Community matrons told us they had no time capacity for conducting research or audits.
- We noted examples in other services of data being collected and monitored to improve services such as at the trust's equipment centre; and evidence of policy changes as result of incident reporting, such as at the Eastham Doppler clinic service; and patient's self-review of their treatment plans influencing the future configuration of the service at the Livewell service.
- At the podiatry clinic we noted targets set for managers to collect patient experience questionnaires and this was being managed by a staff member who fed the information back to the teams. However staff told us that a new centralised booking system had raised the incidence of 'did not attend clinic' and this was not being managed.

Competent staff

- We noted when we accompanied them on visits, that community nursing teams were well functioning and highly skilled. Community matrons were competent to prescribe medications and met regularly for professional peer support and development.
- Therapists and nursing staff in clinics were qualified to the appropriate level and worked well in teams or in pairs with patients.
- Staff that we spoke with at all levels told us that they had regular supervision, support from their manager and annual appraisals. They told us they undertook their 'essential training' bi-annually and were able to keep track of their own training accounts on staff zone. However one podiatry clinic manager told us some staff were not up to date with mandatory training or supervision.
- We noted good examples of professional development opportunities for staff, such as in exercise physiology within the adults cardiac team. Community HCA's told us that their prospects were limited and Community matrons expressed uncertainty about their role in integrated care teams and therefore their future in the trust.

Use of equipment and facilities

- We noted that clinics provided in purpose built facilities such as St Catherine's Health Centre and also at the wheelchair service were clean, spacious and well organised. The podiatry clinics facilities and equipment, for example were excellent. One staff member told us "This is a great facility to work in".

Good

Are Community health services for adults effective?

- Waiting rooms at St Catherine's Health Centre included chairs designed for bariatric patients and the catering outlet provided fresh, healthy foods and drinks for patients, staff and visitors.
- We visited the trust's equipment store and noted good systems in place to respond in a timely way to requests for equipment for patients, including urgent requests.
- Most therapy staff told us they had easy access to IT facilities for their work. Community nursing staff expressed frustration with the pace of roll out of the new IT recording system and their access to computers. Some teams told us this meant waiting until the end of their shifts to return to the office and make records 'after work'.
- IT systems did not always easily support the work of staff. For example some staff in the wheelchair services clinic said they were unsure how to use the BEST system to its full potential and this meant it 'got in the way' of clinic visits. Community matrons told us SystmOne was running well for them and they were awaiting laptop computers.

Multi-disciplinary working and coordination of care pathways

- We saw good examples of multi-disciplinary working in the community nursing and physiotherapy teams. For example, close work with diabetes nurses and continence services locally, nurse prescribers working closely with GPs to ensure patients had continuity of treatment and we observed a comprehensive handover from the night service.
- Community matrons told us they worked closely with local acute hospitals and social care managers for effective discharge of patients from hospital to community health services. They were not so confident about the multi-disciplinary arrangements in place to enable the trust to effectively support young people with complex needs transferring from children's services.
- Therapists in podiatry clinics told us that communication was generally good within the team and they had a monthly team briefing, but that communication across the team and the community, intermediate care and local GP's was not so good. At the nurse led heart failure clinic we observed good cooperation between staff and disciplines and the nurses confirmed that this was usual.
- The volunteer co-ordinator told us of use of networks and links across professional and geographical boundaries.

Good

Are Community health services for adults caring?

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

Summary

We spoke with approximately 120 patients or their carers across the trust from clinics to visiting patients in their homes or contacting them by telephone. All told us how pleased they were with the care and treatment provided by Wirral Community Health NHS Trust and said that the staff were kind and caring supporting them in their needs.

Every patient that we spoke to spoke highly of the kindness of the nurses and therapy staff. Most staff that we met demonstrated a real pleasure at their work and seemed happy to be at work.

Staff were very good at talking patients and their carers through their treatment**,** they could access interpreter services for patients and there was good joined up help for patients with other services they needed.

No facilities were provided to occupy children at any of the clinics we visited. Patients told us this added to the strain of attending for their own appointments.

