Bridgewater Community Healthcare NHS Foundation Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Bridgewater Community Healthcare NHS Foundation Trust is a provider of community health services in the north west of England. The trust provides community and specialist services to a population of 1,304,500 people living in Halton, Oldham, Bolton, St. Helens, Warrington, Wigan Borough. The trust employs over 2,972 staff and has an income of £143 million which comes from commissioners, NHS England and local authorities.

The trust provides a range of community services. These include child health, urgent care walk in centres, community services for long term conditions, specialist services such as maternity, palliative care, physiotherapy, occupational therapy and dietetics. Services are also offered in prisons and young offender institutions. The community dental network provides services across several boroughs.

Most of the services are delivered in patients’ homes or at locations close to where they live, such as clinics, health centres, GP practices, community centres and schools.
Is this organisation well-led?

Leadership

Board Members

The trust had an established chief executive who was appointed in 2015. The calibre of the executive team was good however the tenure was lacking in the executive portfolios. The director of nursing and chief operating officer, medical director and finance director had all taken up post in this calendar year. There was currently a vacancy for a director of workforce although recruitment was in progress and an interim appointment was in place.

The Chair of the trust retired in July 2018. An interim Chair had been appointed and would start in post in October 2018. There were eight non-executive directors who had been in the role for several years with one new non-executive appointment.

The board had a range of finance, commercial and clinical experience amongst the non-executive directors. Arising from a board commissioned governance review the arrangements for appraisal of the non-executives was being strengthened and the trust had adopted a value-based approach to both recruitment and appraisal.

The finance director was an experienced accountant who had worked across both the private and public sector. This was their first director level appointment and their NHS experience had been gained from working in a large acute trust. The portfolio covered finance, business planning, IT, information and estates.

There were senior leads for estates and IT and an experienced deputy director of finance. All the senior finance team were qualified and there was a progressive approach to accountancy training and good success through use of an apprenticeship scheme.

There was protected time for board development and the focus of this activity in the last six months had been on the recommendations of the governance review commissioned by the board. The programme going forward was under review pending the imminent appointment of the interim Chair.

Senior managers had access to a range of leadership development opportunities. It was recognised there was more to do at middle management levels and to support this the trust had introduced leadership development sessions targeted at this group. A talent management and succession planning framework was being developed to link the leadership development programme into the trust talent management framework.

The trust met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. We looked at all executive and non-executive director employment files, which were completed in line with the FPPR regulations. An external audit report undertaken to review recruitment processes and compliance with FPPR regulations showed significant assurance.

Of the executive board members at the trust, 0% were British Minority Ethnic (BME) and 40.0% were female.

Of the non-executive board members 0% were BME and 71.4% were female.
<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0.0%</td>
<td>71.4%</td>
</tr>
<tr>
<td>All board members</td>
<td>0.0%</td>
<td>58.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

**Vision and strategy**

Following comprehensive stakeholder engagement involving staff, governors and external partners the trust relaunched its strategic vision at the outset of 2018.

The strategy had a clear focus on quality and integrated care models for the local authority boroughs which the trust served. Within this the trust had restated its organisational values which had been well tested through staff engagement.

Whilst the overarching vision was clear there was less clarity about the process for implementing the strategy. Board members, both executives and non-executive directors were assigned to boroughs and services to strengthen joint working with commissioners. The organisational structures within the trust were currently being aligned to marry with this revised strategic focus.

At this early stage of implementation detailed delivery plans were lacking, as were the mechanisms by which progress on the strategy was being tracked by the board. These were not evident at the time of the inspection in September 2018.

The board recognised that a key challenge to the sustainability of the trust was the approach of commissioners to delivering integrated care models in their respective health economies. The proposed transfer of the Wigan community services out of the trust to an alternative provider as a first step in the creation of a local care organisation was a risk to the trust’s viability as it had the potential to generate significant financial risk in the form of stranded overhead costs.

It was important that the board had effective plans to manage this risk and such plans were not well developed at the time of the inspection in September 2018. A key next step was formal written agreement with commissioners.

The operational plan was linked to the strategy and the trust was currently modifying its management arrangements to marry with the strategic focus on local authority boroughs. It was evident that organisational objectives flowed through to the objectives of the chief executive and the wider executive management team and these were visible to staff throughout the trust. This link was positive however the objectives of the chief executive and executive team would benefit from measurable outcomes.

There was no workforce and organisational development strategy which aimed to ensure that future patient needs could be met through the transformation and development of the workforce. This was part of the work plan when the Director of Workforce was in post.

There was a medicines management strategy which the Chief Pharmacist had used to evaluate progress of the department. Updates to the strategy included changes because of issues raised by other organisations. Medicines management staff were involved in the production of the initial
strategy and had been briefed at team meetings on ongoing changes. This included the use of medicine technicians to administer medicines and the proposed introduction of seven-day week at the prison services.

**Culture**

There was an improving culture across the organisation and a recognition that there was more work to do. Arising from a relatively poor response on the staff survey the trust had invested considerable time and effort in staff engagement and this had been led by the chief executive. A staff engagement strategy had been developed with wide staff involvement and was currently being rolled out.

The geography of the trust and multiple sites did make visibility more difficult, but the executive team had protected time to undertake monthly “back to the floor” activities and this was being extended to include the senior leadership team.

Since March 2018, the trust had carried out a Pulse survey which was showing signs of improvement across several indicators.

There was now a structured approach to team brief to improve staff communications and a focus on compassionate leadership in response to concerns about bullying and harassment. The chief executive was the lead in this area.

Work on the new Bridgewater Anti Bullying and Harassment campaign started last year. This involved partnership work with staff side on developing a reporting app, manager’s toolkit, and awareness raising. This was launched in October 2017.

The Freedom to Speak up Guardian arrangements were not effective. Staff were using alternative routes to raise concerns. There had been approximately four concerns raised in the last two years using the guardian. At the time of inspection, the trust reported that an advert was going out for the appointment of guardians in all boroughs.

Evidence from the trust post inspection indicated that five Freedom to Speak up Guardians had been recruited and were subject to training. These included a clinical manager, IT professional, quality and safety lead, outreach and inclusion co-ordinator and administration.

**Staff Diversity**

As at 31 March 2017 there were 3,305 staff employed at the trust. Of these, 2.6% of the overall workforce were Black and Minority Ethnic.

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by ethnic group.

A breakdown of staffing rates by band for white and black and minority ethnic staff are in the below table, the trust reported no significant changes across the bands for either clinical staff.
The trust’s submitted information to the NHS Workforce Race Equality Standard. The standard was mandated in the 2015/2016 NHS standard contract, requiring trusts to submit and publish annual data and carry out actions to improve race equality performance in future years.

The data for 2017, showed the trust employed 3,305 staff, of which 2.6% were black and minority ethic, this was a total of 87 members of staff, an increase from 77 in 2016. The total percentage of white staff was 90.8%. This figure broadly represented the boroughs in Halton, St Helens, Warrington and Wigan.

The trust had expanded to Bolton and Oldham where the community demographics had changed and the trust was working with community members to represent this increasing diversity.

For several of the indicators the number of black and minority ethic staff was very low which had led to issues in previous years on reporting on the NHS staff survey indicators and led to problems ensuring statistical significance in other indicators such as formal disciplinary data.
Until recently the trust had employed two members of staff to deliver on a broad equality and inclusiveness action plan. The senior member of staff had left and this post was not replaced. This had presented time and capacity challenges for one relatively junior staff member to move the agenda forward.

It was not evident whether a black minority ethnic staff network or similar engagement forums for staff with protected characteristics existed. In a report to the board several staff fed back their wish for a staff network for people with disabilities. A proposal was sent to the Workforce and Organisational Development Committee who approved the development of a group. At the time of the inspection these networks were not developed.

Post inspection the trust gave several examples of the awards they had achieved with regards to the equality agenda. In May 2018 the trust was awarded the Navajo Charter Mark. This award recognised organisations in Merseyside and Cheshire who understand and meet the needs of LGBTQ+ staff and patients, and who through their policies, practices and services sought to ensure equity and inclusion for these communities.

In November 2017, the Equality and Inclusion staff were awarded the Greater Manchester Clinical Research Network’s award for Best Community Research Contribution. This was in recognition of the work undertaken on the Working Longer project, carried out by the University of Bath on behalf of NHS Employers and the DWP. As the only community provider in the project trust staff could provide a unique perspective to the research team on the effects of pension reforms and longer working lives. The final report was to be presented by the University to the DWP and to the Working Longer Group in early 2019.

**NHS Staff Survey 2017 – results better than average for Community NHS Trusts.**

The trust had four key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key finding 28: Percentage witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>Key finding 15: Percentage satisfied with the opportunities for flexible working patterns</td>
<td>60%</td>
<td>57%</td>
</tr>
<tr>
<td>Key finding 16: Percentage working extra hours</td>
<td>69%</td>
<td>71%</td>
</tr>
<tr>
<td>Key finding 22: Percentage experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>5%</td>
<td>8%</td>
</tr>
</tbody>
</table>

**NHS Staff Survey 2017 – results worse than average of Community NHS Trusts**

The trust has 20 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Finding</td>
<td>Description</td>
<td>Score 1</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>11</td>
<td>Percentage appraised in last 12 months</td>
<td>80%</td>
</tr>
<tr>
<td>12</td>
<td>Quality of appraisals</td>
<td>2.89</td>
</tr>
<tr>
<td>13</td>
<td>Quality of non-mandatory training, learning or development</td>
<td>3.97</td>
</tr>
<tr>
<td>29</td>
<td>Percentage of staff reporting errors, near misses or incidents witnessed in last month</td>
<td>89%</td>
</tr>
<tr>
<td>30</td>
<td>Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.68</td>
</tr>
<tr>
<td>31</td>
<td>Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.58</td>
</tr>
<tr>
<td>17</td>
<td>Percentage feeling unwell due to work related stress in last 12 months</td>
<td>45%</td>
</tr>
<tr>
<td>18</td>
<td>Percentage attending work in last 3 months despite feeling unwell because they felt pressure</td>
<td>58%</td>
</tr>
<tr>
<td>19</td>
<td>Org and management interest in and action on health and wellbeing</td>
<td>3.55</td>
</tr>
<tr>
<td>1</td>
<td>Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.51</td>
</tr>
<tr>
<td>4</td>
<td>Staff motivation at work</td>
<td>3.84</td>
</tr>
<tr>
<td>14</td>
<td>Staff satisfaction with resourcing and support</td>
<td>3.15</td>
</tr>
<tr>
<td>5</td>
<td>Recognition and value of staff by managers and the organisation</td>
<td>3.43</td>
</tr>
<tr>
<td>6</td>
<td>Percentage reporting good communication between senior management and staff</td>
<td>23%</td>
</tr>
<tr>
<td>3</td>
<td>Percentage agreeing that their role makes a difference to patients / service users</td>
<td>89%</td>
</tr>
<tr>
<td>32</td>
<td>Effective use of patient / service user feedback</td>
<td>3.55</td>
</tr>
<tr>
<td>24</td>
<td>Percentage reporting most recent experience of violence</td>
<td>64%</td>
</tr>
<tr>
<td>25</td>
<td>Percentage experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>26%</td>
</tr>
<tr>
<td>26</td>
<td>Percentage experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>20%</td>
</tr>
<tr>
<td>27</td>
<td>Percentage reporting most recent experience of harassment, bullying or abuse</td>
<td>52%</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

**Workforce race equality standard**

The scores presented below were the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic staff, as required for the Workforce Race Equality Standard.
For question 17b, the percentage featured was that of “Yes” responses to the question. Key finding and question numbers have changed since 2014.

To preserve the anonymity of individual staff, a score was replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

<table>
<thead>
<tr>
<th></th>
<th>Trust 2017</th>
<th>Average (median) for community trusts</th>
<th>Trust 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF25</td>
<td>White</td>
<td>26%</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>29%</td>
<td>26%</td>
</tr>
<tr>
<td>KF26</td>
<td>White</td>
<td>20%</td>
<td>18%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>21%</td>
<td>22%</td>
</tr>
<tr>
<td>KF21</td>
<td>White</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>93%</td>
<td>76%</td>
</tr>
<tr>
<td>Q17b</td>
<td>White</td>
<td>8%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>BME</td>
<td>11%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Of the four questions above, no questions showed a statistically significant difference in scores between White and Black Minority Ethnic staff:

(Source: NHS Staff Survey 2017 - link)

Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust performed about the same as the England average for recommending the trust as a place to receive care from July 2017 to June 2018 however performance fluctuated around the average more in 2017 compared to 2018.
Sickness absence rates

The trust set a target of 3.8% for sickness absence rates. Performance against this target by core service from April 2017 to March 2018 is in the table below. Staff in all core services did not meet this target.

<table>
<thead>
<tr>
<th>Core service</th>
<th>Total sickness absence (days)</th>
<th>Total establishment (days)</th>
<th>Sickness rate</th>
<th>Target met Yes / No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children, Young People and Families</td>
<td>17,196.9</td>
<td>280,432.2</td>
<td>6.1%</td>
<td>No</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>279.5</td>
<td>4,788.4</td>
<td>5.8%</td>
<td>No</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>1,867.5</td>
<td>36,005.4</td>
<td>5.2%</td>
<td>No</td>
</tr>
<tr>
<td>Adults Community</td>
<td>17,460.7</td>
<td>332,589.9</td>
<td>5.2%</td>
<td>No</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>457.2</td>
<td>10,453.7</td>
<td>4.4%</td>
<td>No</td>
</tr>
<tr>
<td>Other</td>
<td>6,246.6</td>
<td>149,864.4</td>
<td>4.2%</td>
<td>No</td>
</tr>
<tr>
<td>Dental</td>
<td>1,390.9</td>
<td>33,362.1</td>
<td>4.2%</td>
<td>No</td>
</tr>
<tr>
<td><strong>All core services</strong></td>
<td><strong>44,899.1</strong></td>
<td><strong>847,496.1</strong></td>
<td><strong>5.3%</strong></td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: NHS Digital)

The trust was aware of its challenges to improve staff sickness absence. An external audit report showed no assurance in the systems for managing staff sickness. The trust had strengthened its sickness management policy and an action plan was in place. The issues were flagged to the Workforce Committee and to the Board. Human resource managers were now aligned to each borough, staff received back to work interviews and referral to occupational health. Processes were linked to the health and wellbeing team. Staff sickness was highlighted on the board assurance framework.
Health and wellbeing updates were included in the managers brief each month. The trust achieved full compliance of The National Institute for Health and Care Excellence Workplace health: management practices.

**General Medical Council – National Training Scheme Survey**

Bridgewater Community Healthcare NHS Foundation Trust did not participate in the 2018 General Medical Council Survey.

(Source: General Medical Council National Training Scheme Survey)

**Governance**

**Board assurance Framework**

The trust provided their Board Assurance Framework, which details four strategic objectives within each and accompanying risks. A summary of these is below:

- Quality - To deliver high quality, safe and effective care which meets both individual and community needs.
- Innovation and Collaboration – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living.
- Sustainability – to deliver value for money, be financially viable and commercially successful.
- People – to be a highly effective organisation with empowered, highly skilled competent staff.

(Source: Trust Board Assurance Framework)

The board assurance framework was reviewed at each board meeting. There was good evidence through the board and committee structures that this was a dynamic framework. All board members who were interviewed were clear on the role of the board assurance framework. The refresh of the arrangements for managing and reporting operational risk through the introduction of a risk council would strengthen the process of risk management. Following the inspection two meetings of the risk council had taken place.

Executive portfolios had recently been refined in the context of the new executives and refresh of the trust’s strategic direction. These were clear although they were at an early stage of implementation and would take time to become fully embedded.

The portfolio of the chief nurse was large covering both nursing and operations. However, the quality governance agenda was split with the medical director and coupled with plans to enhance the capacity of the operational management teams would provide sufficient support to cover this portfolio.

The trust was in the process of strengthening the senior management arrangements and it was implementing a triumvirate structure at borough and specialist service level. This was being
complemented with a revised governance framework covering risk and performance management through the establishment of executive lead risk and performance councils. These changes were aligned to organisational structures with the revised strategic focus on local boroughs but again these were yet to be fully implemented.

Arrangements for board committees were more established and there was an annual process for reviewing the remit of these committees. The former finance and investment committee had been revamped and was now the finance and performance committee to reflect a greater focus on performance delivery. The cross cover in non–executive membership of the quality and audit committees had been well considered.

Governor representatives were designated to attend board committees in an observer capacity. The board was mindful of the potential conflict and blurring of roles but had found attendance by governors as a useful mechanism to discharge their duty of holding the non-executive directors to account.

Arrangements for budget setting were in place and the operational teams were engaged in this activity. It was recognised that budgets needed some realignment to match with the changes in organisational structure and this was work in progress. There were some deficiencies in non-pay budgets and these were being addressed to ensure they were realistic.

The trust currently had a broad-brush approach to efficiency planning. The cost improvement target for the current year was set at a modest level of 2 % and board members were clear this was a conscious decision given the difficulty in delivering this programme on a sustainable basis in the prior year.

Through the revised performance arrangements there was a plan to strengthen efficiency planning and its delivery and it was considered there were opportunities in estates and in procurement where the skill set was currently being strengthened. It was also recognised the approach to quality impact assessment of cost improvement schemes would need to be reviewed as part of these arrangements.

There was a risk-based approach to setting the annual internal audit plan and oversight from the audit committee. The newly appointed chair of the audit committee was focused on improving the style of internal audit reports and the arrangements for tracking the implementation of internal audit recommendations. The audit chair had taken steps to tighten reporting arrangements along with a focus on the evidence base to support assurances.

There appeared to be effective arrangements for board committees and there was evidence that their roles were reviewed and refined through an annual self-assessment process.

Management of risk, issues and performance

Finances Overview
The trust had a planned turnover of £143m in 2018/2019. The trust’s financial performance had deteriorated over recent years. The trust reported a deficit of £1.9m in 2016/2017, £4.8m in 2017/2018 and was planning a deficit of £7.6m in 2018/2019. The trust had not accepted the
financial control total from NHS Improvement and would therefore not receive provider sustainability funding in 2018/2019.

The deterioration in the underlying financial position was largely due to loss of community service contracts and under achievement of prior year cost improvement plans. The trust had set a less ambitious efficiency programme for 2018/2019 and at the time of the inspection in September 2018 was forecasting to achieve the planned deficit of £7.6m.

The trust remained vulnerable to further contracts reduction with the potential loss of the Wigan community services contract from April 2019 with a value of £46m. The trust had accessed interim revenue loan funding to support its cashflow and a further loan of £7.5m was planned in the current year.

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£164.1m</td>
<td>£151.8m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>£2.1m</td>
<td>(£3.5m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£162.0m</td>
<td>£155.4m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>£165.7m</td>
<td>£152.3m</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The deterioration in the trust’s financial position over the last couple of years was a concern. Board members expressed reasonable confidence in achieving the financial plan in the current year, but this was a deficit plan of £7.6m. Over 70% of the cost improvement plan for the year was identified and was mainly recurrent. There was to be a sharpened focus on financial delivery through the newly formed performance council, co–chaired by the director of finance, the director of nursing/chief operating officer, and oversight through the board’s finance and performance committee.

There was a good understanding of the key drivers of the trust’s underlying financial position. There was an outline plan to get the trust into financial balance over a two-year period. This was largely based on estates rationalisation and the transfer out of the loss-making Wigan community services. The latter component was a high risk due to the overheads associated with these services.

Currently the trust was relying on verbal assurances from commissioners that this will be resolved to the satisfaction of the trust. Whilst it was acknowledged that the governance and programme management arrangements for this service transfer were still being established with the key stakeholders, it was of critical importance that the trust formalised an agreement with commissioners which confirmed the financial arrangements for the transfer.
All board members who were interviewed on the inspection visit were sighted on the financial challenges of the trust. There was commitment to deliver the current year financial plan albeit there was cognisance of the need for more pace on the delivery of the cost improvement programme. The financial risk associated with the proposed transfer of the Wigan community services to an alternative provider is understood but assurances that the trust will not be left with stranded costs needs to be formalised with commissioners.

All board members interviewed were committed to achieving the financial plan in the current year but acknowledged some frustration at the pace of delivery on the efficiency programme.

There was heightened scrutiny from the Finance and Performance Committee and the executives were currently refreshing performance management arrangements in respect of the operational teams, but these arrangements were at an early stage of implementation. The priority was patient safety but not at any cost and it was reported that there was challenge from both executives and non-executives to ensure cost effective use of resources.

There was a business partner model for both finance and human resources in supporting the operational teams which provided reasonable coverage. This was supplemented by the recent refresh of performance management arrangements. The finance team were in the process of developing a suite of online training tools for non-financial managers.

The trust had a transformation management office which sat in the Chief Nurse’s portfolio. Staff were allocated to a borough to work up cost saving schemes. The types of schemes included redesign of services in Bolton. There was a Quality Impact Assessment process which was signed off by the medical director and chief nurse.

To strengthen the focus on achieving cost improvement programmes the trust was developing a cost improvement programme counsel this was to encourage over and under performing managers to share good practice.

An external review of the trust’s risk management arrangements was conducted in accordance with the requirements of the 2017/18 Internal Audit Plan, as approved by the Audit Committee. The report showed moderate assurance.

All staff members have access to the trust’s risk management system for flagging risks and adverse incidents. The trust recognised there was more work to do on scrutiny and challenge to operational risk registers and standardising the reporting formats. The proposed executive led risk council would have an important role in streamlining these arrangements. Risks above 15 were recorded on the corporate risk register and mapped through to the board assurance framework. The Quality and Safety Committee were providing oversight of these changes.

The trust had been subject to commissioner scrutiny for quality concerns related to some of its services. Whilst remedial action had been taken and oversight arrangements strengthened the board may wish to consider a standardised approach to risk assessment in respect of service development opportunities going forward.

There was a new process for stronger review of serious incidents. All serious incidents were seen by the chief nurse and reviewed by the serious incident review panel chaired by the chief nurse. Actions were followed up by the review panel and the various quality committees.
We looked at a sample of 10 serious incident investigations in the last 12 months. These were of variable quality. In six reports information to establish the facts, what happened, when, how and why was not clear and there was a lack of focus on learning. The reports did not show if the patient, family and carers were engaged in the investigation. There was evidence that a duty of candour letter had been sent in two cases. In one case the clinical commissioning group had sent the investigation back for further work.

The chief nurse acknowledged there had been no effective root cause analysis process. There was now a new tool for incident review. Changes had been made to processes for investigating pressure ulcer incidents and work was being undertaken to put a process in place so that it was possible for all services to see if and where harms had been caused.

Following the inspection, the trust sent evidence to show the quality of the serious incident investigation reports were improving. Feedback from Warrington Clinical Commissioning Group on 11 October 2018 commended one report on the quality and content including the levels of curiosity from a human factors perspective.

Work was being undertaken to ensure that information was more meaningful and could be triangulated, including staff competencies and what level of care was being provided. All serious incidents were reported to the Quality and Safety Committee. The chief nurse reported there were five serious incidents currently open and these were being managed within timescales.

Unexpected deaths were reported on the incident reporting system and were subject to a 72-hour review. Due to the nature of the trust most unexpected deaths were Deaths in Custody and SCRs or domestic homicides. These reviews were not led by the trust however the actions and lessons learned were shared through the newly established serious incident panel process.

The trust post inspection reported there had been no unexpected deaths which fell outside these processes and required further review by the trust.

However, the medical director acknowledged that learning from deaths was behind the national average. A report was presented to the board in September 2018. Work was in progress to ensure that staff were reporting and updating incidents. A non-executive was assigned to be involved in the learning from deaths panel to ensure that independent challenge was provided.

Although there were audit programmes at service level, the medical director acknowledged there were gaps in the audit process where some audits remained unfinished from 2016/2017. The medical director was picking this up to ensure clinical and internal audit processes functioned well and had a positive impact on quality governance, with clear evidence of action to resolve concerns.

A report to the board set out a series of actions and assurance for the trust from the recommendations of the Report of the Liverpool Community Health Independent Review (February 2018). Several actions were already in place, and all recommendations were being tracked as business as usual. For areas where changes were required, these changes were being implemented and monitored by the relevant board committees.

The chief nurse was the executive director for safeguarding adults and children. There were ten safeguarding boards which the trust worked with. The safeguarding lead reported they had good relationships with the designated nurses. The trust was reviewing its attendance across the executive team to ensure adequate representation across the boards.
There was close partnership working by the Safeguarding and Looked after Children’s teams with local social services and the Local Safeguarding Children’s Board. The children’s service’s named nurses for safeguarding delivered safeguarding level three training for staff, including workshops and bespoke training when requested.

Safeguarding supervision was provided by the designated nurses for children and adults safeguarding in the Clinical Commissioning Groups. The named nurses for safeguarding met weekly, while the specialist safeguarding nurses attended a quarterly workshop to share relevant information and learning. The safeguarding assurance group reported quarterly to the Quality and Safety Committee, a sub group of the board.

Medicines optimisation within the trust was well-led. Key priorities and risks had been identified and incorporated within the medicines management strategy. Updates to the strategy and monitoring continued with the use of the department’s risk register and action plans. The trust had recently taken on a medicine safety officer, to improve oversight within the trust regarding medicine safety. However, the department had limited input within the trust due to limited resources of the medicines management team and information technology.

The medicines safety officer was evaluating incidents reported to the trust as involving medicines and sharing lessons learned through the trust. The evaluation of other incidents which do not appear to be overtly related to medicines had recently been started by the medicine safety officer. Incidents before this may have been overlooked for example a serious incident involving the replacement of oxygen cylinders had not been investigated by the medicines optimisation department.

The trust carried out an annual programme of self-audits around safe storage of medicines, however the medicines management department had initiated a trust-wide audit programme to identify areas of good practice and concern. This had not been fully completed due to staffing issues and the chief pharmacist had initiated a review of the template used to collect the data to improve compliance.

The pharmacy department maintained a separate risk register, which was reviewed by the senior management team on a regular basis. It included input from the medical director and action plans to alleviate the risk where possible. It concluded that medication may be prescribed, stored or administered incorrectly to a patient. Action plans included movement of staff to improve patient safety and increased support from the head of medicines management.

Trust corporate risk register

In their board assurance framework, the trust provided a document detailing their 8 highest profile risks. Two of these have a current risk score of 15 or higher, and are detailed below:

<table>
<thead>
<tr>
<th>ID</th>
<th>Description</th>
<th>Risk level (current)</th>
<th>Risk level (target)</th>
<th>Last review date</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAF2</td>
<td>There is a risk that the Trust may be unable to achieve and maintain the required levels of safe and effective patient care. This could be caused by inadequate clinical practice</td>
<td>15</td>
<td>10</td>
<td>12 March 2018</td>
</tr>
</tbody>
</table>
and / or ineffective governance;

If this were to happen it may result in widespread instances of avoidable patient harm, this in turn could lead to regulatory intervention and adverse publicity that damages the Trust’s reputation and could affect CQC registration.

BAF6

Staffing levels

If the Trust fails to have an appropriately resourced, focused, resilient workforce in place that meets service requirements;

Caused by an inability to recruit, retain and/or appropriately deploy a workforce with the necessary skills and experience;

It may result in extended unplanned service closure and disruption to services across divisions, leading to poor clinical outcomes & experience for large numbers of patients; failure to achieve constitutional standards; unmanageable staff workloads; and increased costs.

15 8 7 March 2018

(Source: Board assurance framework)

Information management

There was an integrated performance report covering operational performance, finance, workforce and quality metrics but this was not sufficiently granular to enable triangulation of quality and performance at a service level.

There was also a lack of standardised performance dashboards at service level and a considerable time lag in reporting on key quality indicators which may be two to three months in arrears.

The trust recognised this weakness and were currently implementing a data warehouse to improve the trust’s analytical capability and timeliness of information. It would be some months before this implementation was complete and in the interim the trust had developed service” heat maps” to aid the triangulation of quality and performance.

There was a partially implemented electronic patient record system and the trust was continuing to roll out the coverage of this programme. The trust had work to do in rolling out the use of the electronic staff records system and e- rostering. The status of digitisation was mixed and there was still reliance on manual systems held at local level.

There are no reported concerns about data quality although commissioners had registered some concern about the timeliness of reporting. This was due in part to the lack of analytical capability which was being addressed through the data warehouse facility which the trust was currently implementing.
Timeliness of reporting on the financial position of the trust was satisfactory. The finance report to the board provided a comprehensive range of information covering income, expenditure, cost improvement, working capital and the capital programme.

There was analysis by commissioner and by broad service area. At the time of the inspection in September 2018 the key risk to the delivery of the financial plan related to the full identification of the cost improvement programme. Over 70% of the schemes had been identified and the finance and performance committee were seeking further traction on the unidentified component.

The trust appeared to have a good grip on service line reporting and understanding the cost of services in relation to funding levels. This information was reported to be transparently shared with commissioners which was positive.

Information governance was overseen by the Information Governance Sub Group chaired by the Caldicott Guardian, the trust’s medical director and attended by the senior information risk owner, the director of finance.

The Information Governance Sub Group minutes were circulated to the Clinical Governance Committee. The quarterly information governance reports were also reported to the Quality and Safety Committee which included members of the Board.

The Information Governance Assurance Statement showed significant assurance. This demonstrated that the trust had effective systems for handling information securely and confidentially.

The trust used paper based prescription in most areas, there was no clinical oversight of these prescriptions until the prescriptions had been dispensed in the community. The medicines management department monitored the prescribing trends from the e-PAC data supplied nationally, however this was at some time after dispensing.

**Engagement**

The Staff Engagement Strategy was approved by the Board in March 2017. The Board received regular reports and updates on the strategy and staff engagement activities, including progress against the action plan.

There was programme of director visits to each borough. There were staff engagement champions across the boroughs who had made various improvements during the year. This included staff engagement events, increasing executive visibility and development of a starter staff engagement video for new employees.

The trust had implemented a ‘Leader in Me’ development programme for staff and managers, and conducted ‘listening into action’ events to improve staff engagement.

There was no Patient Experience Strategy, the first draft of the strategy would be available in December 2018.

Patient experience information was shared in the board performance report and a patient story was presented at each meeting. At a local service level there were examples of patient engagement.

The Halton community nursing team was in the process of implementing an ‘experience based design’ approach to engaging with children and their parents, the Bolton healthy schools team hosted a public engagement event in the town centre, and district nursing teams had started a
survey covering care in the last three days of life which included, individual needs, communication, access to services, pain relief and nutrition.

The governors came across as engaged and well informed. The trust covered many health economies which was a challenge however the governors were strong about the arrangements available to them to connect with their local communities and constituent groups and the opportunities for them to interface with the board.

There was a mixed picture in respect of the strength of collaborative working with commissioners and other external stakeholders. Following the revision of the trust’s strategic direction the board adopted a twinning arrangement where an executive and non-executive director were designated leads for each of the boroughs and commissioners which the trust served to improve partnership working.

The trust reported they were leading contributors to all place-based reform programmes and in respect of specialist services development in the community dental networks. The trust was refocusing executive and non-executive support to places and services. Commissioners and provider colleagues were involved in the ‘big conversations’ that were held to develop the Trust’s Quality and Place Strategy in 2017.

The chief executive has recently been elected to the board of NHS Providers as the trustee representing community trust chief executives.

Learning, continuous improvement and innovation

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Current performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>25</td>
<td>83%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>75</td>
<td>99%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>278 (April 2017 to March 2018)</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

The trust received 53 complaints from April 2017 to March 2018. Children, young people and families received the most complaints with 17.
<table>
<thead>
<tr>
<th>Core service</th>
<th>Number of compliments</th>
<th>Percentage of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults Community</td>
<td>328</td>
<td>49.8%</td>
</tr>
<tr>
<td>Children, Young People and Families</td>
<td>189</td>
<td>28.7%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>57</td>
<td>8.7%</td>
</tr>
<tr>
<td>Community Dental</td>
<td>53</td>
<td>8.1%</td>
</tr>
<tr>
<td>End of life care</td>
<td>15</td>
<td>2.3%</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>9</td>
<td>1.4%</td>
</tr>
<tr>
<td>Community Inpatients</td>
<td>1</td>
<td>0.2%</td>
</tr>
<tr>
<td>Other - PMS service</td>
<td>6</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>658</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From April 2017 to March 2018, the trust received a total of 658 compliments. A breakdown by core service can be seen in the table below:

We looked at ten complaints. In most cases the complaint was managed appropriately and people were supported. In two cases the records kept and regular updates to the complainant were less effective. In another two cases the complainant was not satisfied with the outcome and it was not clear if they had been informed of all the alternative options available to them.

Healthwatch Halton published a report in July 2018 following an online survey in December 2017 to gather information about Woodview Child Development Centre. Within the summary report Healthwatch recommended that the service improve the handling of complaints after parents had tried to raise formal complaints and had received no response.

The trust did not have a formal methodology of quality improvement albeit they were able to cite services and care pathways which were a matter of pride to them for both the quality of patient services and innovation in delivery model for example sexual health services in Warrington,
continence services in St Helens and the 0-19 children’s service in Oldham. At the time of the inspection the trust had just celebrated its annual staff awards ceremony which was a positive and uplifting event.

The finance team were connected to the finance staff development programme and encouraged to participate in its training events. The finance director sat on the regional finance staff development board which oversees these development activities. The team were planning to apply for accreditation at level one in the current year.

**Accreditations**

NHS trusts can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made if to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The trust did not provide details of accreditations in their routine provider information request.  

*Source: Routine Provider Information Request (RPIR) – Accreditations tab).*

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**Community health services**

**Community health services for adults**

**Facts and data about this service**

The trust provided the following information about community services for adults at Bridgewater Community Healthcare NHS Foundation Trust:

Bridgewater Community Healthcare NHS Foundation Trust delivers adult services in Wigan, Warrington, Halton and St Helens. These include such services as: Community Nursing, Continence, SLT, Wheelchair service, Rapid Access Rehabilitation Service, Catheter, Intermediate Care Service, Integrated Community Equipment Store, Long Term Conditions teams.

Adult services are commissioned to provide:

- A 24 hour a day, 7 day a week nursing service across all settings including patients’ homes, community venues and Care Homes (this includes Residential & Nursing Homes).
- Respond to variable demand and prioritise accordingly to provide care at the right time, in the right place.
- Deliver care in the most appropriate location dependent on patient need.
- Deliver skilled and competent clinical nursing care within the framework of ‘Compassion in Practice’.
- Provide a comprehensive nursing service for patients with nursing care needs and for those patients at the end of their life.
• Ensure all patients are supported, managed and reviewed with care plans, and evidence based pathways, which address their individual needs.

• Administer medication and prescribe where appropriate, using the formularies agreed by NHS Halton Clinical Commissioning Group & Bridgewater Community Healthcare NHS Foundation Trust.

• Provide education and advice on self-care, to maximise independence.

• Promote integrated care through working in partnership with General Practice, secondary care, social services, voluntary & third sector organisations using joint assessments and care plans where possible.

• Prevent unplanned hospital admissions through the delivery of care to patients at the greatest risk of admission and readmission.

• Facilitate the early discharge of patients in hospital through effective and timely community support.

• Safeguard patients and their families through identification and reporting of risk.

**Wigan Integrated Community Services (ICS)**

Wigan Integrated Community Services (ICS) is the integration and transformation of adult services in community provided by Bridgewater NHS, Wrightington, Wigan & Leigh NHS and Wigan Council. Nurses, therapists, social care workers and reablement wrap around GP practices in seven service delivery footprints to support the following objectives:

• Integrated care for patients with community health and social; care needs;

• Co-ordinated joint care planning between multi-disciplinary professionals across organisational boundaries to patients with long-term conditions;

• Rapid crisis intervention, admission avoidance and care escalation to maintain care in a community setting; and

• Co-ordinated discharge planning on admission, rapid early discharge and de-escalation to receive care in community

• Working in a strength based way using new conversations, focusing on enabling people to self-care and maintain good health and wellbeing whilst living and being supported in their local community.

The Director of ICS is a joint appointment between Bridgewater and Wigan Council, enabling integration, transformation and co-location across a workforce of just over 1000 staff. Services within ICS provided by the acute are managed via a prime vendor contractual arrangement. Step up care beds are funded by Wigan Council and managed by ICS, clinically led by the ICS Consultant Geriatrician.

ICS is one of the key transformation programmes of the Healthier Wigan Partnership Alliance, which represents all the NHS service providers including mental health, Wigan Council, Wigan Clinical Commissioning Group, and primary care, collaborating to deliver against improved population health outcomes and supporting more out of hospital care.

(Source: CHS Routine Provider Information Request (RPIR) - CHS Context tab)
Is the service safe?

Mandatory training

Mandatory Training completion

The trust was unable to provide data on mandatory training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust, for all staff groups from April 2017 to March 2018 are in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>2,632</td>
<td>2,883</td>
<td>91.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Wrap 3</td>
<td>636</td>
<td>719</td>
<td>88.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>1,768</td>
<td>2,114</td>
<td>83.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1,768</td>
<td>2,114</td>
<td>83.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Risk Assessment</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>secure transfer of personal data</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Lone working &amp; security</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>634</td>
<td>769</td>
<td>82.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>634</td>
<td>769</td>
<td>82.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Customer Care</td>
<td>633</td>
<td>769</td>
<td>82.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent</td>
<td>2,231</td>
<td>2,883</td>
<td>77.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - refresher</td>
<td>1,637</td>
<td>2,232</td>
<td>73.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Record Keeping</td>
<td>1,445</td>
<td>2,114</td>
<td>68.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>229</td>
<td>336</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - initial*</td>
<td>1,400</td>
<td>2,100</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>1,349</td>
<td>2,114</td>
<td>63.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Non- Clinical staff*</td>
<td>391</td>
<td>613</td>
<td>63.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Clinical Staff</td>
<td>1,832</td>
<td>2,883</td>
<td>63.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>1,620</td>
<td>2,883</td>
<td>56.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
*Training completion data for these courses is provided for the previous year as this course is not undertaken annually.

The 90% target was met for one of the 23 mandatory training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

During our inspection we were informed of a fault with the trust electronic system used to monitor staff training. The trust was aware of the issue and in response all staff were advised to keep their own record of training. Team leaders collated the information which was sent to the trust learning and development team to update a centrally held record. We observed team handovers where training was discussed and all staff were asked to present their current mandatory training figures.

We spoke with the trust following our inspection and were given assurance that a complete record of staff training was available with the learning and development team. Due to the failure in the electronic system and staff presenting their training manually to the team leaders, a delay in reporting was evident.

The evidence we received following the on-site inspection was divided by services and identified all mandatory subjects. Whilst there was non-compliance identified across the service in some training, we were assured that the initial figures were improving and compliance was being addressed. We spoke with staff during our inspection and saw evidence of compliance in each team we visited. Overall, the trust reported compliance at 81.96% at the time of completing this report.

The trust provided training for specific roles in the services we visited. Staff working in one of the clinics told us of difficulties accessing extra training as their clinics were booked in advance and they were not always able to attend at short notice. Staff also reported access to training could be difficult when staffing levels were low. However, arrangements were made for training to be delivered locally, for example during team meetings and the number of sessions was increased to improve access.

The Warrington clinical services manager designated two and a half hours protected learning time per month for each team where specific training sessions were provided. Training around documentation, risk management and bladder and bowel management were delivered for community nursing staff. To ensure time was fully protected, other teams were called on to support the caseloads and this was managed on a rolling programme throughout the month. This meant all teams would benefit from training and the time was used effectively.

We were told this was working well and discussions were underway with all clinical services managers to trial this in their areas. This meant staff were kept updated on current practice and managers could monitor staff competencies.

The trust provided mandatory training in identifying and managing sepsis. Staff told us aspects of the training did not apply to community but the learning and key messages were adapted. Staff were also issued an A5 sized information leaflet to help identify signs of sepsis.
Safeguarding

Safeguarding Training completion

The trust was unable to provide data on safeguarding training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust from April 2017 to March 2018 is in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>2,719</td>
<td>2,883</td>
<td>94.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>2,699</td>
<td>2,883</td>
<td>93.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>756</td>
<td>811</td>
<td>93.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>229</td>
<td>336</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for three of the four safeguarding training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Staff in the Wigan teams told us they had identified a shortfall in the number of staff accessing mental capacity training. In response, face to face training sessions had been arranged with the trust safeguarding team and staff had been allocated protected time to attend these.

We spoke with the trust following our inspection about the shortfall of staff access to safeguarding training. They were aware of this and acknowledged the provision of extra training sessions.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.
Community services for adults made 34 safeguarding referrals of adults from April 2017 to March 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Staff were aware and had knowledge of how to safeguard patients and those close to them. We were given examples of concerns raised by staff and discussions among team members which supported decision making.

Where concerns were raised about patient safety, staff submitted a safeguarding referral to ensure the appropriate team was aware. We were told by staff they were encouraged to discuss any concerns within their teams and were well supported by the safeguarding team.

We observed examples of safeguarding referrals submitted by staff in the services we visited. There were discussions between a patient and staff members about a potential vulnerable situation. There was a good explanation indicating why they felt the patient was vulnerable and evidence of staff understanding of the patient’s right to make decisions. There was documented evidence of consent from the patient to refer on to the safeguarding team and clear multi-disciplinary working between services.

Staff told us they were kept well informed of any safeguarding outcomes and were invited to strategy meetings to ensure the patient was supported. Each meeting was attended by relevant multi-disciplinary staff including local authority, nursing and medical staff.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Infection prevention and control formed part of the trust mandatory training and all staff we spoke with were compliant with this at the time of inspection.

The trust had a standard (Universal) infection control precautions policy which informed staff of the safe management of sharps, procedure for dealing with bodily fluids, personal protective equipment and decontamination of the environment. Staff were aware of the policy and how to access this on the trust intranet.

We observed staff maintaining hand hygiene before, during and after patient contact. We observed safe disposal of materials used for patient intervention and thorough cleaning of surfaces using appropriate decontamination wipes.

All clinical areas were clean and hand washing facilities with hot and cold running water, soap, moisturiser and paper towels were available. There were appropriate waste disposal bins for non-clinical, clinical and offensive waste with the appropriate coloured bags and sharps containers. Staff were responsible for emptying the bins they had used and dispose of them in a locked cupboard away from the clinical area.

Environment and equipment

Premises used in the provision of care and treatment were visibly clean and tidy. Deep environmental cleaning of the clinics was undertaken by housekeeping staff on site. At the end of
each clinic, staff delivering the clinic session disposed of waste and maintained the cleanliness of the room.

All clinic rooms had hard flooring in line with infection prevention and control guidance for effective decontamination. There were curtains in the clinics providing dignity and these could be disposed of in the event of contamination or soiling.

The trust kept a maintenance record of all equipment used by the services. The trust maintenance team kept track of equipment that required regular servicing and attended the clinics when this was due. In some cases, access to clinics was limited due to patient priorities and the maintenance team planned to return where they could not gain access. There were processes in place to report faulty equipment and staff reported these were repaired or replaced quickly.