Compassionate care

- We spoke with approximately 120 patients or their carers across the trust from clinics to visiting patients in their homes or contacting them by telephone. All the patients we spoke with told us how pleased they were with the care and treatment provided by the trust.
- The trust reported for the period December 2013 to June 2014 a total of ten complaints were received about community health services for adults and seven of these were upheld, including two about the attitudes of staff.
- Bank staff, including clinic receptionists spoke highly of the permanent staff, "nurses are very good with people, and they communicate well and come out to waiting rooms to explain any delay".
- All staff we observed at clinics and in community nursing were considerate, polite and welcoming and held open, honest two-way conversations with patients and their relatives that were not judgemental.
- We observed real compassion and respect for dignity; particularly from community nurses on home visits which included unfaultable injection control methods. They showed an excellent rapport with their regular patients and explained all procedures to patients each step of the way.
- All staff we observed were eager to be helpful to people. In a number of services including in the equipment store, managers told us that staff worked over their contracted hours to make sure patients got what they needed.
- Most staff that we met demonstrated a real pleasure at their work and seemed happy to be at work. A happy working atmosphere was generated by the majority of staff, "I love my job"; "I'm proud of the service".

Dignity and respect

- We noted that formal signed consent was obtained for photographic records and monitoring equipment. Therapy staff double checked they had the correct name of patient prior to calling them from waiting areas for their appointments at clinics.
- We observed nurses responding in a helpful, practical way to patients who were embarrassed by the odour created by their conditions.
- We noted that staff knocked before entering closed treatment rooms. Patients were covered appropriately during their treatment and their privacy was respected at all times.

Patient understanding and involvement

- Most patients and relatives that we spoke with told us that staff were very good at talking them through their treatment**.**
- We noted good joined up help for patients, for example the Livewell service had a scheme to identify unpaid carers and to sign post them to carer support.
- We saw that patients treated in their own homes had a copy of their care and treatment plan and were made aware of what was in it. Those who we spoke with told us they felt part of their care and were pleased with their treatment. We observed a lot of talking and demonstration of delegation of tasks between the health care team and the family.

Good

Are Community health services for adults caring?

- We heard explanations of all procedures prior to and during treatments in clinics, confirming the patient's understanding. We observed that patient's consent was sought verbally prior to all activities or treatments and staff encouraged patients and families to ask questions.
- We did not have the opportunity observe any contact with patients where staff had a doubt over the person's ability to understand their treatment and give informed consent.

Emotional support

- We noted that no facilities had been provided to occupy children at any of the locations we visited. Patients told us this added to the strain of attending for their own appointments.
- We observed staff used two way humour to bond with patients and had skills to deflect any prejudicial comments. We saw examples of staff acknowledging patients personal identity such as a discussion about the colour choice of a dressing to match a patient's clothing.
- We observed in clinics and in community nursing services, empathetic responses made to sad news and the difficulties physical illness can put on the individual patient emotionally and their family.
- We heard staff explain to patients when they were leaving employment with the service and handle persons disappointment/ attachment appropriately. The penultimate appointment was arranged to introduce the patient to the member of staff taking over their treatment.

Promotion of self-care

- We saw patients independence respected and actively encouraged in community nursing and clinic services.
- We noted that achievable and realist goals were set with patients attending the Livewell service, for weight reduction, smoking cessation and healthy life styles including exercise.
- A number of patient's told us that not being given an approximate time of day for community nursing staff visits further restricted their ability to manage their lives.

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

Good

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

Summary

The trust was meeting its targets for access to urgent and non-urgent assessments.

There were formal agreements between trusts locally to ensure that patients could access the services they needed; some services were specifically addressing the needs of younger people and some clinics ran on Saturday mornings also so that working age patients could get to them.

Most patients in clinics told us they had not had to wait long once they arrived for their appointments although waiting times for first and follow up appointments varied between clinics. Patients being discharged from hospitals were picked up by the community nursing service either on the same day or the next day.

Staff expressed lack of confidence in the responsibility and arrangements for CHC assessment, communication between community nursing teams and local mental health teams and arrangements for young people transferring from children's services.

Many staff were not clear about the difference between a complaint and a concern and this affected the way that complaints were managed locally.

Patient experience cards were very visible in most clinics; patients did use them and the trust set targets for clinics and teams to gather in completed cards. This encouraged staff to seek immediate feedback on their services.