Some devices used by the teams were serviced by the manufacturers and arrangements were made for the companies to attend the clinics to service them.

We observed one set of digital scales in the long-term conditions team that was overdue for calibrating. This was discussed with the nurse on duty and was addressed at the time of inspection. We saw a record of all devices kept by the team and all were compliant with servicing.

We found an item of equipment in use at Westbrook Health Centre that was overdue for safety testing. This had been identified by staff and raised with the maintenance team in July. This was addressed at the time of inspection.

Staff in the Warrington borough identified inequalities in facilities available across the clinics. For example, some of the newer clinics had good provision for leg washing for patients with leg ulcers but some older clinics did not have this facility. This had been entered onto the trust risk register.

There were a low number of specialised chairs available in the phlebotomy clinics to accommodate the high volume of patients using the service. We were told the trust estates department had increased chairs in one clinic and plans were in place to increase in other clinics. This had been entered onto the trust risk register.

The trust had a fully equipped store facility covering all services. Staff had access to a range of equipment to support patient’s mobility, comfort, pressure relief and daily living needs. Equipment was ordered from the team bases and the store staff arranged delivery to the patient’s home. The staff completed safety checks and a risk assessment once items were delivered to ensure the equipment was suitable and safe for use.

Staff spoke highly of the equipment store and their efficiency in supplying equipment quickly. They also had access to support by telephone for any equipment related queries.

**Assessing and responding to patient risk**

The service used safety monitoring results well. Staff collected safety information and shared it with staff, patients and visitors. The service used information to improve the service.

All teams we visited had either a notice board or electronic record of information about patient risks such as pressure ulcers, falls risks and vulnerable patients. This information was kept by the clinical services managers and updated monthly.

Risks were highlighted on the patient’s electronic record system which alerted staff when accessing the record. As well as complex conditions and health related risks, we observed information alerting staff to pets and difficulties in access to premises. This ensured staff were kept
aware of any potential issues when visiting patients and any risks identified could be added easily as alerts to the record.

There were alerts to identify risks such as allergies and adverse reactions to treatment. There were also alerts to inform staff of patient resuscitation orders and preferred place of care which meant patient’s wishes were known prior to any visits. The system showed alerts created by other teams which meant all staff involved with the patient were aware.

Patients with paper records had a sheet at the front of their record indicating any risks and a copy of this was left in the patient home to alert all staff. Prior to any visits staff could review the notes held in the office which contained copies of the risk assessments.

All teams we visited held a daily safety huddle where patient concerns were discussed. We observed staff discussion on return from their visits and any significant issues were added to a handover sheet. Those who could not attend telephoned the office and fed back any relevant information to the team.

Team leaders kept a log of all patients allocated for the day and the member of staff responsible for each patient. This ensured all patients requiring visits had been allocated and helped to mitigate the risk of missed visits. It also ensured the most appropriately skilled staff member was allocated and was reallocated as necessary where further issues were identified.

Staff discussed patient referrals to other services and arranged follow up appointments as required. There were discussions of patient progress and responses to treatment which meant patient treatment was reviewed regularly.

Assessment of patients were graded for their complexity so the caseloads could be managed appropriately. For example, complex wound management and end of life care were graded four where non-complex assessments such as eye drop administration and basic dressing changes were graded one. This meant staff and patients were allocated an appropriate length of time to complete the assessment.

Staff told us the complexity of patient needs varied daily and staff may need to attend to a patient for longer than expected. We were told that whilst this did not impact on the quality of patient care, the way complexity of the caseloads was monitored was not always effective. The district nursing teams had raised this with the trust and the services capacity and demand tool was under review.

There were clear processes in place to triage new referrals in the district nursing teams we visited. New referrals were prioritised during triage using a numbering system. If the triage was identified as a one, the patient received a visit on the same day; two, the patient would be visited the following day and three, the patient was visited within one week.

Staff stated all initial visits were completed within the allocated time to ensure patients were safe. If there was a delay in visiting within an allocated time frame, they sought support from neighbouring community nursing teams. Teams were accessible and supported where possible and we heard of examples where this had occurred.

Patients requiring palliative care and those requiring pain management were prioritised for a visit on the same day.

We saw good management of the caseloads across the services we visited and observed members of staff offering help to others where required. Patients were reviewed at the daily team safety huddles and assessed where staff needed support. We were told by team leaders that due to the locality of some bases, teams often supported each other and shared visits where possible.
Staff we spoke with showed good knowledge and understanding of deteriorating patients and the interventions needed to maintain safety. We saw examples of patient records where risk had been identified and the staff response to this.

The trust had a sepsis policy which was in date and based on current National Institute for Health and Care Excellence guidance. Staff we spoke with were aware of this and referred to this when necessary. There was a clear pathway indicating signs, symptoms and what to do in the event of suspected sepsis. There was also a flowchart which guided staff in their decision making and provided guidance on patient observations.

Teams in the Wigan borough held a multidisciplinary team safety huddle. Staff from the hospital at home team, district nurses, advanced nurse practitioners and social workers met daily to discuss patients who had been referred by the single point of access team. These patients were identified as particularly vulnerable and met the criteria for discussion at the huddle.

The aim was to reduce the risk of avoidable hospital admission, reduce the length of hospital stay for patients who could be supported at home or increase services by utilising the multi-disciplinary team. Staff discussed each patient and agreed a plan of care that involved the most appropriate staff and service involvement.

The community therapy and falls prevention team used a falls risk assessment tool which was developed using national guidelines. Following assessment, staff used SMART goals led therapy to monitor patient progress. We were told by the team the tools used to measure risk had been reviewed and were being replaced with a new multifactorial screening tool. This was being developed using national guidelines and aimed at providing a more effective way to calculate the patients risk of falls.

The long-term conditions team told us of an issue with oxygen provision for patients in the community. It had been identified that long term oxygen dependent patients were not being supported adequately and the respiratory team had taken the caseload to manage within their team. The team developed further skills in oxygen therapy management to enable them to support the patients they had identified at risk. However, we were told the team did not currently have an oxygen therapy lead and this had been added to the trust risk register. In the meantime, the respiratory team continued to manage the caseload effectively.

Staff in the lymphoedema specialist team told us the electronic template for recording patient information and risk was due for update. They had access to other team templates which were used to populate their assessment records. This meant any of the risks identified that the team did not have a specific template for were completed either by free text or using another team template. One example given was the assessment of pain. Whilst this was recorded in free text, it was identified by the team that a dedicated addition to the electronic template was needed. In the records we observed pain was identified and discussion of intervention where relevant.

Staff told us of the effectiveness of the pilot so far and patients had remained at home with the right support. Staff at the community response team told us how they had demonstrated a reduction in hospital admissions and delivered shared care with other services. We were also told how the pilot had identified younger service users and those at risk of deteriorating mental health. The team worked closely with acute and mental health children’s services for onward referrals.

Staff in the intravenous therapy (IV) team told us all patients having antibiotic treatment and those showing signs of symptoms were routinely screened for sepsis. This meant risks associated with IV therapy were identified at the earliest opportunity and could be managed effectively.
Staffing

Planned v Actual Establishment

Details of staffing levels within community services for adults by staff group as at 30 April 2018 are below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>118.2</td>
<td>118.1</td>
<td>100.1%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>18.1</td>
<td>19.3</td>
<td>94.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>443.4</td>
<td>477.0</td>
<td>93.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>229.3</td>
<td>250.5</td>
<td>91.6%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>161.9</td>
<td>188.8</td>
<td>85.8%</td>
</tr>
<tr>
<td>Public Health and Community Health Services</td>
<td>1.8</td>
<td>3.7</td>
<td>48.6%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>0.6</td>
<td>1.6</td>
<td>37.5%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>973.4</td>
<td>1,058.9</td>
<td>91.9%</td>
</tr>
</tbody>
</table>

One of the staff groups was slightly over-established, with low fill rates for Public Health and Community Health Services and medical and dental staff (although planned staff numbers are low for both staff groups).

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

Vacancies

The trust did not provide a target for vacancy rate. From April 2017 to March 2018, the trust reported an overall vacancy rate of 13.7% in community health services for adults. Across the trust overall vacancy rates for nursing staff were 14.8%; for medical staff were 52.2% and for allied health professionals were 12.0%.

A breakdown of vacancy rates by staff group in community services for adults at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total vacancies (12 months)</th>
<th>Total WTE establishment (12 months)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff group</td>
<td>Total leavers</td>
<td>Average monthly staff establishment</td>
<td>Annual turnover rate</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>---------------</td>
<td>-------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>12.6</td>
<td>24.1</td>
<td>52.2%</td>
</tr>
<tr>
<td>Public Health and Community Health Services</td>
<td>55.2</td>
<td>184.4</td>
<td>29.9%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>98.9</td>
<td>599.6</td>
<td>16.5%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>579.6</td>
<td>3,904.2</td>
<td>14.8%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>476.3</td>
<td>3,609.1</td>
<td>13.2%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>205.4</td>
<td>1,715.9</td>
<td>12.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>129.2</td>
<td>1,123.1</td>
<td>11.5%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>40.0</td>
<td>482.4</td>
<td>8.3%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>1,597.3</td>
<td>11,643.0</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

**Turnover**

From August 2017 to March 2018 the trust reported an average turnover rate of 22.5% in community health services for adults. Across the trust average turnover rates for nursing staff were 23.7%; for medical staff were 109.1% and for allied health professionals were 15.8%.

A breakdown of turnover rates by staff group in community services for adults at trust level for the year ending March 2018 is below:

**Community adults total**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total leavers</th>
<th>Average monthly staff establishment</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>0.6</td>
<td>0.6</td>
<td>109.1%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1.5</td>
<td>2.6</td>
<td>57.3%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>4.5</td>
<td>11.9</td>
<td>37.7%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>4.4</td>
<td>12.1</td>
<td>36.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>21.2</td>
<td>77.4</td>
<td>27.4%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>54.0</td>
<td>227.6</td>
<td>23.7%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>27.4</td>
<td>173.3</td>
<td>15.8%</td>
</tr>
</tbody>
</table>
All staff groups | 113.6 | 505.4 | 22.5%

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

Sickness

The trust set a target of 3.8% for sickness rates. From April 2017 to March 2018 the trust reported an overall sickness rate of 5.2% in community health services for adults. This did not meet the trust’s target. Across the trust overall sickness rates for nursing staff were 6.0%; for medical staff were 0.0% and for allied health professionals were 3.1%.

A breakdown of sickness rates by staff group in community services for adults at trust level is below:

### Community adults total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total sickness absence (days)</th>
<th>Total establishment (days)</th>
<th>Sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>0.0</td>
<td>494.2</td>
<td>0.0%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>2,370.9</td>
<td>76,539.7</td>
<td>3.1%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>314.1</td>
<td>6,726.8</td>
<td>4.7%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>689.2</td>
<td>13,589.1</td>
<td>5.1%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4,288.2</td>
<td>73,231.5</td>
<td>5.9%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>8,804.2</td>
<td>147,014.6</td>
<td>6.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>994.0</td>
<td>14,994.1</td>
<td>6.6%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>17,460.7</td>
<td>332,589.9</td>
<td>5.2%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

Nursing – Bank and Agency Qualified nurses

Data on total shifts provided by the trust did not include shifts covered by permanent staff, therefore the proportions of bank and agency staff below are not proportions of nursing staff.

From April 2017 to March 2018, of the 1,412 total shifts covered by bank and agency staff, 0.0% were filled by bank staff and 83.6% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.
In the same period, 16.4% of available shifts were unfilled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Total shifts available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>GP out of hours</td>
<td>737</td>
<td>0.0%</td>
<td>728</td>
<td>98.8%</td>
</tr>
<tr>
<td>District nursing</td>
<td>353</td>
<td>0.0%</td>
<td>326</td>
<td>92.4%</td>
</tr>
<tr>
<td>Leigh walk in centre</td>
<td>201</td>
<td>0.0%</td>
<td>87</td>
<td>43.3%</td>
</tr>
<tr>
<td>St Helens walk in centre</td>
<td>109</td>
<td>0.0%</td>
<td>35</td>
<td>32.1%</td>
</tr>
<tr>
<td>Single point of access</td>
<td>7</td>
<td>0.0%</td>
<td>3</td>
<td>42.9%</td>
</tr>
<tr>
<td>Care home support team</td>
<td>4</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Home care support</td>
<td>1</td>
<td>0.0%</td>
<td>1</td>
<td>98.8%</td>
</tr>
<tr>
<td>Community adults total</td>
<td>1,412</td>
<td>0.0%</td>
<td>1,180</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Nursing - Bank and Agency Nursing assistants

From April 2017 to March 2018, of the 118 total shifts covered by bank and agency staff, 0.0% were filled by bank staff and 99.2% were covered by agency staff to cover sickness, absence or vacancy for qualified nurses.

In the same period, 0.8% of available hours were unable to be filled by either bank or agency staff.

<table>
<thead>
<tr>
<th>Ward/Team</th>
<th>Total hours available</th>
<th>Bank Usage</th>
<th>Agency Usage</th>
<th>NOT filled by bank or agency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hrs</td>
<td>%</td>
<td>Hrs</td>
<td>%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>93</td>
<td>0.0%</td>
<td>93</td>
<td>100%</td>
</tr>
<tr>
<td>District nursing</td>
<td>25</td>
<td>0.0%</td>
<td>24</td>
<td>96.0%</td>
</tr>
<tr>
<td>Community adults total</td>
<td>118</td>
<td>0.0%</td>
<td>117</td>
<td>99.2%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)
Medical locums

This information is routinely requested within the universal provider information request spreadsheets, to be completed within a standard template. The trust has only provided partial data on 'total shifts' for medical agency and locum staff. In community adult services, medical agency and locum staff were not employed.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Suspensions and supervisions

During the reporting period from May 2017 to May 2018, community services for adults reported that there were three cases where staff have been suspended.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Each month a week-long snapshot of the service was audited by the quality and safety team. Each team leader provided caseload figures, complexity of patients and staff available which were sent to the quality and safety team for review.

However, staff had raised concerns that the audit each month was not equitable and did not always show a true picture of each team's workload. We discussed this with the clinical services managers who told us the systems for measuring capacity and demand were under review.

Staff in the Wigan district nursing teams told us of the trust support in staffing vacancies. A list of vacancies was sent to the trust and teams across the region were approached to see where support could be offered.

The trust used a capacity and demand tool based on complexity of the caseloads and the number of staff available to deliver care. The teams also utilised a bank system of staff and reported that these were easily accessible. The bank staff had experience of working in the community and familiar with the district nursing teams which meant they could work autonomously.

We saw examples of staff supporting each other in the teams we visited. Staff visited patients in pairs where staff requested extra support or where it was assessed the visit would benefit from two staff members.

Staff across disciplines supported each other on patient visits. We heard examples of nurses and physiotherapists attending jointly to carry out health and mobility assessments. We saw examples of advanced practitioners and community nurses working together to complete a joint assessment.

We were told staffing in community nursing was improving with the recent recruitment of newly qualified staff. These staff were being supported by mentors in the learning and development team whilst completing a comprehensive preceptorship programme. This meant staff were competent in some aspects of the role after their preceptorship and could be better utilised across the services.

Staff vacancies within the podiatry department were highlighted as an issue and some staff felt this had impacted on response times to see urgent patients. The trust responded to these concerns and recruited three additional staff.

The assistant director for the Warrington borough told us of joint working with the clinical commissioning group to support gaps in staffing. There were plans in place to utilise agency
advanced nurse practitioners to support patients during the winter pressures. However, this was to be reviewed to bridge staffing gaps throughout the year.

Staff in the dietetics team told us they had raised concerns with managers about staff vacancies and felt the trust could be more proactive when covering vacancies.

The trust had a lone worker policy which was accessible and staff were aware of it. However, the way in which lone worker safety was supported differed across the trust. This was due to some services having access to electronic devices and others in the process of transferring over.

District nursing teams operated a buddy system as part of lone working procedures. Senior staff had access to the visit allocation list for each nurse using the electronic system and could view progress with visits.

Staff with access to electronic devices managed their caseload remotely. This meant anyone with access to the electronic system could remotely monitor where staff had visited and where they were due to visit. Once the staff member had finished their visit, they updated the system to reflect this.

The community nursing team in central east and central north Warrington were piloting a work allocation and staff safety tracker system to monitor staff safety and visit allocations. This scheduled work lists based on staff band, competencies, rota and estimated visit length and was checked and adjusted by a senior staff member as required.

If staff were delayed on their visit by 15 minutes, they were contacted by the administrative staff to check on their safety. Staff also telephoned their team if they were delayed on their visits or required assistance.

Staff told us of a safety word used in telephone calls to request support. The safe word was used by the person requesting assistance to alert the person at the other end of an issue. Whilst this was good practice we did not hear reports of this being used in all teams.

**Quality of records**

During our inspection we observed different systems for patient record keeping. The trust was in the process of transferring all services onto a single electronic record system that was used by other services in the area. For example, plans were in place for the Halton borough to transfer onto an electronic system used by GP’s in the area. This meant staff could access relevant information held by GP’s and well as practice staff and ensured sharing of information across the relevant services.

In areas where electronic records were established, all services using the same system had access to the patient record. This meant quicker access to information from all staff involved in the patient’s care.

At the time of our inspection, teams in the Halton area were using paper records whilst teams in Warrington and Wigan were using electronic systems. This meant accessibility to records varied in some services and not all teams were consistent in their management of records. However, all services we visited, including those in the process of transferring from one system to another, maintained records appropriately and the quality of records we observed was good.

The trust commissioned an independent audit of paper and electronic records in the district nursing teams across the trust. Results from the audit identified discrepancies across all services in both paper and electronic records. During our inspection we saw improvements had been made in the quality of records since publication of the audit report.
We found that teams using electronic records could access documents from other multidisciplinary services using the same system. This meant information was shared by all staff involved in the patients care and care delivery was managed more effectively between services. Staff had access to information such as referrals from and to other teams which meant there was less duplication.

Staff using a paper record were reliant on accessible notes at the point of care. Other disciplines involved with the patient would have a set of notes at the home where staff could refer to if necessary.

All patient records we reviewed had a full holistic assessment of needs at the initial assessment, clear and legible information and care plans identified goals discussed with the patient. All patient risk assessments were up to date and measures were in place to support any issues. Patient nutrition and pain was assessed.

Staff using the electronic system completed templates for each visit which included discussion of consent to treatment. There were templates with tick boxes and drop-down menus to indicate completed tasks. There was a free text box where we observed narratives of the intervention, outcome and a brief plan for the next visits.

Staff using paper records completed relevant risk assessments and documented the date and time reviewed. These were duplicated into the notes kept at the office. There were care plans at the patient’s home to inform staff of what needed to be completed. These were reviewed at the point of care and duplicated into the notes kept at the office. We observed two paper copies of a care plan in the office notes with a short delay in review. This was addressed at the time of inspection.

We observed evidence of good multidisciplinary working in patient records and staff told us how this supported the care they delivered. All care recorded in the records we reviewed was centred around the patient and discussion with the patients was evident.

The trust had a clinical systems specialist who was responsible for updating the templates used on the electronic record system. This ensured templates contained the relevant information required for staff to complete their assessments.

Each team had their own template relevant to the services they provided but could use templates created for other teams using the same system. For example, nursing staff identifying mobility issues could use a template created for physiotherapists to record relevant information if required.

The clinical systems specialist sent regular updates to staff informing them of any changes to the templates. There were staff groups such as the wound care task and finish group where staff submitted requests to develop and improve the templates. These were reviewed by the clinical systems specialist and the IT team looked at developing these further.

We were assured that the different process of record keeping across the trust did not have a negative impact on patient care and the use of electronic records trust wide would ensure more integrated ways of working.

**Medicines**

There were several non-medical prescribers across the services we visited. All teams had dedicated lockable drawers for staff to keep their prescription pads secure. Staff maintained their competencies through individual learning using websites and publications such as the British National Formulary and guidance from professional bodies such as the National Institute for Health and Care Excellence. Nursing staff were required to maintain competencies as part of their professional registration.
Staff in the lymphoedema specialist team told us of delays in prescribing for patients as there was only one prescriber currently in the team. This meant patients had to wait for specific hosiery or devices. However, this had been submitted to the trust risk register and we were told a team member completing the specialist qualification in lymphoedema management would also be start a prescribing course.

We were told by the clinical services manager at Warrington the trust had responded to concerns about the low number of non-medical prescribers. Plans were in place to enrol staff on the prescribing course in each team.

Safety performance

Safety Thermometer
The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Community Settings
Data from the Patient Safety Thermometer showed that the trust reported 98 new pressure ulcers, 45 falls with harm and 21 new catheter urinary tract infections from June 2017 to May 2018 within community settings.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and catheter urinary tract infections at community settings at Bridgewater Community Healthcare NHS Foundation Trust.
Pressure ulcer rates fluctuated over the period, rates of falls were generally lower in the early part of the year and C.UTI rates fell after a peak in October 2017.

Of the 9,426 patients surveyed from June 2017 to May 2018, 9,237 (98.0%) reported harm free care. Rates over the year are in the graph below:


All pressure ulcers graded two and above were reported by staff on the trust incident reporting system. Staff told us they were encouraged to report any skin damage and deterioration to their team leaders to ensure these were monitored. All staff we spoke with gave good explanations of their rationale for reporting and were kept informed of their team’s safety performance at team meetings.

Team leaders collected data for their teams on numbers of patients with pressure ulcers, falls and healthcare associated infections. The data was collected by the trust during a set week per month and uploaded to the safety thermometer.

Incident reporting, learning and improvement
Never events

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018 the trust reported one never event within community services for adults, a wrong site surgery (during a nail operation) occurring in March 2018.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported 118 serious incidents (SIs) in community services for adults, which met the reporting criteria, set by NHS England from July 2017 to June 2018. Of these, the most common type of incident reported was pressure ulcers with 106 incidents.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>106</td>
</tr>
<tr>
<td>Pending review</td>
<td>3</td>
</tr>
<tr>
<td>Screening issues</td>
<td>2</td>
</tr>
<tr>
<td>Confidential information leak/information governance breach</td>
<td>2</td>
</tr>
<tr>
<td>Slips/trips/falls</td>
<td>1</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>1</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>1</td>
</tr>
<tr>
<td>Apparent/actual/suspected self-inflicted harm</td>
<td>1</td>
</tr>
<tr>
<td>Abuse/alleged abuse of child patient by third party</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>118</strong></td>
</tr>
</tbody>
</table>

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From April 2017 to April 2018, trust staff within community services for adults reported 140 serious incidents.

Of these, none involved the unexpected death of a patient.
The most common types of serious incidents were pressure ulcers, with 140 incidents.

The number of the most severe incidents recorded by the trust incident reporting system is comparable with that reported to Strategic Executive Information System (STEIS). This gives us more confidence in the validity of the data.

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>Number of Incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure ulcer</td>
<td>140</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Diagnostic incident including delay (including failure to act on test results)</td>
<td>2</td>
</tr>
<tr>
<td>Abuse/alleged abuse of adult patient by third party</td>
<td>2</td>
</tr>
<tr>
<td>Surgical/invasive procedure incident</td>
<td>1</td>
</tr>
<tr>
<td>Screening issues</td>
<td>1</td>
</tr>
<tr>
<td>Treatment delay</td>
<td>1</td>
</tr>
<tr>
<td>Medication incident</td>
<td>1</td>
</tr>
<tr>
<td>Confidential information leak/information governance breach</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All teams we spoke with were encouraged to report incidents of all kinds. We observed reports such as faults with mobile devices, access to premises and a range of clinical safety issues. All incidents were reported electronically and team leaders addressed each one individually. Staff were kept informed of the incident they had reported by email and a copy was sent to the team leader.

A senior member of staff in each team reviewed all incidents related to their teams and assessed whether they met the criteria for further investigation. Serious incidents were reported at the weekly serious incident reporting panel. The panel was made up of senior clinical staff and heads of service where the cases were reviewed. The panel determined if a root cause analysis and further investigation was to be completed and the relevant staff were tasked with completing this.

Not all staff we spoke with were familiar with their duty of candour responsibilities. Most staff we spoke with had not been involved in the formal process but told us they would always escalate any issues to their manager and submit an incident report. Most staff however, gave good examples of their understanding though not all had to exercise this.

We observed handover and safety briefings across the services we visited where incidents related to patient safety were discussed. Staff shared information they felt may be a potential incident and had the opportunity to discuss this with their peers. This helped to support staff with their decision making and discuss the most effective way to address the concerns.
The trust produced a weekly safety bulletin which was sent to all staff by email. This was uploaded to the trust internal hub which was accessible by all staff. There was a shared learning page where a sample of incidents and lessons learned were discussed.

Incidents related to poor discharge from other services were escalated. The trust liaised with other services to report incidents and lessons learned were shared across the relevant services to help mitigate future risks.

Where medication errors were reported, the medicines management team were involved in developing lessons learned and actions to help mitigate future risks.

We heard good examples of lessons learned from incidents that had changed practice and identified the need for a review in procedures. We saw evidence of changes to policy and the introduction of local safety standards because of learning from incidents.

We were told of reported incidents that had identified potential staff safety issues. This had resulted in an assessment of lone working and services reviewed the cut off times for new referrals. This ensured staff were safer when attending visits and supported where there were potential risks.

**Is the service effective?**

**Evidence-based care and treatment**

The trust internal electronic system had a section for staff to keep updated on current practice. Staff could access information on a specific topic, for example sepsis management, and gain relevant guidance and information. These were evidenced based from resources such as the National Institute for Health and Care Excellence.

Staff in the lymphoedema specialist team told us they attended the bi monthly lymphoedema network meetings. These were held locally and evidence based training sessions were delivered by specialists. This training was cascaded to all staff during team meetings.

All staff with a professional prescribing qualification were required to submit evidence of competence as part of their professional registration. Staff kept up to date with current practice using websites and national publications.

Staff participated in specialist networks developed by NHS England that were evidence based. Staff attended local and national groups and information from the groups was fed back to staff during team meetings or dedicated teaching sessions.

Staff used nationally recognised assessment tools to screen patients for certain risks such as pressure damage and malnutrition. Staff in the podiatry service followed national guidelines in prevention and management of diabetic foot problems. They also offered all patients with diabetes yearly foot checks and access to a foot assessment. This was in line with national guidance in the management of rheumatoid arthritis.

**Nutrition and hydration (only include if specific evidence)**

We saw examples of vulnerable patients who were at risk of self-neglect and the interventions by staff in response to the risks. Staff made referrals to social services and carers were arranged to prepare meals for vulnerable patients.
We saw evidence of risk assessments using the Malnutrition Universal Screening Tool to assess patient’s nutrition and hydration intake. There were discussions with patients about nutrition and hydration in relation to wound healing and warm weather conditions. We saw referrals to the trust dietetic team and community matrons to support long term management of patients at risk.

**Patient outcomes**

**Audits – changes to working practices**

The trust has participated in 13 clinical audits in relation to this core service as part of their Clinical Audit Programme.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Area covered</th>
<th>Key Successes</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Audit of Leg Ulcers within District Nursing</td>
<td>Warrington District Nursing Service</td>
<td>Feedback from the patients included in the audit was positive except for receiving leaflets or other written information where 58% of patients stated they did not receive them.</td>
<td>Redesign service to improve accessibility and timeliness for patients with leg ulcers i.e. increase locations where Doppler clinics are run, purchase more Doppler assist machines and train health care assistants in their use, revise treatment room provision to include specific leg ulcer treatment room sessions. Review existing equipment and premises to ensure suitability and safety.</td>
</tr>
<tr>
<td>Priority Audit of Pressure Ulcer Care</td>
<td>Halton, Warrington, Wigan District Nursing Teams</td>
<td>15 standards audited in total, five improvements and three relating to the management of patients deemed higher risk remained the same at 100%. Improvement in photographing ulcer within 7 days - 59% to 90%. Improvement in evidence of agreed plan of care which included preventative measure - 21% to 70%.</td>
<td>Ensure all new paperwork is used for new referrals. This will prompt for all aspects of assessment to be recorded and timely referral to Tissue Viability.</td>
</tr>
<tr>
<td>Priority Audit of Stroke Care Bundle</td>
<td>Halton Specialist Stroke Team</td>
<td>Use of Caregiver Strain Index - 78%. Referrals to lifestyle services offered where appropriate - 100%</td>
<td>Adapt nationally recognized assessment tools so that they can show comparison over time. Ensure that they have space to record dates and signatures of both the original and subsequent assessments. Include space for rationale if the assessment is not deemed appropriate. Include tick box on caregiver strain index to indicate that the patient does not</td>
</tr>
</tbody>
</table>
have a carer and therefore the tool is not relevant. Review of the patient's carer situation should be undertaken and update on this form also. If the loneliness assessment is deemed inappropriate, there should be a section to explain why and further dates set to review any possible change in the patient status in relation to loneliness. The care bundles are a requirement of Halton CCG.

<table>
<thead>
<tr>
<th>Audit of Heart Failure</th>
<th>Halton, St Helens, Wigan Specialist Heart Failure Teams</th>
<th>Of the 12 standards in the audit, 11 achieve compliance of more than 80%. Seven of those achieved 100%.</th>
<th>Ensure that patients who have had medication changed are called for review within 2 weeks, fully documenting any reasons why review was not done in 2-week timescale.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Audit of Heart Failure Care Bundle</td>
<td>Halton Specialist Heart Failure Team</td>
<td>Nine standards stipulated within the care bundle - seven achieved 100% compliance and the remaining two 95% and 98%.</td>
<td>On an annual monitoring audit cycle to meet CCG requirements. The care bundles are a requirement of Halton CCG.</td>
</tr>
<tr>
<td>Priority Audit of Podiatry Care Bundles</td>
<td>Halton Podiatry Services</td>
<td>Good compliance (i.e. 95% and above) for all applicable standards except in relation to Goal Attainment Scores (GAS).</td>
<td>Continue with implementation of GAS tool focussing on ensuring 6-month score is undertaken to show improvement in patient outcome. The care bundles are a requirement of Halton CCG.</td>
</tr>
<tr>
<td>Audit of Wound Assessment (CQUIN)</td>
<td>Halton, Warrington, Wigan District Nursing Teams</td>
<td>Some elements that comprise a 'full wound assessment' were completed consistently such as wound type and wound site, whether a swab was taken and wound duration.</td>
<td>Paperwork has been redesigned in the case of paper patient health records and SystmOne configured in the case of electronic patient health records (latest CQUIN submission shows improvement from 3% to 51%).</td>
</tr>
<tr>
<td>Audit of the Effectiveness of the Macmillan Physiotherapy Acupuncture Treatment</td>
<td>Wigan Macmillan Physiotherapy</td>
<td>Evidence of improved outcome for the patient in 98% of cases.</td>
<td>A standard operating procedure for acupuncture should be written to give a trail of documentation from referral to appointment and to give clarity regarding which outcome tools to be used, how discharge and future plans should be written. Include aspects of outcome in patient questionnaire to ensure comprehensive picture of patient outcome when combined with outcome tools.</td>
</tr>
</tbody>
</table>

| Audit of Continence Care Bundle and NICE Quality Standard 77. | Halton Specialist Continence Team | 100% of patients had an assessment that included medication, conditions relevant to continence and functional ability. | The Loneliness tool was not being completed while current documentation was under review. This is again being completed and the next audit will reflect an increase. The care bundles are a requirement of Halton CCG. All paperwork to be revised and new paperwork to be used on all new referrals. Clarify commissioning agreement about care bundle standard "Male patients are to have examination of PR to examine prostrate size"

| National Audit of Diabetes Foot Care | Halton, Warrington, Wigan Podiatry Teams | At Warrington and Halton, we have always had foot protection teams in community (specialist intervention for at risk foot) At Warrington and Halton we now have a direct referral route into the (new) MDT (Diabetes Centre) at WGH (5 day a week service) | Continue with national audit across all podiatry sites. Re-launch in April 2018 highlighting revised process around consent with updated posters and patient information leaflets provided by national audit provider.

| National Audit of Parkinson's Neuro-Rehab Team Warrington | | 1. Development of condition passport, for patient to document with professional input and plans. 2. Parkinson's' well-being map to be used as standard when completing patient reviews. 3. To be added to MDT initial assessment form. 4. Implementing Preferred Priorities of Care Documentation | Emphasize to staff the association between completion of PR (pulmonary rehabilitation) and better patient outcomes, and: prioritise the offer of referral of eligible patients during consultations, supporting eligible patients to complete PR programmes wherever possible. Add Medical Research Council score to our post-course paperwork so that it is consistently measured at discharge. Explore the usefulness and feasibility of measuring muscle strength pre and post course.

| National Audit of COPD (Pulmonary Rehab) Wigan Respiratory Team | Recorded in all cases were smoking status, patient oxygen therapy, whether the patient was living alone, BMI and FEV1 score. | |
There has been an improvement in results compared to the previous audit. 86% of patients showed and improved outcome score compared to 76% in the previous cycle of audit. Patient feedback was mostly very positive and complimentary. Overall 92% of patients rated the care they received as “excellent”, “very good” or “good

Monitor via requesting frequent reports from the Information and Performance team to ensure the outcome scores are taken
a) for all patients;
b) at first appointment and at discharge

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

The services we visited participated in local and national audits. The outcome of audits was used to monitor and develop services across the trust. We were told of joint working with services across the boroughs where gaps in service provision were identified.

We saw data demonstrating effective service provision for patients such as avoidance of hospital admissions, reduction in hospital stays and management of long term conditions. Data from audits and benchmarking against other services was used to monitor the quality of the services and improve the quality of care for patients.

Staff in the heart failure team told us of their participation in the National Audit for Cardiac Rehabilitation. The audit demonstrated the team were performing well compared to similar trusts and was used as a benchmark for performance.

Data was gathered by the community response team from the acute trust emergency department and the local ambulance service. This showed a consistent reduction in hospital admissions for patients who could be supported at home with the right intervention from the team.

The trust used an online application to monitor patient outcomes such as patient satisfaction surveys and patient experience with the health and social care system. They used data to improve and develop services where necessary and informed staff of good practice.

District nursing teams monitored their wound care practice in line with the national Commissioning for Quality and Innovation framework. Although there had been no targets set this year, the trust had developed their own internal audit to measure quality. Data for this was to be collected from the patient electronic record system to monitor wound care across the services.

All clinical managers gathered data for each of the services they were responsible for. This was collated monthly and identified information such as team performance, waiting list numbers and non-attendance in clinics. A monthly summary was sent to the assistant directors for each region to be presented at the trust board.

Data was used to inform stakeholders of the services performance against the expected targets for the trust. This ensured patient outcomes were being met and identified any gaps in services.

Staff in all services we visited demonstrated effective working across the community to support patients at their preferred place of care. We saw evidence of multi-disciplinary team working to ensure patient pathways were followed and involved the right level of care. We saw integrated teams across all services, some developing and some well-established, supporting positive patient outcomes.
**Competent staff**

**Clinical Supervision**

Not all staff reported receiving formal clinical supervision. However, staff told us they received informal supervision on a regular basis. Incidents, concerns about complex patients and issues that impacted on care were discussed within teams where peer support was given. There were opportunities to discuss these on a one to one basis with peers. Staff told us regular support was provided but not all sessions were planned clinical supervision.

Staff in the long-term conditions management team told us they received regular clinical supervision. This was completed on a one to one basis and group sessions. Staff completed a supervision template prior to their supervision and we saw documented records of supervision sessions and action plans to address any issues. Staff in the team also received supervision from external sources such as peer support groups.

The clinical services managers held formal one to one supervision with all team leaders. There were also group supervision sessions arranged quarterly.

Advanced nurse practitioners we spoke with had booked formal clinical supervision with their clinical services manager. They had informal supervision sessions among their peers and good support networks with GP’s and consultants.

We were told staff could attend informal teaching sessions being provided by consultants in the acute trust and some GP surgeries. Specialist nurses, advanced nurse practitioners and community matrons could attend.

The trust had a preceptorship programme lead by the trust learning and development team. The programme supported newly qualified staff in the district nursing teams and practice educators worked alongside staff to support their learning needs. Staff were given protected time with their preceptor to complete competences related to the role. There was a comprehensive learning package including practical and theoretical learning which staff completed before being assessed as competent to carry out their role.

We spoke with two members of staff who had commenced the preceptorship programme. They told us they had a dedicated senior staff member from the learning and development team who worked with them. They were given a small caseload of patients to visit and supported through all aspects of care delivery. We observed staff held records of competencies and reflective pieces to accompany their learning. This was assessed by the preceptor and competencies were signed off as appropriate.

This meant staff were well supported throughout their preceptorship period and were prepared to work autonomously. Team leaders told us of the benefits of the programme and how this supported the rest of the team. Staff would be able to visit patients with the appropriate knowledge and competencies needed.

There were link nurses in each of the district nursing teams for tissue viability and wound management. Staff were supported by the tissue viability team who delivered training sessions on current practice and they attended meetings every six to eight weeks. The sessions included wound management, training around appropriate dressings and the classification of wounds. Link staff cascaded the learning to their respective teams during team meetings or dedicated teaching sessions.
All staff with a professional prescribing qualification maintained their competencies through individual learning using websites and publications such as the British National Formulary and guidance from professional bodies such as the National Institute for Health and Care Excellence. Nursing staff maintained their competencies as part of their professional registration requirements.

Staff in the long-term conditions management team participated in specialist groups relevant to their profession and role. We were told of respiratory specialists who had helped develop a regional respiratory support group for occupational therapists. This supported learning and development on current and best practice. We were told of specialist groups managed by NHS England attended by dermatology practitioners. Information shared at these events was evidence based and in line with current practice. Any relevant information was fed back to the teams and discussed at team meetings to share learning.

The trust supported staff by sourcing and funding training for the lymphoedema specialist team. Specific training in manual lymphatic drainage and multi-layer lymphoedema bandaging were some of the training sessions delivered. There was a university based course for non-qualified staff in chronic oedema management. There was currently a member of staff completing this course.

The lymphoedema specialist team were working with various district nursing teams across the trust to support patients with lymphoedema. As part of a degree course one of the district nurses was developing a module of training to support staff in the community. They were being supported by the lymphoedema nurse specialist team to deliver training across the trust. Work was in progress with the Halton district nursing teams to start delivering this.

We observed staff with special interests which supported the teams when advanced knowledge of a certain area was required. We spoke with staff with a specialist knowledge in tissue viability and staff in the process of completing specific modules in lymphoedema. Staff could call on the advice from teams for support.

We spoke with six staff across the services we visited who were supported by the trust completing either a bachelor or master’s degree. The subject taken was role specific and helped support patients as well as staff when delivering the services.

Appraisal rates

Community adults total

From April 2017 to March 2018 76.1% of permanent non-medical staff within the community services for adult’s core service had received an appraisal compared to the trust target of 90%.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number of staff appraised</th>
<th>Sum of Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Staff</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>72</td>
<td>76</td>
<td>94.7%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>143</td>
<td>212</td>
<td>67.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
Two of the three staff groups within the core service met the appraisal targets.

A breakdown of appraisal rates for nursing staff by site is below:

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number of staff appraised</th>
<th>Sum of Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Woolston Clinic</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Castlefields</td>
<td>8</td>
<td>8</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Appleton</td>
<td>4</td>
<td>4</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Beeches</td>
<td>6</td>
<td>6</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Grappenhall clinic</td>
<td>24</td>
<td>24</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Tower/Grove</td>
<td>10</td>
<td>11</td>
<td>90.9%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Peel house</td>
<td>8</td>
<td>9</td>
<td>88.9%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Beaconsfield</td>
<td>5</td>
<td>6</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Orford Jubilee</td>
<td>20</td>
<td>28</td>
<td>71.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Hallwood</td>
<td>5</td>
<td>7</td>
<td>71.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Millenium House</td>
<td>18</td>
<td>26</td>
<td>69.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Treatment Room service</td>
<td>15</td>
<td>25</td>
<td>60.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Bath St</td>
<td>8</td>
<td>28</td>
<td>28.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Spencer House</td>
<td>6</td>
<td>24</td>
<td>25.0%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>All locations</td>
<td>143</td>
<td>212</td>
<td>67.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Appraisal targets were met for six of the 14 sites within community services for adults at the trust.

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

During our inspection we were informed of issues with the electronic staff record system. This meant not all appraisal figures were correctly uploaded to the system and there was a delay in updated figures being published. The trust learning and development team were keeping a record of all data that would usually be uploaded to the electronic staff record whilst the system was under review.

We saw the trust electronic system used to upload details from appraisals and areas for staff to input their reflection. This template was used to prepare and identify any needs prior to their appraisal. Staff had been advised to keep a record of their appraisal due to the issues identified with the electronic staff record.
We saw completed staff appraisals with records of outcomes and actions to complete in all areas we visited. Staff in the community therapy team had appraisal every six months, however not all staff in the speech and language therapy team had received an appraisal this year. One staff member told us they had not received an appraisal since 2017 and had not had a six-month review. The clinical services manager was aware of the issues presented by the team and an action plan was in place to support staff.

**Multidisciplinary working and coordinated care pathways**

We saw multi-disciplinary working across all teams we visited. Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, health and social care professionals supported each other to provide good care.  

Staff told us of the benefits of integrated teams and working collaboratively to provide a range of services for patients. There were examples of joint visits between health, social and allied health care professionals which helped staff and patients develop an understanding of the various roles in the community.

We saw examples of effective, well-coordinated multidisciplinary team meetings. Staff in the community response team met daily to discuss vulnerable patients. Staff from the hospital at home team, district nurses, advanced nurse practitioners and social care practitioners were involved in multidisciplinary decision making to ensure patient pathways were effective. There was clear evidence of staff awareness about the availability of services in each area. This meant patients were referred to the most appropriate services and promoted holistic patient care.

Staff in the long-term conditions management teams had access to consultant psychologists and specialist GP’s across the borough. They had good links with the acute trust which meant they could seek advice and guidance where required. The team held a consultant led clinic once a month for cardiac patients and could access the advice of the consultant when required.

The heart failure team had strong links with acute hospital trusts and liaised very well with consultant cardiologists. The team held monthly multidisciplinary meetings to discuss deteriorating and complex patients and there was good attendance from a variety of disciplines across health and social care teams. This meant patients were assessed by appropriate staff following local and national cardiac rehabilitation protocols.

The community response team had developed effective collaborative working with the local ambulance service. Patients who were assessed by paramedics as not requiring hospital care were able to remain at home with the community response team input. The team demonstrated reduced hospital admissions and the collaboration ensured patients were treated in the most appropriate place.

Staff told us they were well supported by the tissue viability team and they were easily accessible. The team offered support at joint visits to assess all deteriorating wounds and provided advice to patients on wound management.

**Health promotion**

We saw a range of health promotion activity delivered across the services we visited. Staff we spoke with were aware of services available in the community to support health promotion such as smoking cessation, mobility issues, falls prevention and wound care management.
The heart failure team worked collaboratively with the local acute trust and developed ‘The Heart Pack’ which was a comprehensive literature pack with a range of guidance and information for patients.