Service planning and delivery to meet the needs of different people

- Wirral has a relatively high older population and a relatively low proportion of people in their twenties and thirties compared to England and Wales as a whole. 3.0% of the population in Wirral belong to non-white minorities.
- During three days of our presence across Wirral, at a variety of clinics and health centres and accompanying a number of community nurses at work over two days, we noted few non- white patients or staff.
- Sets of five publicity posters on display, covering the five CQC inspection domains of a quality health service under the trust's logo, featured eleven images of men and women and all were white people. The trust had not taken this opportunity to address possible barriers to care.
- Staff across all of the services told us that data about patients age, ethnicity and other 'protected characteristics' was collected when they accessed services. Staff were unable to tell us what this data was used for and said they were not asked by the trust to report on it.
- The June 2014 review of the trust Equality Delivery System Action Plan by the board showed the reporting analysis of existing data from equality monitoring of patients to be Amber. This meant that the trust was behind its own target for establishing what this data could show about who services may be failing to reach and addressing barriers to care.
- The trust had a contract with a multicultural centre at Birkenhead for interpreter services. Staff told us they had access to this and it was readily available to cross language barriers to communication.
- External care agencies were invited to attend community nursing team meetings to demonstrate and share what they provided and how to refer and gain access for patients to their services.
- Staff told us there were service level agreements between trusts locally to ensure that patients could access the services they needed.
- Some services were specifically addressing the needs of younger people. The podiatry service had plans to expand in order to meet their needs. It also ran a clinic on Saturday mornings to help working aged people access the service.
- Community matrons work focused specifically on patients who had complex and multiple needs and who were at high risk of re admission to hospital.
- Patients could choose between different locations for some clinics to reduce travel. The service manager of a Doppler clinic moved base to ensure team planning of delivery was optimised. Community matrons retained contact with patient's who did not currently need the service but whose pattern of need indicated that was

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

Good

changeable. One patient at a leg ulcer clinic told us they attended the clinic in the summer because they could manage the two miles by scooter but in the winter nurses visited them at home for their treatment.

- Most patients we spoke with in clinics told us they had not had to wait long once they arrived for their appointments.

Access to the right care at the right time

- The trust was meeting its targets for urgent and non-urgent assessments. Targets for access to dietetics services, community equipment and wheelchairs were also being met.
- The equipment stores close monitoring of response routes showed a 100% response rate for emergency equipment calls (within 24 hours) and a 91% response for all other calls (within 7 days). Physiotherapist managers told us there was a four week wait for their services.
- Tissue viability nurses reported to us that their service had no waiting list and that people were generally seen within a week.
- The trust was not meeting its target for podiatry services. Staff told us that waiting times were poor especially for follow up appointments which could be five to six months. Podiatrists told us the target was to see routine cases within four weeks. We spoke with a patient who said they waited eight weeks for their appointment.
- The Livewell service provided good examples of flexibility to meet working people's lives and some single sex activities to enable comfortable access to exercise for men and for women. Any one could use the Livewell service as they could self-refer as well as get access through their GP.
- The wheelchair service provided a good example of developing a process to support patient's access to equipment outside of the service's catalogue that would better meet their needs.
- We noted across clinics that there were different approaches to managing 'did not attend appointment' rates. Staff in podiatry told us there was no system to manage this while the wheelchair clinic had a system in place to respond, based on risk and vulnerability of the patient.
- We noted that services, such as the nurse led heart failure clinic and the equipment store, scheduled extra services or staff shifts if demand rose. The heart failure clinic provided home visits by the specialist nurse if patients were unable to attend at one of the three locations.
- Community matrons told us that most patients being discharged from hospitals were picked up by their service either on the same day or the next day. Community matrons and nurses said that responsibility and arrangements for CHC assessment were confusing, but the trust had plans in place to attach a matron to this oversee this role.
- Managers told us that communication between community nursing teams and local mental health teams could be slow and ineffective. This was due, they said, to a lack of understanding of mental health need by nursing teams and mental health teams staffing problems that meant they could not always respond in a timely way.
- Community nurses confirmed that they generally had no training in elderly mental health care and found it difficult to liaise with the mental health team.
- The working day of some community nursing teams could not allow for flexibility, that meant when patients required more time than planned on occasion, some visits were late or did not get done that day. Staff told us that sometimes this was not communicated to the waiting patients or the team. This seemed to vary in teams across Wirral.
- One house bound patient we spoke with over the phone told us they had received the service for twelve years, 'They've never cancelled, I've never been kept waiting'. Another patient told us ' They come when they get here'.

Discharge, referral and transition arrangements

- The trust was signed up to the Joint Strategy of Young People with Disabilities and Complex Needs from Children to Adult Services.
- Community matrons told us they did not feel equipped to respond, as they were expected to do, to the needs of young people transferring from children's services. They told us children and young people, particularly those with learning disabilities, have been transferred from children's services, without the correct support in place from other adult services.
- Community matrons were involved with ward rounds in acute sector hospitals locally, to contribute to the assessment of patients who were ready for discharge to community services.