There was clear evidence of cross discipline working in developing the pack and it was current and evidence based. There was clear guidance in simple format for patients to read about their condition and contact numbers for both community and acute teams. There was a comprehensive guide to medications common to heart failure patients identifying common side effects and what they are prescribed for. Staff in the team told us how effective the pack was when discussing concerns with patients and it was a useful tool to leave with the patient to view in their own time.

We observed each team had staff with special interests which helped to promote health and wellbeing messages to both staff and patients. We saw staff with experience in diabetes management who had taken extra courses to become competent in the subject.

We saw infection prevention champions who were responsible for promoting good hand hygiene and infection control to staff as well as patients. They also completed hand hygiene audits to ensure staff compliance. We saw experts in wound care management providing effective promotion of good diet, posture and repositioning to prevent pressure sores.

We observed health promotion notice boards at the physiotherapy outpatient clinics with tips on healthy living and advice on pain management and exercises.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Mental Capacity Act and Deprivation of Liberty training completion

The trust was unable to provide data on mental capacity act training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust from April 2017 to March 2018 is in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for this course at the trust.

(Source: Universal Routine Provider Information Request - P38 Training)

**Deprivation of Liberty Safeguards**
The trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

In the Wigan and Warrington boroughs staff using an electronic system had a template to record consent and the records we reviewed reflected discussions of consent. Those teams using paper records had a copy of the consent form in both the home and office notes.

Consent was sought at each assessment and indicated if a patient had the capacity to give their consent. Where a patient lacked capacity or there was any doubt in their ability to give consent, the process prompted an assessment of the patient’s mental capacity.

Staff completed an early warning assessment to identify memory problems or signs of dementia. This identified the task being undertaken and if care was given in the patient’s best interest. If the patient met the set criteria in the assessment tool, the patient was referred to the GP for a full capacity assessment.

The trust used a Department of Health consent form for adults who were unable to consent to treatment. A copy of the document was retained in the patients notes and a copy was scanned onto the patient record for those who used the electronic system.

However, not all the staff we spoke with in the Halton borough had a good understanding of the Mental Capacity Act 2005. Staff said they would contact the trust safeguarding team for advice when assessing patients who may not have the capacity to make an informed decision and not all staff were aware that consent was decision specific.

Staff had access to a learning disability matron who they could contact for advice. Staff told us they would also discuss with parents of a patient with a learning disability on what action to take regarding consent for the patient.

Not all staff we spoke with completed mental capacity assessments and patients were referred to their GP. District nursing teams in Runcorn and Widnes used the ‘6- CIT’ (Cognitive impairment Tool) for all patients aged 65 and over who were suspected of cognitive impairment (the ‘6- CIT’ Tool is used in primary care as a dementia screening tool).

District nurses then referred the patient to their GP for a full mental capacity assessment or memory test and completion of the Department of Health consent form 4. Patients diagnosed with dementia, learning disability or patients with palliative care needs were excluded from the ‘6-CIT’ process. Staff said they would refer these patients direct to their GP for a mental capacity assessment and consent form 4.

Integrated teams in the Warrington and Wigan boroughs had access to the duty social workers where they would discuss any issues with a patient’s Deprivation of Liberty safeguards (DoLS). Those we spoke with had not been involved in any DoLS applications but could explain what these were and the process they would follow if one was considered.

The district nursing teams documented the consent status in the patient records, including if a patient did not have the capacity to consent. However, when we asked staff in the Halton borough district nursing teams to see assessment documents, they were unable to produce these. We were told these were kept in the patient’s home notes and where the patients electronic record stated these documents had been completed, staff were unable to access the assessment electronically.
We were told by the trust the Halton borough were in the process of transferring all records onto the same electronic record system used by the GP. This meant improved access to shared documentation and assessment tools.

The Warrington podiatry service told us they obtain written consent from all patients for nail surgery. For patients who may not have the capacity to consent, staff said they would consult with the patient’s carer and contact the safeguarding team for further advice. Podiatry staff were observed seeking patient consent to share records with the patients GP.

**Is the service caring?**

**Compassionate care**

During our inspection we spoke with 21 patients and family members. We observed staff in clinics and treatment rooms being sensitive and supportive towards the patients who use the service.

Staff we observed consistently demonstrated compassion for patients and those close to them. Feedback from patients confirmed that staff treated them well and with kindness. We saw cards and letters from patients expressing their thanks and gratitude.

Patients told us of excellent staff attitudes towards them, treating them as individuals and showed empathy to patients and those close to them. All patient and families we spoke with commented on the excellent rapport they observed among team members.

One patient said, ‘all the podiatrists are really friendly and helpful at every appointment” and another stated “staff are fabulous.” Another patient said they did not always follow advice that was given but staff never made them feel bad about it. Staff were always happy to give more advice and explained their rationale for the advice they gave. Other patients said they felt listened to and that they were offered support to understand their condition.

Podiatry patients and carer’s reported being able to see the same podiatrist at each visit which helped develop relationships with patients and those close to them. One patients relative told us “My mum sees the same lady each time and gets on really well with her.”

**Emotional support**

We observed interactions between staff and patients presenting with various conditions. Each were treated individually and given time to express their wishes. We saw staff listening without interruption and offering advice at appropriate times where necessary. Staff were skilled in communication techniques to allow patients time to absorb the information they were given and time to respond.

We were told of excellent responses by staff in supporting patients who were at risk of deterioration. A complex patient had not wanted to follow the advice of the community nursing team and risked a deterioration in their condition. The patient was listened to and supported to understand all the risks associated with the decision and was supported to make an informed choice about their care which was respected by the community nursing team.

We saw examples where staff extended clinic times and home visits to support patients. They spent time listening to patients and allowed time for patients to express their wishes. Staff told us they would try to support patients and their families as much as possible rather than simply referring them on elsewhere.
Staff showed a good understanding and knowledge of available support in the areas they worked and referred patients to an appropriate service where necessary.

We observed a home visit to a recently bereaved family. The nurse used appropriate language to reduce the family’s anxieties and was sensitive to their needs. They showed empathy throughout the conversation and provided appropriate time to answer questions and listen to their concerns. Although the staff member was delayed in their duties, this did not impact on the way they managed the situation and left the family reassured that their concerns were heard and would be escalated.

**Understanding and involvement of patients and those close to them**

We observed effective promotion of patients managing their conditions and participating in their care. We observed staff discussing the task they were performing and giving reassurance throughout treatments. Staff consistently gained assurance from patients during interventions to ensure they were comfortable and understood what was happening at each stage of their treatment or procedure.

Care across all services we visited was fully patient focused with the emphasis on patient and family involvement. Care was delivered in a way that ensured patient’s wishes and circumstances were considered such as social living conditions, complexity of health condition and support from family or carers. We saw examples of staff working outside their remit to ensure patients were supported.

A patient requiring a scan before any intervention could be offered, meant there would be a delay in treatment. This was identified by the therapist who spent time planning for the scan whilst the patient was on site. The team worked collaboratively with the diagnostic services on site to facilitate the scan at the time of the appointment. This meant there was limited delay and safe treatment could commence once any risks were ruled out.

We met patients who had received exemplary support and care from the intravenous therapy team over many years. One patient told us the team had taught them how to safely manage their intravenous lines and support the patient remotely by telephone and skype calls. Whilst the patient was out of the country, they were concerned about an issue with their device. Due to the time difference between countries, the staff had planned to speak to the patient out of hours. This meant the patient had been able to go on holiday abroad and still had access to the team when required.

The patient said, “the support from the team is a godsend, they’ve given me my life back”. Support from the team had developed the patient’s confidence and meant they could educate others involved in their care. This was particularly important to the patient when accessing other healthcare services and the team had an excellent understanding of how to support this.

Another patient and their spouse told us of staff changing clinic times to enable another family member to attend. We heard of teams altering their visit schedule to attend the patients home at a time they were too ill to attend clinic rather than cancelling the clinic and rearranging.

One patient told us the nurses had completed their treatment of a wound that had healed and the patient was ready for discharge. However, staff kept the patient on their caseload as there was a medical device in place. This was not essential as the device was being removed in a week but the team felt they could support the patient further to manage this. The patient appreciated the support and knowing there was support if needed.
We saw effective and well-coordinated management of visits to enable family members or carers to be present. We also observed ways in which patient assessments were jointly planned to ensure a multidisciplinary approach.

We observed exceptional interactions between nurses and GPs when discussing patients. Patients were discussed in a personalised way and it was clear both parties had a good understanding of their patients. Conversations were sensitive and focused around the patient, their family and social circumstances that may have an impact on their care.

Staff in all services we visited had built effective relationships with patients which helped develop an understanding of patient needs and wishes. We spoke with relatives and carers for patients who felt overwhelming support from staff. One told us the positive impact the team had on relieving some of the worry and pressure of caring for their loved one.

### Is the service responsive?

**Planning and delivering services which meet people’s needs**

We observed person-centred care pathways in the community with integrated teams of both health and social care services. The trust worked collaboratively with both community and acute services which supported the patient through their health and social care pathway.

We observed strong multidisciplinary team working across the service which ensured patient needs were assessed and delivered by the right staff.

In the Wigan borough we observed an extremely effective and well managed multi-disciplinary meeting among staff from the community response team, hospital at home team, district nurses, advanced nurse practitioners and social workers. This was a safety huddle that took place daily where staff raised concerns about patients who were known to the service or referred by the single point of access team. Patients were identified who were at risk of a deterioration in their health condition and changes in social circumstances that might impact on their health. These patients were assessed to see if they could be supported at home with the right input.

The aim of the huddles was to assess the current provision of services and offer the appropriate health and/or social care input to support the patient. This reduced the risk of avoidable hospital admission and reduced the length of hospital stay for patients who could be supported at home by utilising the different teams.

There were comprehensive discussions and a clear knowledge of services available which benefitted patients. There was clear evidence of patient wishes throughout the discussions. Staff frequently reflected on what had worked for the patient in the past and what the patient’s preference might be.

Staff in the community response team had access to all electronic record systems of the health and social care services the patient was known to. This meant the team were fully aware of what services were already in place and any referrals made to other services. This avoided duplication of referrals and streamlined access to the services available.

The trust delivered long term condition management with specialist teams in cardiac rehabilitation, respiratory disease, vascular disease, lymphoedema and dermatology. The integrated teams were based at various localities across the trust to meet the needs of the population. We saw knowledge and expertise demonstrated by staff. We observed effective, comprehensive referrals between teams when staff identified patients with multiple long-term conditions. This demonstrated a holistic approach and effective management of patient care.
Based on current national and local evidence, the community cardiac team had identified the benefits of physiotherapy as part of a cardiac rehabilitation programme. During a 12-month pilot, they employed a physiotherapist to join the team delivering therapy to patients who met the rehabilitation criteria. At the time of our inspection, the evidence of benefit to patients was very positive and the team were now in the process of developing a business plan to recruit permanently into the role. This meant the service would offer a fully integrated and holistic approach to cardiac rehabilitation for patients.

The long-term conditions management team identified a gap in provision of electrocardiogram and Echocardiogram (diagnostic tests for patients in the community. In collaboration with colleagues in the acute trust, they set up three clinics per month delivering the tests at a local facility. This had proven beneficial to patients as initial availability was limited and they could attend locally.

We saw evidence of a significant reduction in hospital admissions because of joint working between the community response team and the local ambulance service. The team identified potential patients who might have been admitted to hospital following a fall or exacerbation of their long-term condition. Where it was assessed by the paramedics that admission could be avoided with the right care at home, the patient was referred to the community response team.

We saw data collated between the community response team and the local ambulance service over a two-week period. This identified 143 ambulance call outs avoided admission to hospital because of the community response team intervention.

An advanced nurse practitioner from the team attended the patients home within two hours to assess their needs and discuss relevant community services. The team had access to nurses, physiotherapists, occupational therapists and social workers. This meant social, therapy and healthcare needs were addressed and enabled the patient to remain at home with the appropriate input.

We were told of several pilots in progress across the services that had identified gaps in service provision. The services used data gathered to assess where extra services could be delivered safely which meant they could maintain and improve the quality of care for patients.

Staff in the podiatry service identified all patients with diabetes and offered yearly foot checks and access to a foot assessment. This was in line with national guidance in the management of rheumatoid arthritis.

The trust muscular skeletal team offered a range of rehabilitation classes for patients recovering from surgery, pain management and support following sports injuries. We saw effective collaborative working with the local leisure facilities and provided a range of activities for patients to support their rehabilitation. There were many groups available covering a variety of conditions which meant patients had access to the most appropriate class for their needs. Due to the popularity of these classes, there were waiting lists. In the meantime, patients were supported by an appropriate clinician to manage their condition with exercises and pain management.

**Meeting the needs of people in vulnerable circumstances**

We saw examples of vulnerable patients who were at risk of self-neglect and the interventions by staff in response to the risks. Staff had knowledge of their caseload and we observed skilled assessments of potential situations where a patient might become vulnerable. There was evidence of advanced assessment skills among team members to address risks and avoid a deterioration in patient’s circumstances.
We observed comprehensive discussions between staff about vulnerable patients on their caseload and those identified as being potentially vulnerable following a recent bereavement for example.

We saw effective multi-disciplinary team meetings that were held daily to discuss the most vulnerable patients across all services and where the teams had worked collaboratively to avoid patients deteriorating. Teams worked well with social services to input carers to prepare meals for vulnerable patients. This had helped support patients to remain at home and potentially avoid hospitalisation.

Staff at the intravenous therapy team had completed a very successful trial supporting patients at home with specialist drug treatment. This was an innovative, new way of treating patients who would usually have to attend hospital for the treatment. The outcome of the trial meant that plans were being discussed with the acute trust to develop the service further. A second trial was planned to extend the service to patients with other long-term conditions and the team were identifying patients who would benefit from this service.

The Warrington central east and central north teams told us about Advancing Quality Alliance training for community nurses aimed at improving a patient centered approach to patient care. They told us how this had been put in to practice with a complex patient who had not wanted to follow the advice of the community nursing team and risked a deterioration in their condition. The patient was listened to and supported to understand all the risks associated with their decision and was enabled to make an informed choice about their care which was respected by the community nursing team.

The case study was presented to the patient safety committee and the team received positive feedback from the chair of the committee.

The trust had community matrons and a learning disability matron based in teams across the Halton borough. Staff also had access to the learning disability team where the matron was based. They supported patients with long term conditions and encouraged self-management of conditions to enable patients more autonomy. The impact of the team had reduced the likelihood of hospital admission and helped facilitate earlier discharge from hospital or short-term care.

We spoke with staff who had a special interest in patients with dementia and the impact it had on patients, families and carers. Some staff had signed up to the dementia friends programme which was aimed at raising awareness of the disease. One staff member had been recognised for their contribution to care for patients with dementia and received an award in recognition of this.

Clinical services managers told us of the trust preparation for winter pressures and the potential impact on service delivery. Plans were in place for the intravenous therapy team to have direct access to the acute trust consultant for advice. This would help avoid admission to hospital where appropriate.

Teams across all services were reviewing their clinics to establish capacity and staffing in preparation for an increase in patients. Patients would be prioritised based on complexity which would help avoid admission to hospital. There were plans to utilise agency advanced nurse practitioners to support patients during the winter pressures.

**Access to the right care at the right time**

**Referrals**
The trust has identified the below services within Wigan borough in the table as measured on 'referral to initial assessment'.

A list of services where with the median reported time from referral to treatment against the target is provided in the table below. The trust did not provide data on days from initial assessment to onset of treatment.

<table>
<thead>
<tr>
<th>Name of hospital site or location</th>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Local Target (days)</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Nutritional Support Clinics</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Community Neuro SALT</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>DESMOND</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Nutritional Support Domiciliary</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Community Neuro</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Lymphedema Nursing</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Community Stroke</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Diabetes Dietetics</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Respiratory Specialist Nursing</td>
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<td>Respiratory COPD Nursing</td>
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<tr>
<td>Wigan Borough</td>
<td>Adult SALT</td>
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<tr>
<td>Wigan Borough</td>
<td>Dermatology GPwSI</td>
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</tr>
<tr>
<td>Wigan Borough</td>
<td>Respiratory Pulmonary Rehab (Physio)</td>
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</tr>
<tr>
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<td>LAC Nurse</td>
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<tr>
<td>Wigan Borough</td>
<td>MSK CATS</td>
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<tr>
<td>Wigan Borough</td>
<td>Chronic Fatigue/ME</td>
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<tr>
<td>Wigan Borough</td>
<td>Continence</td>
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<tr>
<td>Wigan Borough</td>
<td>Community Rehab Falls Team</td>
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<td>Wigan Borough</td>
<td>Dermatology Nursing</td>
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<tr>
<td>Wigan Borough</td>
<td>DN Ear Care Service</td>
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</tr>
<tr>
<td>Wigan Borough</td>
<td>Diabetes Nursing</td>
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<tr>
<td>Wigan Borough</td>
<td>CFS Consultant</td>
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<tr>
<td>Wigan Borough</td>
<td>Podiatry Diabetes</td>
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<tr>
<td>Wigan Borough</td>
<td>MSK Physiotherapy</td>
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<tr>
<td>Wigan Borough</td>
<td>TB Service</td>
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<tr>
<td>Wigan Borough</td>
<td>Heart Failure ECHO</td>
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</tr>
<tr>
<td>Name of hospital site or location</td>
<td>Service Type</td>
<td>Days from referral to initial assessment</td>
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<tr>
<td></td>
<td></td>
<td>Local Target (days)</td>
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<tr>
<td>Wigan Borough</td>
<td>Heart Failure ECHO Consultant</td>
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<tr>
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<td>Oxygen Assessment Service</td>
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<td>Wigan Borough</td>
<td>Podiatry Biomechanics Adults</td>
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<td>Community Matron Neuro Rehab</td>
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<td>Chronic Pain Management</td>
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<td>Community OT</td>
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<tr>
<td>Wigan Borough</td>
<td>POPPS</td>
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<tr>
<td>Wigan Borough</td>
<td>Community Physio</td>
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<tr>
<td>Wigan Borough</td>
<td>Cardiac Rehab Physio</td>
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<tr>
<td>Wigan Borough</td>
<td>Fracture Liaison Service</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Respiratory Pulmonary Rehab(OT)</td>
<td>42</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Adult LD Additional Support Service</td>
<td>42</td>
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<tr>
<td>Wigan Borough</td>
<td>Heart Failure Nursing</td>
<td>42</td>
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<tr>
<td>Wigan Borough</td>
<td>Podiatry Nail Surgery Adults</td>
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<td>Adult LD Primary Health Service</td>
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<td>Cardiac Rehab OT</td>
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<td>Community Matrons</td>
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<td>District Nursing Service</td>
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<td>Wigan Borough</td>
<td>Cardiac Rehab Nursing</td>
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<td>Counselling</td>
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<td>Wigan Borough</td>
<td>Intermediate Care Medical Cover</td>
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<td>Wigan Borough</td>
<td>Tissue Viability</td>
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<tr>
<td>Wigan Borough</td>
<td>Blood &amp; Blood Transfusion</td>
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<tr>
<td>Wigan Borough</td>
<td>Access to Community Services</td>
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<tr>
<td>Wigan Borough</td>
<td>Advanced Practitioners for Nursing Homes</td>
<td>42</td>
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<tr>
<td>Wigan Borough</td>
<td>Alex Court/Richmond House</td>
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</tr>
<tr>
<td>Wigan Borough</td>
<td>DN Liaison</td>
<td>42</td>
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</tbody>
</table>
Administrative staff told us of the process for managing referrals into the service. Referrals were accepted from any clinician in the community or acute trust. This included GP’s where many referrals came from as well as staff in social services. The team had criteria for acceptance of patients and a facility on the electronic record system to accept or reject patients. Any patients that did not meet the criteria for any of the teams were contacted by letter sent to the referrer with a rationale for rejection and appropriate options. The patient details were uploaded onto the electronic system where a clinician for the relevant team triaged the patient for assessment.

We spoke with the lymphoedema specialist team who told us their referral to assessment times had significantly improved. Their current waiting time was a maximum of four weeks. Patients were allocated 60 minutes for initial assessment in clinic but these could be adapted depending on the complexity.

The trust community response team were reviewing their ways of working model with the intention of expanding the team to deliver a seven-day service. There was recruitment under way for allied health professionals and advanced nurse practitioners to facilitate this.

Patients who were assessed by paramedics as not requiring hospital care were able to remain at home with the community response team input. The team demonstrated reduced hospital admissions and the collaboration ensured patients were treated in the most appropriate place.

All patients referred into the service were contacted by telephone initially. Patients were triaged on referral and assessed within two to 24 hours depending on complexity. On average, patients remained on the caseload for up to 72 hours during which time referrals for long term services were made where required. We observed referrals to a range of community health and social services such as community matrons, specialist practitioners, district nurses and social care agencies.

The Warrington podiatry clinics operated clinics from eight locations across Warrington providing routine appointments and nail surgery. They also provided an evening service up until 7pm two days per week as well as home and hospital visits. Emergency appointments for existing patients were available at a drop-in clinic and seen on a first come, first seen basis. Drop in clinics were advertised in the clinics we visited and accessed by any patient at any of the clinics.

Patients could self-refer to the podiatry team and referrals were accepted electronically from GP’s and health professionals. A biomechanics clinic operated from Wolves Health Centre and required a GP or clinician referral. This clinic looked at the function and movement of feet, assessing for devices that would aid patients comfort and mobility. The service told us they received an average of ten referrals per day. The podiatry service did not audit referral to appointment response times, however staff told us patients were seen eight to ten weeks following referral for a routine appointment; 12-14 weeks for a biomechanics appointment and all patients are seen within the 18-week target set nationally.