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

Good

- Arrangements were in place for specialist nurses from acute trusts to undertake home visits and advise community nursing teams.
- Community nurses told us there were good links in place to the accident & emergency department and assessment unit in the local acute trust.
- We saw that throughout the trust there were information leaflets available on various conditions, accessing services and they types of support available. Staff confirmed that they could access interpreter services for patients.

Complaints handling (for this service) and learning from feedback

- Data from the trust indicated that a total of ten complaints were received about community health services for adults between December 2013 and June 2014 and seven of these were upheld.
- The trust had a complaints and concerns policy and procedures in place that were last updated in 2013. A governance manager was responsible for the management of the complaints team. A monthly complaints & concerns report was provided to the trust board.
- The policy defined a complaint as 'an expression of dissatisfaction, (written or verbal), about a service provided or which is not provided, which requires a response'. A concern was defined as 'an informal complaint which can usually be resolved immediately by the service involved'. Two different processes were set out for responding to each, with the 'concerns' process to be carried out by local service managers.
- Speaking with staff in clinics and from community nursing services we noted descriptions of a conflated process for handling complaints and concerns. Staff told us that complaints were written and concerns were verbal expressions of dissatisfaction.
- We did not see any information on making a complaint about the service in any of the clinics or health centres that we visited.
- We noted that patient experience cards were very visible in most clinics and patients did use them. We didn't see these questionnaires provided in any alternative formats in adult services and this could result in some groups of patient's being systemically excluded.
- We noted at St Catherine's Health Centre and at Eastham clinic there was a touch screen installation in the foyer that invited patients to tell the trust about their experience. We found the one at Eastham clinic was out of order when we arrived. Staff told us these had been very recently installed.
- In clinics we heard good descriptions by staff of local handling of verbal concerns. Staff told us the trust set targets for services to get returns of patient experience questionnaire forms. We heard a good example of how information from these was fed back to the adult cardiac teams to consider how the service could improve, by the designated patient champion.
- We found a divergent awareness among patients we spoke with about raising complaints. About 55% of patients we asked told us they would not know how to make a complaint if they wanted to; about 40% told us that if they wanted to complain they would approach the clinic manager or write to them. Few patients mentioned a complaint procedure.
- In one clinic, the wheelchair service, we did see information about complaints and concerns on the wall in reception for patients to see.
- We tracked a recent complaint that was about an incident. We noted that the complaint process and the incident reporting process had been linked on the Datix reporting system. This provided target dates, checked by managers and trust governance, for actions at different stages of responding to the complaint as well as the incident investigation. Staff told us how they had supported that patient to make a complaint when asked.

Good

Are Community health services for adults well-led?

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

Summary

The trust had a strategic plan in place for integrated discharge planning with the local acute hospitals and social services.

Staff were clear about their roles and management arrangements at a local level of the trust. They knew the chief executive and members of the board but were less clear about the management arrangements in between. There was an annual programme of 'walk arounds' by different members of the trust board. This gave staff and patients direct access to board members.

Regular safety audits were carried out by the trust and services were risk rated. Lead staff were made aware of where improvements were required.

Incidents were generally well managed at a local level and all staff knew about how that was done. 'Low level' incidents may be going under reported and trends being missed because of other pressures on staff.

The trust encouraged staff professional development and generally communication within the trust was good. At a local level staff felt involved in developing and improving their services including achieving better value for money.

The trust worked with partner providers locally to improve its services and found ways to bring in visiting professionals to share innovative practice and new ideas with staff.

Vision and strategy for this service

- There was a two to five year plan for integrated discharge planning with the local acute hospitals and social services.
- Where significant change was planned for services, some local managers and staff teams had been involved with the process but some others, such as the equipment store, said they had not. Some staff in podiatry clinics felt disengaged from the planning of service development.
- Community matrons were not clear about the vision for their continuing role within the trust.
- Staff were clear about roles at service delivery level and were aware of the chief executive officer but many were less sure above the roles and the structure in between.
- Some teams said that having a clinical lead in post would improve their service.

Guidance, risk management and quality measurement

- A system of audits was in place, the safety thermometer was completed monthly and services were risk rated. Lead staff were made aware of where improvements were required, "If your scores are low you are checked on by quality and governance or, for example, the tissue viability specialist".
- Incidents were generally well managed at a local level and all staff knew about how that was done. Incident reporting was better embedded in some clinic's practice than others.
- The case load pressure on community nursing teams in some parts of the trust, together with the duplicated recording systems and competing access to IT could generate risk of 'low level' incidents going unreported and trends being missed.
- There was a conflation in some services of 'complaints' and 'concerns'. Staff understanding was divergent from the definition set out in the trust's policy.
- The trust set targets for completed patient experience questionnaires. Staff confirmed that this encouraged them to prompt patients to complete them and helped them to keep the quality of patient experience at the front of their mind. We didn't see these questionnaires provided in any alternative formats in adult services.
- Staff told us about a system of 'Front Line Focus Visits' where specialist staff observed the practice of clinic staff and therapists and managers were provided with written feedback from these audits.
- An understanding of DoLs and mental capacity in practice was generally not clearly articulated among staff at any level across the service. Staff saw it as the role of 'others'.

Good

Are Community health services for adults well-led?

- Staff expressed a lack of confidence in providing effective services for young people transferring from children's services and with their own relationships with mental health teams.

Leadership of this service

- All the staff that we spoke with knew the chief executive by name and most said they had met him and seen him around their service. Informal walkabouts by board members were common. Some staff told us the trust leadership had improved over the last two years.
- Nursing staff knew who was director of nursing (DON) and they said they regularly saw her and she was interested in their views. Community matrons confirmed that she regularly visited their meetings and acted promptly on issues that they raised. Some senior nursing staff expressed the view that the DON carried too much responsibility across the trust.
- There was an annual programme of 'walk arounds' by different members of the trust
  board
- Some staff did not who the clinical lead was for the service they worked in or commented that the operations manager was not sufficiently visible in the service.
- Managers at service level in clinics and community teams were visible and most staff told us their managers were approachable. We found that team managers were generally very well respected and some described in glowing terms by colleagues and staff. Patients told us they believed the services they received were well led.
- Staff commented on the consistent communication from the top of the trust, there was a monthly managers communication bulletin and the chief executive's monthly BLOG.
- Staff confirmed the trust had leadership programme and succession planning in place and some staff were involved in an Open University and NHS leadership programme
- Some community nursing manager's said they did not have sufficient access to computer time for their teams to complete essential e learning from audits.
- Community nurses reported high levels of long term sickness this year in some parts of the trust, however they were very positive about the return to work support provided.
- Community nursing managers had control over identifying and booking training and learning events a year in advance for their teams. They said that managers and matrons got regular clinical and professional supervision, but the one to one supervision for more junior nurses and assistants 'rarely happened more than two or three times a year'.
- Clinic staff and community nurses told us the trust supported and encouraged their professional development.
- There was good multi-disciplinary team working in clinics and in community nursing.

Public and staff engagement

- The chief executive was highly visible and used a Twitter account to publicise trust activity and praise staff.
- A weekly bulletin went out to staff on the intranet and this included a 'focus' feature. Most staff we spoke with referred to this bulletin as source of information and confirmed it often included a reminder of staff's duty to 'speak out'.
- Staff felt supported in their roles and happy to be at work.
- Recognised national training was provided for the volunteer's manager.
- Clinic guides, developed by administration staff as simple manuals addressing everything to do with the running of a clinic was put online and rolled out by the trust and was updated regularly.
- There was a system of 'patient experience' leads in place and these staff met monthly to share ideas, feedback from patients and learning.
- Most staff including managers said that communication within and from outside the trust was good especially through e mail and the intranet.
- We noted no visible promotion of the trust board structure and an absence, or very low level of 'branding' of the trust's services, including its vision and values, in clinics. This meant that patients may not always be clear about who was providing the service or what they could expect.

Innovation, improvement and sustainability

- Although the board reviewed monthly the trust's action plan for the equality delivery system (EDS), not all plans were on target and this was reflected in its low profile within the service.

Good

Are Community health services for adults well-led?

- Community matrons believed that a lot of innovative work was created by their team that did not appear to be taken to levels for effective implementation by the trust.
- Most staff reported they had good access to study days, training and practice conference events.
- At a local level staff felt involved in developing and improving their services and achieving better value for money.
- The trust worked with partner providers locally to improve services. For example, there was a new arrangement in place with the ambulance service for ensuring any 'do not resuscitate' instructions were highly visible in patient's notes.
- The trust hosted annual national conferences with guest speakers to bring innovative practice and new ideas to its staff.