### Table: Provider Statistics

<table>
<thead>
<tr>
<th>Wigan Borough</th>
<th>Hospital at Home Service</th>
<th>42</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wigan Borough</td>
<td>Integrated Community Nursing and Therapies</td>
<td>42</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: CHS Routine Provider Information Request – CHS10 Referrals)
Staff in the podiatry service told us about an unexpected surge in referrals during July 2018 due to a problem with the local access service gateway. In response to the increased referrals, patients were prioritised and additional clinics were held to meet the demand.

The service experienced a high number of patients not attending for their appointments. For example, we were told that 48 patients did not attend at Wolves clinic during the week preceding our inspection. The service used a text reminder system to alert patients of their appointment and displayed lost clinic times to inform staff and patients of the impact of not attending. Staff stated clinics were very busy and available slots were used as ‘catchup time’ when clinics overran.

Staff in the dermatology specialist team told us their service had no waiting lists and patients would be seen within 24 hours of referral. The service was provided across three sites which meant access for patients was good.

Patients who requested prompts about their appointments were offered a reminder telephone call on the day of the appointment. The request was logged in the patient clinic list alongside the appointment when booking and was visible to the clinician managing the clinic.

The single point of access service provided a nurse led approach across Warrington to coordinate urgent referrals for unplanned care needs. The team had a positive impact on patient care by reducing the likelihood of hospital admissions, expedite hospital discharge and ensure patients and staff had access to the most appropriate care pathways. The team also identified gaps in service provision and signposted health professionals to the most appropriate services.

Referrals were accepted from health professionals, social services and high-risk patients who had been identified by staff across the services. Referrals were received by telephone and a call handler, supported by a senior nurse practitioner, assessed the most appropriate pathway for the patient. The team had access to 57 different pathways of care which meant patients were assessed in a timely way and helped to mitigate the risk of inappropriate referrals.

Staff in the Warrington speech and language therapy team told us of delays in patients accessing swallowing assessments. The team had raised these concerns urgently with the clinical services manager and actions were put in place to respond to delays. The action plan identified the recruitment of senior locum staff to specifically manage the swallowing assessment caseload and the list had reduced significantly. When the action plan was initiated there were 40 patients on priority 2 list. At the time of inspection, this had been reduced to four.

There were plans in place to mitigate risks by recruiting two agency staff and a telephone triage system was reinstated.

Learning from complaints and concerns

Complaints

From April 2017 to March 2018 there were 15 complaints about community services for adults. The trust took an average of 36.8 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 25 working days.

A summary of complaints within community services for adults by subject is below:

Community Adults Total
<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>2</td>
</tr>
<tr>
<td>Waiting times</td>
<td>2</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

We observed questionnaires and patient satisfaction surveys in the clinics we visited. Staff were encouraged to ask patients to complete these during their visit. Staff were aware of the patient complaints process and told us they directed patients to the patient advice and liaison service if they wanted to make a complaint.

Complaints were discussed at the quality and safety group meetings. Any complaints needing investigation were raised by the teams initially and taken to the group by the clinical services managers. Any outcomes or actions were shared with the appropriate team. Any lessons learned were identified in the quarterly team briefing and discussed as part of the team meetings.

Staff we spoke with were aware of the complaints procedure for the trust but those we spoke with had not had any involvement with any formal complaints. We were told of situations where patients raised a complaint informally and how this was dealt with by the staff or team leader.

Not all staff we spoke with were familiar with the duty of candour process. Most staff however, gave good examples of their understanding though not all had to exercise this. One example was given where a patient record had been stolen and the formal duty of candour process was followed.

**Compliments**

From April 2017 to March 2018 the trust received 655 compliments. Of these 325 related to community services for adults, which accounted for 49.6% of all compliments received by the trust. A breakdown by location is below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warrington</td>
<td>163</td>
</tr>
<tr>
<td>Wigan</td>
<td>85</td>
</tr>
<tr>
<td>Halton</td>
<td>48</td>
</tr>
<tr>
<td>St Helens</td>
<td>24</td>
</tr>
<tr>
<td>Bolton</td>
<td>5</td>
</tr>
<tr>
<td><strong>All locations</strong></td>
<td><strong>325</strong></td>
</tr>
</tbody>
</table>
Is the service well-led?

Leadership

The trust had managers at all levels with the right skills and abilities to run a service providing high-quality sustainable care. All staff we spoke with told us they were well supported by their managers.

Team leaders were approachable and staff spoke highly of their support and presence in each team. We saw evidence of team leaders managing staff effectively and working alongside staff to support them and their patients. We observed one new team leader in post who was well supported by the managers and told us how they were accessible on site or by email and telephone.

All clinical services managers we spoke with told us of their team leader competencies in managing their teams. They were reliant on supportive leaders and this was evident in the teams we visited. Managers were visible and frequently visited the teams.

Team leaders told us the clinical services managers were accessible and worked closely with them to maintain high standards across the services. They held regular meetings to monitor team performance and share information from the trust board.

We spoke to the assistant directors for each borough who told us the trust was in the process of senior management restructuring. Roles were being reviewed and developed to ensure effective delivery of the trust vision and strategy.

Vision and strategy

The trust had a clear vision and strategy. Their mission was “to improve local health and promote wellbeing in the communities. (we will do this) … “by working closely with local people and partners to promote good health and to be a leading provider of excellent community healthcare services in the North West.” During our inspection we saw effective examples of this in practice.

There was a clear commitment to developing an integrated care model across all services we visited. However, not all services had integrated fully and we observed staff did not always share good practice across the services. We spoke with the trust and were given assurance that work was being done across all services to implement this.

The clinical services managers for each borough met weekly to discuss good practice and areas for improvement which helped develop integrated working across the services.

Staff across all services we visited were clear on the plans for the trust in bringing together health and social services to ensure integrated working. The trust was working with stakeholders and clinical commissioning groups in the boroughs to support this.

Staff we spoke with in the Warrington borough were aware of the Warrington Together Initiative which aimed to support patients with input from multidisciplinary teams across health and social care. We saw very good examples of this in practice.

Staff in the Halton borough told us of a similar initiative ‘One Halton’ which aimed to bring health and social care together to deliver holistic care for patients across the borough. We saw excellent examples of joint working between services and GPs which supported the initiative ethos.
Staff in the Wigan borough spoke positively of the integrated services and we saw examples of joint working, team meetings and patient safety huddles incorporating staff from all disciplines across the borough.

**Culture**

Staff in all services we visited had effective working relationships with each other. There were clear staff support networks and all staff we spoke with felt supported by their colleagues. We observed staff offering support and advice about individual patients through informal discussion, shared experience and knowledge.

We observed a range of staff disciplines in the services we visited. At the time of our inspection, the service was in the process of integrating all staff across health and social care into single teams. This meant all staff delivering care were working together as one team and delivering holistic care across the communities.

We observed staff supporting each other in all teams we visited and heard of staff supporting those who were off sick or needing moral support.

We observed good examples of nursing, occupational therapy, physiotherapy and social work staff working together to address patient needs. Staff told us there had been some challenges during the transformation of community services and some staff had felt unsettled. However, there had been improvements in staff morale and there was good evidence of staff support for each other.

Speech and language therapy staff in Warrington told us of pressures of workload and a poor response from senior management. Meetings were held with the clinical services manager to discuss ways to improve the situation and developed an action plan to help mitigate some of the issues.

We saw evidence of management intervention and the issues raised to us by the team were identified on the action plan. There were clear processes to support staff and help reduce the burden on the team. We saw systems to provide extra support to staff such as support from other teams, group supervision for staff and senior management meetings with the team to discuss options.

Despite the issues raised, the speech and language team told us they were proud of their team and how they support one another. There was a clear positive team spirit which reflected across the team. This helped to ensure the issues did not have a negative impact on the quality of the service delivered.

**Governance**

Community health services for adults were delivered across Wigan, Warrington, Halton and St Helens. There were clear divisional governance arrangements in place and all staff we spoke with were clear of their lines of accountability.

The organisational structure in each borough comprised of team leaders who were responsible for the daily management of each team and reported directly to the clinical service managers for each service.

Clinical services managers were responsible for services in a borough based structure across the trust. This meant services were delivered to meet the needs of the population in each borough and were varied according to locality and stakeholder requirements.
The trust was developing an integrated care model and managed teams across health and social care. Clinical services managers reported directly to an associate director for each borough who in turn reported to the chief nurse and operating officer.

Community services for adults were represented at trust board level by the chief nurse and operating officer. Actions from the board meetings were fed back down to each team by the respective clinical service managers.

Data of performance and service delivery from each team were reported at the quality and safety group for each region and submitted to the board by the clinical services managers.

The transformation board made up of local stakeholders, social care services and trust representatives met monthly to discuss the progress with integrating services. Actions and discussion points from the group were reported back at the staff team meetings.

Management of risk, issues and performance

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The service held a divisional and trust wide risk register. Risks we expected the trust to be aware of were on the risk register. The clinical services managers and assistant directors for each borough could discuss these with us.

The trust quality and safety group met monthly where all risks, serious incidents and performance were addressed. All clinical managers attended the meetings representing their boroughs and team leaders were encouraged to attend for development opportunities.

The trust produced a quarterly safety briefing that identified lessons learned and good practice. This was sent to all staff by email and onto the trust intranet.

The clinical commissioning group for each borough set the trust targets for performance. These varied according to the needs of each borough and within localities of each borough. For example, an area populated by a lot of patients with diabetes were provided services to meet those needs. The teams we visited reviewed their services to monitor the risks of the community.

Information management

The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care. All services monitored their performance using the trust activity dashboard. Data was gathered which identified team’s performance, referrals figures, patient caseload, diagnoses and interventions.

Data was submitted to the clinical services leads for each service and a report was submitted to the trust board. The data was collected by stakeholders and agencies working with the trust such as the local ambulance service. The data was monitored to ensure the trust were meeting the needs of the communities and assess the effectiveness of the services across the trust.

Each service we visited had a standard operating procedure that outlined their service provision and these were reviewed to ensure the trust was meeting the needs of the community.

We saw evidence of standard operating procedures under review in the Wigan integrated teams. Services were being restructured to ensure they were meeting the changing needs of the community and stakeholder requirements.
We were told of pilots that had identified gaps in service provision and the trust were in
discussions with stakeholders to develop services. One example came from the community
response team who were working closely with GPs in the area to identify high intensity service
users. The trust used information available across the services to maintain and improve the quality
of their services and assessed where extra services could be delivered safely.

We were told of effective use of the trust IT systems to monitor patients through the health and
social care system. The community response team had access to health and social care records
which meant staff could ensure patients had the appropriate services involved and refer to
services where they did not.

There was access to the hospital electronic system and any patients admitted to the hospital could
be monitored. This meant staff could ensure their patients were discharged home with the
appropriate care or liaise with the hospital staff to avoid unnecessary prolonged admission.

Engagement

The trust engaged well with patients, staff, the public and local organisations to plan and manage
appropriate services, and collaborated with partner organisations effectively.

Since the inception of integrated care services across the trust all clinical services managers met
weekly to discuss the services in their regions. Members of associated services such as local
authority, acute trust and stakeholders met at the transformation working group.

The lymphoedema specialist team had identified the benefits of networking with the cancer
specialists in the region. The team identified several cancer associated lymphoedema patients and
reviving the cancer network meant they could develop effective working relationships with
associated services in the community. This developed the team’s knowledge of cancer related
lymphoedema and a better understanding of patients in their community.

During the transformation of integrated care services, the community response team held regular
stakeholder operational meetings. The team held weekly team meetings and once a month these
were open to all staff across health and social services.

We were told of the trust organisational meeting held once a month and lead by the chief
executive. This was an opportunity for the chief executive to address all senior management and
the teams to discuss good practice, improvements and areas for development.

There was effective engagement with GP’s across all services we visited. GP’s were kept
informed of patients progress when they were admitted onto the community team caseloads. This
varied across all services ranging from alerts and summaries sent by the patients’ electronic
record system to daily telephone calls. We observed discussions between community staff nurses
and GP’s to discuss patients progress and arrangements for joint visiting.

The trust introduced ‘Glimpses of Brilliance’ to monitor staff performance that enhanced patient
outcomes. We saw many examples of patient feedback and statements identifying positive staff
interventions.

Learning, continuous improvement and innovation

Accreditations
NHS Trusts can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made if to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

The trust did not provide information for this section.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

Staff participated in local and national networks developed by NHS England which meant they were kept informed of current and innovative practice nationally. Staff disseminated information to staff during team meetings or dedicated teaching sessions.

The intravenous therapy team participated in the northwest therapy forum. There were dedicated speakers and training provided at each session. The groups provided an opportunity to share innovation in practice which was then disseminated to the team. The team were in the process of developing an intravenous passport which would be used for patients to keep a record of their own therapy. The aim was to develop patients understanding of their therapy and encourage management of their care.

The team had also identified an innovative, new way of treating patients at home. Working with colleagues in the acute trust, the team completed a trial which had identified patients who could be treated at home. Due to the complex nature of the treatment, patients would usually have to attend hospital for their treatment. The team successfully supported the patients at home which lead to plans being made to further develop the service.

We spoke to three Queen’s Nurses Institute members, one of whom was the local lead for the north west. We were told the trust supported staff to attend the conferences nationally and attend the local meetings.

The Runcorn community nursing team acknowledged excellent practice of a colleague and informed us during our inspection. A health care assistant in the team had received the Cavell Nurses Trust Award for going above and beyond their duties in supporting dementia and palliative care patients to remain at home.

The trust was completing a pilot with GPs, the local ambulance service and the acute trust to identify high intensity service users in the boroughs. Patients at risk of hospital admission and those who frequent GP surgeries were being reviewed to see where community services could provide support at home. It was anticipated that patients would benefit from the community team input to avoid admissions to hospital where appropriate.

Advanced nurse practitioners worked closely with colleagues in the acute trust to identify patients requiring access to physiotherapy and occupational therapy. They completed a pilot with the frailty group using a functional assessment tool to see where support could be given to patients who wanted to remain at home. The outcome of an audit identified positive results and we were told other services had adopted the tool. This meant a range of services worked together to address patient outcomes and patients meeting set criteria were referred to the advanced nurse practitioner.

Staff in the dermatology team told us of their participation in local and national research projects. The team were involved in research on the impact of materials, specifically silk clothing, and
bathing oils had on various skin conditions. The outcome of the research had identified changes in advice given to patients and prescribing activity for the team.

Community health services for children, young people and families

Facts and data about this service

The trust provided the following information about community services for children at Bridgewater Community Healthcare NHS Foundation Trust:

Bridgewater Community Healthcare NHS Foundation Trust are commissioned to provide the healthy child programme 0-19 services in Halton, Warrington, Wigan, Oldham and Bolton. The trust has family nurse practitioner (FNP) teams in Halton, Oldham, Warrington and Wigan. Oldham is an integrated early years’ service delivered from children centres. Bolton is an integrated young person’s service including a bespoke adolescent sexual health and substance misuse element. All boroughs have a NHS England commissioned immunisation service. In Bolton this is a Greater Manchester wide commission to respond to public health outbreaks.

The trust offers a community paediatric service in St Helens, Warrington and Halton. In St Helens the service includes a provision for looked after children. In the Halton, Warrington and Wigan Boroughs the trust delivers a range of community children’s therapies and in St Helens speech and language therapy only.

The trust delivers community children’s nursing and continence services in St Helens, Warrington Halton and Wigan.

The Warrington and Oldham 0-19 services have volunteers who are integral to service delivery.

All services work to the local special educational needs and disabilities (SEND) pathways and local safeguarding children board guidance. Internally teams in all boroughs are supported by safeguarding and looked after children teams. Teams work with complex and vulnerable children young people and families offering tailored interventions to meet individual need. All teams work locally to support effective transition to adult services.

There is active parental and young people involvement in ongoing review and development of the services the trust delivers, with a focus on joined up working with early years settings and schools to support children and young people throughout the day.

Assessment, support and referral onto other services are provided as required.

(Source: CHS Routine Provider Information Request (RPIR) - CHS Context tab)
Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received mandatory online and face-to-face training in a range of modules including health and safety, infection control, moving and handling, equality and diversity, conflict resolution, information governance, fire safety, and the Prevent Strategy. Prevent Strategy training was aimed at identifying individuals at risk of extremism or radicalisation.

The average completion rate for mandatory training in children and young people’s services for all staff, clinical and non-clinical across all the boroughs was 88% just below the trust’s target of 90%, within a range from 84% in Oldham to 94% in Warrington. By subject, the completion rate ranged from 72% in information governance to 97% in health, safety and welfare. By staff group, overall completion rates ranged from 84% for administration and scientific staff to 91% by additional clinical services staff.

The services were moving to electronic recording and management of mandatory training, which alerted individual staff in advance of the expiry of training. Line managers across the services we visited were confident that, where gaps in training existed, staff were booked onto a relevant course. However, staff we spoke with were less confident in the accuracy of centrally held mandatory training data, and there was a reliance in several services on locally held training spreadsheets. At least three members of staff told us they had repeated mandatory training modules before they were due as the centrally held information on last completion dates appeared to be incorrect.

Mandatory training completion

The trust set a target of 90% for completion of mandatory training. Average mandatory training completion rates by subject for staff within the community children, young people and families’ services across all the boroughs at the time of the inspection was as follows:

<table>
<thead>
<tr>
<th>Module name</th>
<th>Medical staff</th>
<th>Nursing staff</th>
<th>Allied health professional staff</th>
<th>Additional clinical services staff</th>
<th>Other staff</th>
<th>Total for all staff groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>90%</td>
<td>85%</td>
<td>75%</td>
<td>88%</td>
<td>72%</td>
<td>81%</td>
</tr>
<tr>
<td>Equality and diversity</td>
<td>95%</td>
<td>97%</td>
<td>96%</td>
<td>98%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>95%</td>
<td>89%</td>
<td>88%</td>
<td>92%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Health, safety and welfare</td>
<td>95%</td>
<td>97%</td>
<td>96%</td>
<td>100%</td>
<td>96%</td>
<td>97%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>57%</td>
<td>74%</td>
<td>85%</td>
<td>80%</td>
<td>62%</td>
<td>72%</td>
</tr>
<tr>
<td>Infection prevention and control - clinical</td>
<td>57%</td>
<td>80%</td>
<td>90%</td>
<td>78%</td>
<td>67%</td>
<td>78%</td>
</tr>
<tr>
<td>Infection prevention and control – non-clinical</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>95%</td>
<td>95%</td>
</tr>
</tbody>
</table>
Moving and handling | 95% | 95% | 96% | 99% | 93% | 95%
---|---|---|---|---|---|---
Preventing radicalisation | 95% | 92% | 88% | 90% | 94% | 88%
**Total** | **85%** | **89%** | **89%** | **91%** | **84%** | **88%**

(Source: Post-inspection additional data request – DR1)

Average mandatory training completion rates for all staff groups by borough was as follows:

<table>
<thead>
<tr>
<th>Conflict resolution</th>
<th>Bolton</th>
<th>Halton</th>
<th>Oldham</th>
<th>St Helens</th>
<th>Warrington</th>
<th>Wigan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and diversity</td>
<td>99%</td>
<td>93%</td>
<td>98%</td>
<td>93%</td>
<td>99%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Fire safety</td>
<td>90%</td>
<td>90%</td>
<td>80%</td>
<td>84%</td>
<td>97%</td>
<td>92%</td>
<td>89%</td>
</tr>
<tr>
<td>Health safety and welfare</td>
<td>99%</td>
<td>94%</td>
<td>98%</td>
<td>96%</td>
<td>99%</td>
<td>98%</td>
<td>97%</td>
</tr>
<tr>
<td>Information governance</td>
<td>64%</td>
<td>65%</td>
<td>59%</td>
<td>75%</td>
<td>87%</td>
<td>73%</td>
<td>72%</td>
</tr>
<tr>
<td>Infection prevention and control - clinical</td>
<td>56%</td>
<td>71%</td>
<td>55%</td>
<td>87%</td>
<td>93%</td>
<td>83%</td>
<td>78%</td>
</tr>
<tr>
<td>Infection prevention and control – non-clinical</td>
<td>95%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>95%</td>
</tr>
<tr>
<td>Moving and handling</td>
<td>98%</td>
<td>92%</td>
<td>96%</td>
<td>95%</td>
<td>96%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Preventing radicalisation</td>
<td>99%</td>
<td>88%</td>
<td>90%</td>
<td>93%</td>
<td>90%</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>87%</strong></td>
<td><strong>85%</strong></td>
<td><strong>84%</strong></td>
<td><strong>87%</strong></td>
<td><strong>94%</strong></td>
<td><strong>90%</strong></td>
<td><strong>88%</strong></td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request – DR1)

**Safeguarding**

There were systems, processes and practices in place to keep people safe and safeguarded from abuse. Staff were aware of how to access support from the safeguarding team and had received training at the appropriate level.

The trust had a safeguarding children policy. The policy was comprehensive and adhered to national legislation and guidance. It clearly set out its objectives, scope, definitions and staff members’ accountabilities. It included information on the safeguarding referrals process, capturing the voice of the child, and standards for safeguarding record keeping, information sharing and interagency working.

The service had a safeguarding supervision policy, which set out the statutory, legal and national best practice requirements, including the trust’s commitment to safeguarding supervision. The policy also set out clear roles and responsibilities for staff, including which staff groups were to receive individual or group supervision, and how supervision was to be recorded.

Staff we spoke with throughout the service were aware of how to make safeguarding referrals via the trust’s intranet ‘The Hub’; how to contact the social service emergency duty team for urgent
referrals; and how to obtain further information and advice if required. Staff had received training on, and had an awareness of, child sexual exploitation (CSE) and female genital mutilation (FGM). In addition, staff received training on the government’s anti-radicalisation Prevent Strategy. Staff we asked confirmed they received safeguarding supervision both formal and on an ad-hoc basis as required.

The trust’s electronic patient record system included a warning flag facility that alerted staff to any known concerns about a child, including whether they were at risk of child sexual exploitation, were a child in need, or who had child protection plans in place. Although some of the trust’s services still used paper records, the electronic system was used by all the children’s services to ‘accept’ patients. As such, all staff could access any warning flags on children’s records.

We reviewed a safeguarding referral record made by staff in the Woodview Child Development Centre. The referral was completed accurately, and set out the reasons for the referral. The record clearly detailed the actions staff took to discuss the case before, during and after the referral was made.

There was close partnership working by the Safeguarding and Looked after Children’s teams with local social services and the Local Safeguarding Children’s Board.

The children’s service’s named nurses for safeguarding delivered safeguarding level three training for staff, including workshops and bespoke training when requested. The team supported telephone advice to staff within the services, and provided safeguarding group supervision quarterly, and one to one safeguarding supervision for case-holders.

The named nurses for safeguarding met weekly, while the specialist safeguarding nurses attended a quarterly workshop to share relevant information and learning.

The trust’s safeguarding team assurance group provided governance and quality oversight of safeguarding in the children’s services.

**Safeguarding Training completion**

The trust provided up-to-date safeguarding training completion rates. The figures for the community children, young people and families service by staff group and by borough at the time of the inspection are detailed below. The trust’s target for training completion was 90%.

Training completion rates by staff group showed that most of the staff providing care and treatment met or exceeded the trust’s target.

<table>
<thead>
<tr>
<th></th>
<th>Medical staff</th>
<th>Nursing staff</th>
<th>Allied health professional staff</th>
<th>Additional clinical services staff</th>
<th>All staff groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>90%</td>
<td>95%</td>
<td>99%</td>
<td>98%</td>
<td>93%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>90%</td>
<td>89%</td>
<td>87%</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>66%*</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
<td>75%*</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>95%</td>
<td>91%</td>
<td>89%</td>
<td>94%</td>
<td>91%</td>
</tr>
</tbody>
</table>

* Note: Only four medical staff members were eligible for this training.

(Source: Post-inspection additional data request – DR3)
Training completion by borough, which included all clinical and non-clinical staff groups, was:

<table>
<thead>
<tr>
<th></th>
<th>Bolton</th>
<th>Halton</th>
<th>Oldham</th>
<th>St Helens</th>
<th>Warrington</th>
<th>Wigan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>91%</td>
<td>96%</td>
<td>98%</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>81%</td>
<td>88%</td>
<td>85%</td>
<td>84%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 3)</td>
<td>N/A</td>
<td>50%**</td>
<td>N/A</td>
<td>100%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85%</td>
<td>90%</td>
<td>88%</td>
<td>86%</td>
<td>95%</td>
<td>97%</td>
</tr>
</tbody>
</table>

** Note: Only two staff members were eligible for this training.

(Source: Post-inspection additional data request – DR3)

** Safeguarding referrals **

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has its own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community services for children made 102 safeguarding referrals of children from April 2017 to March 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

** Cleanliness, infection control and hygiene **

The service controlled infection risk. Staff kept equipment and the premises clean. They used control measures to prevent the spread of infection.

Children, young people and families’ services were delivered by the trust in a wide variety of locations, including trust premises, schools and children’s centres, multi-occupancy shared-use health centres and community centres.

Responsibility for cleaning varied dependant on the nature of each location and which organisation held the contracts with third party cleaning contractors. We reviewed cleaning schedules, where available, in the centres that we visited including in Halton, Woolston and Warrington. Cleaning audits for these centres showed high levels of compliance. Although the audits provided some assurance to the trust on cleanliness standards, we did not see evidence of daily cleaning checklists to confirm that cleaning had been completed as per the schedule. However, the facilities were visibly clean.

In the services we visited where assessment and treatment was provided, clinic and treatment rooms had appropriate hand washing facilities, including antibacterial gel dispensers for use by
staff and patients. Sterile wipes were available, visible, and were used to clean toys after use and before storing.

Nursing, medical and additional clinical services staff undertook clinical infection prevention and control training. At the time of the inspection 78% of these staff across all the boroughs were compliant with training. All other staff undertook non-clinical infection prevention and control training; this staff group was 95% compliant with the training.

Infection prevention and control audits were undertaken throughout the service in 2017/18. The audit report included review of infection prevention and control management, hand hygiene, the environment, waste, body fluid spills, sharps and decontamination for each site visited. Between September 2017 and August 2018, overall compliance scores each site varied from 88% to 100%, which exceeded the trust’s target of 85% for audit compliance.

At the time of the inspection, 76% of staff across the children’s services division were compliant with hand hygiene practices. This was expected to rise as teams had until the end of September 2018 to provide evidence of full compliance.

Environment and equipment

The physical environment from, and in, which services were delivered varied by location but storage limitations in some buildings meant that equipment was not always stored securely.

Sites included modern purpose-built shared-use health centres through to older legacy buildings. The shared-use nature of several the sites meant that the service had limited control over the layout, equipment and maintenance of the facilities provided.

Equipment within the areas we visited was visibly clean, and portable electrical equipment was appropriately tested. Equipment within the modern shared-use facilities was managed and serviced centrally by building management teams. Staff reported good working relationships with the building landlords.

Staff had access to equipment needed to do their jobs and to provide safe care and treatment to their patients. We checked a random sample of paediatric equipment held within each of the sites. All the equipment we viewed was within the manufacturers’ recommended expiry dates.

However, equipment was not always stored securely. In Woodview Children’s Development Centre, there was insufficient storage available for the children’s community nursing team. This meant that, aside from the main storage cupboard, equipment was being stored in a metal cabinet outside the storage room, and in a larger unlocked sliding-door shelving unit in a general corridor. The equipment within this unit was specific to the complex needs of individual children within the team’s caseload.

Staff told us the risk of equipment being stolen or tampered with was mitigated as these storage cupboards were in staff-only areas. However, aside from the keypad controlled door from the waiting area to the treatment areas, all other corridors within the building were accessible to anyone.

Staff in the Oldham Hollingwood 0-5 RightStart, early education and school nursing teams had recently relocated into the St Chad’s children’s centre. The shared-use children’s centre was centrally managed by the building landlord, and staff described the relationship as good. The environment was visibly clean; however, staff complained that an odorous smell coming from the staff kitchen area, which was evident during inspection. This had been reported but not resolved.
We identified several potential ligature points in the toilets in Hollingwood, which included a fixed unbreakable coat hanger on the door, and an unbreakable emergency pull cord. A cleaning cupboard was unlocked and contained several containers of cleaning products marked as hazardous stored on the floor. We raised these issues with staff who noted that the areas were mainly used by staff and therefore risk to children and visitors was minimal.

All public areas we visited, including common areas and treatment rooms, were clean, tidy and well maintained.

Assessing and responding to patient risk

Risks to patients were assessed, monitored and managed so that they were supported to stay safe. However, training and knowledge of the recognition and treatment of sepsis was not embedded although work was underway to address this. Staff compliance with basic life support training was low across the services in the Halton and Oldham boroughs.

The trust had developed a sepsis identification and screening policy to support staff in identifying suspected sepsis and ensuring patients received the correct treatment in the appropriate environment. Staff also had access to a sepsis information and resources page on the trust’s intranet. At the time of the inspection, the trust had only just introduced an e-learning package for sepsis that could be accessed by clinical staff. The trust and the service had not yet started collection of data on how many staff had completed the training. The quality matron was in the process of developing a training needs analysis for all staff. We received varying responses from staff, where we asked the question, about their knowledge or awareness of the sepsis six protocols.

Initial risk assessments were carried out for all children, young people and families who were referred to the services. Health and safety risk assessments were in place for the services we visited.

Assessments considered information provided in referrals, and included any indications of safeguarding issues such as female genital mutilation and child sexual exploitation. Staff used paediatric early warning scores when appropriate to detect deterioration in a child’s condition and these were acted on as needed.

Staff managed their own caseloads, and would escalate any concerns or risks to their managers. Staff were aware of the need to monitor for, and identify, any changes in patients’ circumstances or health and wellbeing that may indicate a risk to safety. Risks to patients and services were discussed within safeguarding and clinical supervision meetings, at team meetings and within the services’ quality and safety sub-groups.

Staff throughout the children, young people and families’ services received training in basic life support as part of their mandatory training. Staff did not receive training in paediatric intermediate life support, or advanced paediatric life support. In the event of a collapse, all staff we asked confirmed they would commence basic life support until the emergency services arrived.

Compliance levels varied, ranging from 71% for allied health professional staff to 83% for medical staff. Within the trust’s boroughs, completion rates varied from 53% in Oldham to 89% in Bolton and Warrington. The following tables show basic life support training completion rates.

<table>
<thead>
<tr>
<th></th>
<th>Medical staff</th>
<th>Nursing staff</th>
<th>Allied health professional</th>
<th>Additional clinical services</th>
<th>All clinical and non-clinical*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic life support training</td>
<td>Bolton</td>
<td>Halton</td>
<td>Oldham</td>
<td>St Helens</td>
<td>Warrington</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--------</td>
<td>--------</td>
<td>--------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>staff</td>
<td>83%</td>
<td>75%</td>
<td>71%</td>
<td>73%</td>
<td>76%</td>
</tr>
</tbody>
</table>

* Includes scientific, technical and administrative staff.

(Source: Post-inspection additional data request – DR2)

By borough (includes all staff groups including scientific, technical and administrative staff):

None of the services we visited had a trust-supplied resuscitation trolley. However, several of the shared-use buildings had automatic electronic defibrillator machines located in common areas, and staff in some services had access to pocket resuscitation masks.

**Staffing**

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. A shortage of community paediatricians was being mitigated by using long-term locum staff and senior staff filling additional clinics as needed.

**Planned v Actual Establishment**

At the time of the inspection, the trust reported a total of 647.5 whole time equivalent nursing, medical and additional clinical services staff employed within the children, young people and families’ services.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Nursing (WTE)*</th>
<th>Nursing vacancies (WTE)*</th>
<th>Additional clinical services (WTE)*</th>
<th>Additional clinical services vacancies (WTE)*</th>
<th>Medical (WTE)*</th>
<th>Medical vacancies (WTE)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>45.6</td>
<td>3.1</td>
<td>7.9</td>
<td>0.5</td>
<td>0.11</td>
<td>0</td>
</tr>
<tr>
<td>Halton</td>
<td>95.4</td>
<td>7.7</td>
<td>25</td>
<td>3</td>
<td>3.7</td>
<td>1</td>
</tr>
<tr>
<td>Oldham</td>
<td>115.4</td>
<td>11.7</td>
<td>61</td>
<td>2.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>St Helens</td>
<td>12.6</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>6.5</td>
<td>1.6</td>
</tr>
<tr>
<td>Warrington</td>
<td>75.5</td>
<td>14.2</td>
<td>21.8</td>
<td>0</td>
<td>4.9</td>
<td>0</td>
</tr>
<tr>
<td>Wigan</td>
<td>130.5</td>
<td>8.4</td>
<td>38.6</td>
<td>15.4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total*</td>
<td>475.1</td>
<td>46</td>
<td>157.2</td>
<td>21.3</td>
<td>15.2</td>
<td>2.6</td>
</tr>
</tbody>
</table>

* Figures are rounded to the neared 0.1

(Source: Post-inspection additional data request – DR40)

**Vacancies**

The trust did not provide a target for vacancy rate. At the time of the inspection, across all boroughs, there was an overall 9.7% vacancy rate for nursing and midwifery council registered staff. The vacancy rate varied by borough with Wigan reporting the lowest rate of 6.4% and Warrington reporting the highest rate of 18.8%.
For additional clinical services staff, across all boroughs there was a 13.5% vacancy rate. The vacancy rate varied by borough with St Helens and Warrington reporting no vacancies in this staff group, while Wigan reported a 39.9% vacancy rate.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Nursing (WTE)*</th>
<th>Nursing vacancies (WTE)*</th>
<th>Vacancy rate</th>
<th>Additional clinical services (WTE)*</th>
<th>Additional clinical services vacancies (WTE)*</th>
<th>Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>45.6</td>
<td>3.1</td>
<td>6.8%</td>
<td>7.9</td>
<td>0.5</td>
<td>6.3%</td>
</tr>
<tr>
<td>Halton</td>
<td>95.4</td>
<td>7.7</td>
<td>8.1%</td>
<td>25</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Oldham</td>
<td>115.4</td>
<td>11.7</td>
<td>10.0%</td>
<td>61</td>
<td>2.4</td>
<td>3.9%</td>
</tr>
<tr>
<td>St Helens</td>
<td>12.6</td>
<td>1</td>
<td>7.9%</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Warrington</td>
<td>75.5</td>
<td>14.2</td>
<td>18.8%</td>
<td>21.8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wigan</td>
<td>130.5</td>
<td>8.4</td>
<td>6.4%</td>
<td>38.6</td>
<td>15.4</td>
<td>39.9%</td>
</tr>
<tr>
<td>Average*</td>
<td></td>
<td></td>
<td>9.7%</td>
<td></td>
<td></td>
<td>13.5%</td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request – DR40)

At the time of the inspection, Oldham and Wigan did not employ medical staff within the children, young people and families’ services. Bolton and Warrington did not have any medical vacancies, which meant the average vacancy rate across the four boroughs for medical staff was 17.1%.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Medical (WTE)*</th>
<th>Medical vacancies (WTE)*</th>
<th>Vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>0.11</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Halton</td>
<td>3.7</td>
<td>1</td>
<td>27%</td>
</tr>
<tr>
<td>St Helens</td>
<td>6.5</td>
<td>1.6</td>
<td>32.6</td>
</tr>
<tr>
<td>Warrington</td>
<td>4.9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Average*</td>
<td></td>
<td></td>
<td>17.1%</td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request – DR40)

Turnover

From August 2017 to March 2018 the trust reported an average turnover rate of 17.2% in community health services for children. Across the trust average turnover rates for nursing staff were 16.5%; for medical staff were 39.5% and for allied health professionals were 12.3%.

A breakdown of turnover rates by staff group in community services for children at trust level for the year ending March 2018 is below:

Community children total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total leavers</th>
<th>Average monthly staff establishment</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>1.0</td>
<td>0.7</td>
<td>150.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>1.0</td>
<td>2.5</td>
<td>39.5%</td>
</tr>
<tr>
<td>Public Health and Community Health Services</td>
<td>1.6</td>
<td>5.6</td>
<td>28.5%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>22.4</td>
<td>104.6</td>
<td>21.4%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>2.3</td>
<td>10.8</td>
<td>21.3%</td>
</tr>
</tbody>
</table>
Qualified nursing & health visiting staff (Qualified nurses) | 51.3 | 310.9 | 16.5%
Support to ST&T staff | 0.4 | 3.0 | 13.6%
Qualified Allied Health Professionals (Qualified AHPs) | 7.5 | 60.8 | 12.3%
Qualified nursing midwifery staff (Qualified nurses) | 2.4 | 22.2 | 10.8%
All staff groups | 89.9 | 521.1 | 17.2%

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

Sickness
The trust set a target of 3.8% for sickness rates. Between 1 September 2017 and 31 August 2018, the average sickness rate for all nursing, additional clinical services and medical staff was 5.4%. This did not meet the trust’s target, but was better than the period between April 2017 and March 2018.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Average nursing staff sickness %</th>
<th>Average additional clinical services staff sickness %</th>
<th>Average medical staff sickness % *</th>
<th>Average all staff sickness %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>6.3</td>
<td>1.8</td>
<td>0</td>
<td>3.5</td>
</tr>
<tr>
<td>Halton</td>
<td>7.1</td>
<td>8.7</td>
<td>0.5</td>
<td>7.7</td>
</tr>
<tr>
<td>Oldham</td>
<td>5.0</td>
<td>9.4</td>
<td></td>
<td>6.9</td>
</tr>
<tr>
<td>St Helens</td>
<td>8.5</td>
<td>0.3</td>
<td>1.7</td>
<td>3.5</td>
</tr>
<tr>
<td>Warrington</td>
<td>3.5</td>
<td>4.9</td>
<td>10.9</td>
<td>4.4</td>
</tr>
<tr>
<td>Wigan</td>
<td>4.2</td>
<td>2.7</td>
<td></td>
<td>3.5</td>
</tr>
<tr>
<td>Total*</td>
<td>5.5</td>
<td>5.6</td>
<td>3.0</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

* Oldham and Wigan do not have any medical staff in the service. Rates are likely to be proportionately higher due to the small numbers of medical staff employed.

(Source: Post-inspection additional data request – DR40)

From April 2017 to March 2018 the trust reported an overall sickness rate of 6.1% in community health services for children. This did not meet the trust’s target.

Across the trust overall sickness rates for nursing and midwifery staff were 3.4%, for nursing and health visiting were 6.5%, for medical staff were 24.9% and for allied health professionals were 3.9%.

A breakdown of sickness rates by staff group in community services for children at trust level is below:

Community children total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total sickness absence (days)</th>
<th>Total establishment (days)</th>
<th>Sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>32.8</td>
<td>1,270.8</td>
<td>2.6%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>176.1</td>
<td>6,175.1</td>
<td>2.9%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>273.8</td>
<td>8,136.2</td>
<td>3.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>1,242.8</td>
<td>31,866.7</td>
<td>3.9%</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>285.0</td>
<td>6,562.5</td>
<td>4.3%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>4,573.4</td>
<td>78,952.9</td>
<td>5.8%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>8,855.6</td>
<td>135,258.6</td>
<td>6.5%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1,521.9</td>
<td>11,262.9</td>
<td>13.5%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>235.4</td>
<td>946.5</td>
<td>24.9%</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>17,196.9</strong></td>
<td><strong>280,432.2</strong></td>
<td><strong>6.1%</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

**Nursing – Bank and Agency Qualified nurses**

The trust reported no bank and agency use within community services for children.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Leaders and staff we spoke with during inspection confirmed that gaps in staffing were filled by staff working overtime or increasing the number of hours available for part-time staff.

**Nursing - Bank and Agency Nursing assistants**

The trust reported no bank and agency use within community services for children.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

**Medical locums**

Between 1 April 2018 to 2 September 2018, 280 medical shifts were covered by a medical locum. These shifts were in the community paediatric medical services in Halton, St Helens, and Warrington.

(Source: Post-inspection additional data request – DR40)

**Suspensions and supervisions**

During the period from May 2017 to May 2018, community services for children reported that there were two cases where staff have been suspended.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

**Quality of records**

Staff kept detailed records of patients’ care and treatment. Records were clear and up-to-date.

The children, young people and families service was in the process of rolling out electronic patient records. This meant some individual services such as the community children’s nursing teams were fully electronic while others including the therapies teams still maintained mainly paper-based records. Alongside the trust’s electronic patient record system, audiology services had introduced an audiology specific electronic system in January 2018.

The children, young people and families service undertook records audits. We reviewed the audit results for 35 of the services delivered across all boroughs, which combined had an average 90%
compliance rate for year 2017 to 2018. This was slightly higher than the 89% average for the previous year (for the 28 services that were being delivered by Bridgewater at that time).

Fourteen services had improved the quality of their records in 2017/18 compared with the previous year. Ten services had either maintained the quality of their records, or had not previously undergone a records audit (because of transfer of the service into Bridgewater). The remaining 11 services had seen a deterioration in the quality of their records.

The audits identified several common themes including lack of recording of the child’s allergies, the child’s demographic information, parental or carer’s responsibility, and the lack of recording the child’s NHS number on each page.

**Medicines**

The service followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time. However, the recording of medicines prescription pads was not robust enough to ensure accountability for prescription pad issuing and usage.

The trust had a medicines management strategy for 2017 to 2020 with key objectives focused on quality, innovation, sustainability, and people.

We reviewed the management of medicines within the Bolton 5-19 immunisation service. Vaccines and anaphylaxis kits held by the service were stored safely and securely.

The anaphylaxis kits were stored at room temperature. Maximum ambient room temperatures were recorded clearly. We reviewed the records which showed that all maximum readings were below the threshold of 25 degrees Celsius.

Temperature sensitive vaccines were stored appropriately in refrigerators. The service kept clear and accurate records of daily maximum and minimum refrigerator temperatures.

A flowchart showed the actions staff should take in the event of the refrigerator temperature exceeding the standard range of two to eight degrees Celsius, and the relevant contact telephone numbers for the trust’s pharmacy team were displayed on the refrigerator door.

Staff transported vaccines to school premises using insulated ‘cool bags’ that were monitored with portable maximum/minimum thermometers. This meant staff were assured that the ‘cold chain’ was maintained during school clinics.

The service undertook several audits relating to the management of medicines. These included medicines stock, fridge temperatures, fridge cleaning, and six-monthly battery checks for portable thermometers.

Staff in the service received annual immunisation update training, which included medicines competency review for nurses.

Patient group directions provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). We reviewed the patient group directions for the immunisation service; these were up-to-date, individual for each medicine or vaccine type and confirmed the staff who were competent and authorised to administer medicines under the direction. Nurses authorised to give vaccines by a patient group direction were therefore competent for the role and the patient group directions met legal requirements.
An audit in May 2018 of the community paediatrics service's compliance with the recommendations of the National Institute of Health and Care Excellence clinical guideline NG87 Attention deficit hyperactivity disorder: diagnosis and management, had raised concerns about the monitoring of patients taking medicine for the disorder. Following our inspection, the trust provided evidence of compliance with the guidelines recommendations, which included measuring height and weight of children as appropriate.

Managers of children’s and families’ services were invited to Medicines Management Operational Group meetings. We saw from the minutes of the January and July 2018 meetings that current issues around medicines, including incident reporting, were discussed. The Group’s task was to ensure quality and safety was foremost in all aspects of medicines management within the trust.

The trust’s medicines management (pharmacy) team carry out a detailed, annual audit of medicines management to identify shortfalls at core service and location level. The 2017/2018 audit was still in progress. No serious concerns affecting patients accessing children’s and families’ services were found in the audit conducted at the end of 2016 and first three months of 2017.

**Incident reporting, learning and improvement**

Staff recognised and could describe incidents appropriately, including near misses. When things went wrong, staff apologised and gave patients honest information and suitable support. However, we were not assured that all staff reported incidents via the trust incident reporting system. There was only limited staff awareness of the sharing of incidents and learning across borough boundaries.

The service had an incident reporting policy, which was compliant with the national framework for reporting and learning from serious incidents requiring investigation.

Between 1 September 2017 and 31 August 2018, staff in the children, young people and families’ services recorded 1042 incidents of which 922 resulted in minor harm, no injuries or were near misses. A further 120 incidents were classed as either moderate harm, major harm or were catastrophic.

We reviewed the incidents recorded as major harm/extensive injuries and catastrophic/death. Of the ten recorded as major harm/extensive injuries, one related to internal communication, three related to failure of IT or telephony systems, one related to a breach of confidentiality, one related to a delay in the provision of medical equipment, and three related to safeguarding concerns.

Of the 18 recorded as catastrophic/death, all were notifications of the death of a child where the child had died elsewhere. This was in line with the service’s practice to record incidents where they had made aware of concerns affecting their children, young people or families, or a child’s death, by another agency or provider. This enabled the trust, particularly in safeguarding cases, to track incidents, outcomes, and trends.

<table>
<thead>
<tr>
<th>Service</th>
<th>Near miss</th>
<th>No injuries</th>
<th>Minor harm</th>
<th>Moderate harm</th>
<th>Major harm</th>
<th>Catastrophic / Death</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology</td>
<td>8</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td>Bolton Integrated Children’s Services</td>
<td>10</td>
<td>35</td>
<td>13</td>
<td>18</td>
<td>0</td>
<td>0</td>
<td>76</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>---</td>
<td>---</td>
<td>----</td>
</tr>
<tr>
<td>Child Development Centre</td>
<td>10</td>
<td>20</td>
<td>4</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>42</td>
</tr>
<tr>
<td>Child Health System Team</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Children’s Learning Disability Nursing</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Children’s Safeguarding</td>
<td>7</td>
<td>17</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>9</td>
<td>38</td>
</tr>
<tr>
<td>Children’s Therapies</td>
<td>29</td>
<td>86</td>
<td>46</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>174</td>
</tr>
<tr>
<td>Community Paediatrics</td>
<td>12</td>
<td>47</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>62</td>
<td></td>
</tr>
<tr>
<td>Complex Needs / Children’s Community Nursing</td>
<td>12</td>
<td>14</td>
<td>7</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>38</td>
</tr>
<tr>
<td>Continence Paediatric</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td>0</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Health Visiting</td>
<td>54</td>
<td>126</td>
<td>37</td>
<td>10</td>
<td>3</td>
<td>0</td>
<td>230</td>
</tr>
<tr>
<td>Learning Disability Nursing [Children’s]</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Oldham Integrated Children’s Services</td>
<td>3</td>
<td>59</td>
<td>23</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>97</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>7</td>
<td>12</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>9</td>
<td>37</td>
</tr>
<tr>
<td>School Nursing</td>
<td>64</td>
<td>86</td>
<td>26</td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>191</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>224</strong></td>
<td><strong>525</strong></td>
<td><strong>173</strong></td>
<td><strong>92</strong></td>
<td><strong>10</strong></td>
<td><strong>18</strong></td>
<td><strong>1042</strong></td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request – DR32)

Staff we spoke with across the services could describe the types of incidents they would report, including near misses. For example, staff in the Bolton immunisation team had reported incidents where vaccines had been administered twice. Staff told us they knew how to report incidents, and where to seek additional advice if needed. However, one staff member was concerned that the system’s built-in ‘drop-down options’ were not always relevant for the types of incidents they needed to record, which ‘disengaged’ staff to record incidents. Other staff members told us they would raise concerns about an incident verbally with their line manager rather than reporting it online.

Managers in the services reviewed and graded incidents reported by their teams.

Staff gave us varying responses, when asked, if they received feedback on incidents they had individually reported; however, there was a more consistent recognition of feedback from incidents being shared at team meetings. This included feedback from relevant trust-wide incidents; although there was only limited staff awareness of the sharing of incidents and learning across borough boundaries. However, we saw evidence that incidents were reviewed by leaders in the divisional quality and safety subgroups, and in the finance, workforce and performance meetings.

Staff we asked were aware of the duty of candour, the triggers for the duty and when it would apply. Staff told us they would escalate any concerns or incidents that may trigger the duty to their line managers, and would be ‘open and honest’ with the child’s parents or guardian, and with the child if appropriate. We saw evidence of the duty of candour being applied in the incident reports we reviewed during the inspection.

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018 the trust reported no incidents classified as never events within community services for children.
Serious Incidents

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include 'never events' (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in community services for children, which met the reporting criteria, set by NHS England from July 2017 to June 2018, one incident relating to misfiling of patient records, the other relating to adverse media coverage or public concern about the organisation or the wider NHS.

<table>
<thead>
<tr>
<th>Incident type</th>
<th>Number of incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mishandling of patient information</td>
<td>1</td>
</tr>
<tr>
<td>Adverse media coverage or public concern about the organisation or the wider NHS</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. The care, treatment and support provided by the service were based on best practice guidance. The services’ policies were in line with current national guidelines and there were processes in place to regularly review and update these policies.

Care pathways in all the services were based on recognised and approved guidelines, including from the National Institute for Health and Care Excellence, the Scottish Intercollegiate Guidelines Network, the Royal College of Paediatrics, and other professional standards and guidelines.

During our inspection we found that there were suitable policies in place including policies for the care of children with complex needs such as those with a tracheostomy (a tube inserted at the front of the neck to help someone breathe). There was a review schedule in place and we found that policies were within review date. Staff we spoke to were aware of how to access trust policies and guidelines and could tell us about changes made to policies and guidelines.

Services reviewed and incorporated updates to guidelines within care pathways. For example, we were told that the guidelines which included care of children with cystic fibrosis and care of children with asthma had been recently audited and the service was fully compliant with national standards and guidelines.

There had been a recent change to national obstetric brachial plexus injury guidelines. The joint occupational therapy and physiotherapy team based within Warrington had an update scheduled so that this change could be shared with staff and planned to develop a new patient pathway which would include occupational therapy input.

Staff who ran the attention deficit hyperactivity disorder clinic in Warrington had recently altered their practice to be in line with national guidelines. Children under the age of 10 years would now be reviewed by a nurse every three months and children over the age of 10 years would be reviewed every six months.
The service used a tool to monitor compliance with the recommendations of the National Institute of Health and Care Excellence clinical guideline NG87 Attention deficit hyperactivity disorder: diagnosis and management. At the time of the inspection the tool indicated that the service was 79% compliant against the relevant recommendations. Areas of non-compliance were included in an action plan which aimed to achieve full compliance by the end of November 2018.

We observed home visits with the health visiting teams during our inspection and found that staff followed Department of Health and Social Care guidelines in delivery of the Healthy Child Programme.

**Nutrition and hydration**

Children’s care plans included an assessment of their nutritional and hydration needs where relevant. We saw examples where children’s preferences as well as their clinical needs at meal times had been considered and documented in care plans.

The service had achieved accreditation with the UNICEF Baby Friendly Initiative. There was an infant feeding team within the service who could provide additional support to parents when needed.

**Patient outcomes**

The service had begun to consider how people’s care and treatment outcomes could be effectively monitored. Some teams had implemented tools to capture more qualitative information to evidence outcomes.

Teams across the service used a range of ways to gather information and evaluate performance against patient outcomes. When we spoke with service leads they told us of new outcome measures that were being developed to better demonstrate the positive impact of the care delivered. Case studies and feedback from parents and children were also used to demonstrate patient outcomes.

The speech and language therapy team in Warrington told us about how they used goal attainment scores, therapy outcome measures, outcomes of care questionnaires and functional targets to better understand the value of treatment and intervention.

The 0-19 integrated teams measured performance against delivery of the Healthy Child Programme and produced regular reports to monitor progress.

In Wigan, the audiology team consistently met their key performance targets with regards to timely diagnosis, receipt of hearing aids and time to initial assessment.

The children’s community nursing team monitored the rate of hospital admissions with the aim of reducing the numbers of avoidable admissions. As well as this, the team consistently met their targets for the referral of complex cases and communication with partner agencies around discharge information and ongoing care plans.

The family nurse partnership team had not reached their target for the percentage of clients who had 80% or more of the expected antenatal contacts but the attrition rates and rate against expected contacts postnatally had met the target across the previous year.

Within the health visitor team in Wigan, 87% of new birth visits were completed by day 14 across quarter one and rates of completion of 12 month and two to two and a half years old assessments
were high. In the information provided the number of children meeting the expected level for motor and communication skills was not recorded.

The occupational therapy and physiotherapy teams had submitted samples for audit and across quarter one the rates of children who achieved their treatment goal were 89% for occupational therapy and 91% for physiotherapy. The rates are not comparable as the sample size for physiotherapy was below the 10% standard.

In Halton, the percentage of children at the expected level for motor, communication and problem-solving skills were monitored as well as completion of 12 month and two to two and a half years old assessments. 82% of new birth visits had been completed by day 14 across quarter one. The family nurse partnership team recruited 67% of clients between 12 and 16 weeks of pregnancy and 63% received 80% or more of the expected number of visits during pregnancy.

In Bolton, 100% of educational establishments had a named school nurse identified. The school nursing team also monitored participation in screening programmes, attendance at clinics, numbers of emotional wellbeing assessments completed and referral to child and adolescent mental health services although it was difficult to identify themes or trends from the way this information was presented.

The family nurse partnership team in Warrington carried out 80% or more of expected antenatal contacts to 56% of clients on average but exceeded targets for completion of postnatal contacts. The information supplied showed that 66.7% of clients over the past year had reduced their cigarette use by the time they were 36 weeks pregnant. Breastfeeding initiation rates were 38.7% and 6.3% had continued to breastfeed at 6 months postnatal. The health visitor team completed 80% of new birth visits by day 14 across quarter one.

**Audits – changes to working practices**

The trust participated in three clinical audits in relation to this core service as part of their Clinical Audit Programme.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Area covered</th>
<th>Key successes</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit of Care Pathway for Children with Speech Delay/Disorder</td>
<td>St Helens Paediatric Speech &amp; Language</td>
<td>Out of the 8 standards audited 4 scored more than 80% and 100% had their outcome achieved.</td>
<td>Despite using electronic patient records, the record keeping needs to be improved. The team will continue with the Trust record keeping audit and action where necessary on an ongoing basis.</td>
</tr>
<tr>
<td>Audit of Care Pathway for Children with Speech Delay/Disorder</td>
<td>Wigan Paediatric Speech &amp; Language</td>
<td>100% of patients had a discharge report written and circulated.</td>
<td>Improvements in record keeping are required so that clinical notes are both accurate and comprehensive. A patient feedback aspect will be included in the re-audit as regards communication and sharing of information.</td>
</tr>
<tr>
<td>Audit of the Diagnosis and Management of Attention Deficit Hyperactivity</td>
<td>St Helens Paediatric Speech &amp; Language</td>
<td>95% of cases the school was given information regarding the ADHD diagnosis. 97% had a 6 monthly follow up and an ECG was done in all cases where there was a family</td>
<td>Clinic letter to be copied to Special Educational Needs Coordinator (SENCO) with parents’ consent. Emphasize to medical staff the importance of recording heart rate, height and weight on centile chart and taking family</td>
</tr>
</tbody>
</table>
Disorder (ADHD) | history of cardiac disease/sudden death or abnormal findings. | history of heart disease. Ensure that review appointment is offered in 4-6 weeks following commencement of medication.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

**Competent staff**

The service made sure staff were competent for their roles and had the right skills, knowledge and experience to deliver effective care, support and treatment. Managers appraised staff’s work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Staff had regular appraisals in which they could identify any additional training needs.

Staff we spoke to told us that they had regular opportunity to discuss development with their line manager. Roles were available within the service for staff who wanted to take on additional responsibilities and learning. For example, the advanced nurse practitioner role had been introduced within Warrington. Non-clinical members of staff were encouraged to complete additional learning such as completion of the care certificate.

Staff had their competencies assessed before undertaking more specialist tasks. Gastrostomy training was available and nursery nurses providing care for children with a gastrostomy were observed by qualified nurse staff prior to undertaking this alone. Tracheostomy care and cardiac care training was also available and provided by external services where appropriate.

The 0-19 integrated service in Halton had introduced a band five induction competency framework to support newly qualified and less senior staff who gained employment within the service. This framework provided an opportunity for staff to shadow partner agencies with the aim of improving understanding of these services.

Paediatric staff we spoke to told us that part of their appraisals included feedback from colleagues and patients. In some areas, the appraisal structure had changed to provide more focus on development and aligned with the service goals and objectives. Staff we spoke to had found this beneficial.

The Wigan complex and acute children’s community nursing teams had received funding for two staff to attend an external paediatric epilepsy course. Tracheostomy training opportunities were available through tertiary training centres.

Staff spoke positively about the trust’s support of external training and learning opportunities identified as part of individuals’ performance and development reviews. One staff member told us they were supported by the trust to undertake a master of science module. An administration staff member was being supported to undertake a national vocational qualification (NVQ) in business studies.

**Clinical Supervision**

Clinical supervision was available to most of the staff within the services we visited. This was delivered in a range of methods including peer supervision, one-to-one supervision, and was confirmed by staff we spoke with.

By borough, average clinical supervision rates were as follows:
### Average clinical supervision figures

<table>
<thead>
<tr>
<th>Borough</th>
<th>Average clinical supervision figures</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Helens/Halton*</td>
<td>100%</td>
</tr>
<tr>
<td>Halton**</td>
<td>99%</td>
</tr>
<tr>
<td>St Helens</td>
<td>97%</td>
</tr>
<tr>
<td>Wigan</td>
<td>96%</td>
</tr>
<tr>
<td>Warrington</td>
<td>95%</td>
</tr>
<tr>
<td>Bolton***</td>
<td>89%</td>
</tr>
<tr>
<td>Oldham</td>
<td>Waiting for training, peer support available</td>
</tr>
<tr>
<td>Overall</td>
<td>96%</td>
</tr>
</tbody>
</table>

* Includes new-born hearing screening and audiology teams.

** In Halton, the additional needs nursing team received information clinical supervision supported by the paediatric medical team and team leader.

*** In Bolton, formal supervision was not in place for the school nursing, family healthy lifestyles, immunisation, and the management and safeguarding teams. However, this was a known risk that was on the services’ risk register, and peer support was in place for each of the relevant teams while the service was waiting for staff to receive the appropriate training to provide supervision.

(Source: Post-inspection additional information request – DR5)

### Appraisal rates

#### Community children total

From April 2017 to March 2018 95.4% of staff within community services for children had received an appraisal compared to the trust target of 90%, this met the trust’s appraisal target.

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number of staff appraised</th>
<th>Sum of Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Healthcare Scientists</td>
<td>17</td>
<td>17</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>59</td>
<td>59</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Nursing and Health Visiting Staff</td>
<td>224</td>
<td>233</td>
<td>96.1%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Other Non-Medical Staff</td>
<td>32</td>
<td>39</td>
<td>82.1%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>333</strong></td>
<td><strong>349</strong></td>
<td><strong>95.4%</strong></td>
<td><strong>90.0%</strong></td>
<td><strong>Yes</strong></td>
</tr>
</tbody>
</table>

Four of the five staff groups within the core service met the appraisal targets.

Following our inspection, the service provided appraisal compliance figures for all staff broken down by each borough as shown in the table below.

<table>
<thead>
<tr>
<th>Row Labels</th>
<th>Total staff</th>
<th>Number compliant</th>
<th>Compliance (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>87</td>
<td>75</td>
<td>86.21</td>
</tr>
<tr>
<td>Oldham</td>
<td>179</td>
<td>143</td>
<td>79.89</td>
</tr>
</tbody>
</table>
Multidisciplinary working and coordinated care pathways

Staff throughout the service worked closely with other teams within their boroughs and external organisations to deliver effective care and treatment. However, processes to improve effectiveness of the multidisciplinary complex case panels in Halton was still embedding.

The community paediatrics service was commissioned to provide a complex case panel in Halton and Warrington; however, as a result of parental feedback and complaints to the Halton Healthwatch service, the trust had identified that some children at the Woodview Child Development Centre in Halton had waited up to a year or more for review by the panel. Staff told us that some diagnoses were delayed as a result of the limited availability of some internal and external multidisciplinary panel professionals.

Staff in Warrington told us their complex case panel process had experienced similar pressure points within the process and had also struggled with limited availability of some multidisciplinary panel professionals. However, we did not find evidence of a similar backlog of referrals in the Warrington area.

The investigation of the delays within the panel process at Woodview Child Development Centre and the implementation of an improvement plan was ongoing at the time of our inspection. This included senior staff liaison with other healthcare providers to improve availability of all relevant multidisciplinary panel professionals.

A joint infant feeding clinic took place in which there were combined appointments with speech and language therapists and a dietician from the local acute provider. At the time of our inspection the dietician post was vacant and the clinic was being carried out by speech and language therapy alone. This was not causing a problem but staff hoped that the vacancy would be filled by October as, if not, they would then have to consider cancelling clinics.

We saw examples of good multidisciplinary working in areas where joint clinics were taking place. For example, in Warrington, the occupational therapy and physiotherapy teams had combined and had started running joint clinics at the time of our inspection.

The Woodview community children’s nursing team worked closely with the end of life palliative care team. The teams met each quarter to discuss relevant children within their caseloads. Direct access to the palliative care team was available for staff who identified any child that deteriorated suddenly.

The Wigan audiology service had a close working relationship with the local authority, and specialist teachers from local schools. The team worked in a shared office with teaching and council staff, which enabled good sharing of information.

The Bolton immunisation team worked closely with their designated schools. Nurses attended school assemblies to talk about immunisation.

Health promotion
The service supported people to live healthier lives. Staff took a holistic approach to planning care using health assessments where appropriate.

The service worked towards improving the health of the local population in line with public health priorities such as obesity reduction, improving breastfeeding rates and improving immunisation uptake.

School nurses completed assessments as to the needs of the schools on their caseloads and tailored sessions to address these needs which included promotion of healthy lifestyles and provision of information around human papilloma virus (HPV) vaccinations.

The health visitors, dieticians and infant feeding team worked closely together to promote informed choice around infant feeding and provide support to mothers who wished to carry on breastfeeding but were having difficulties.

We observed that smoking cessation services were promoted by family nurse practitioners to women and their partners.

The Bolton adolescent health team worked with local schools to undertake health promotion. Their work also included screening for chlamydia, and pregnancy testing.

The public health and well-being service, part of the Bolton 5-19 service, provided train-the-trainer sessions to local teachers on health and well-being. The team also delivered public health sessions to pupils at schools following an agreed action plan. Awareness sessions delivered included puberty, alcohol, bereavement, sexual health and emotional health.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Consent to care and treatment was sought in line with legislation and guidance. Staff could assess when children were unable to give consent and if this should be obtained from a person with parental responsibility.

The trust had a current and up to date Consent to Assessment Examination and/or Treatment Policy (including Mental Capacity Act). The policy included sections on the consideration of assessment of capacity to consent in line with the Mental Capacity Act 2005, and specific sections on the treatment of children and young persons (aged 16 or 17).

A separate section included consideration of Gillick competency (a child’s capability to give consent) and the Fraser guidelines (to decide if a child can consent to contraceptive or sexual health advice and treatment or both without parental consent).

Staff we spoke with who were involved in the care and treatment of children were aware of the need and process to obtain consent, before providing care and treatment. This included awareness of Gillick competency and the Fraser guidelines.

Staff across the services told us they aimed for child centred care, and with a view to obtaining ‘the voice of the child’. We saw evidence in records across the services of consent being obtained although this was not consistently documented.

When we spoke to staff they demonstrated good understanding of the principles of consent and when we observed staff interactions with children the care provided was child-focussed; however, this was not clear in the documentation we reviewed. Managers showed us that the templates within the electronic records system had a mandatory field for recording ‘the voice of the child’ and a new doctors letter template had been developed in Halton which included a separate section for
recording this information. It was the intention that these measures would improve the consistency in documentation.

Consent could be obtained in several ways across all the services. This included parental consent on referral forms, verbally, or as implied informal consent. Staff told us that, where possible, they obtained consent directly from the child or young person, ensuring the child understood what they were consenting to, particularly within the school nursing and immunisation services. If staff were concerned about an individual child or young person’s capacity to consent they could refer them for a separate capacity assessment.

**Mental Capacity Act and Deprivation of Liberty training completion**

Training completion rates by staff group showed that medical nursing and allied health professional staff providing care and treatment exceeded the trust's target of 90%. Additional clinical services staff had high levels of completion but did not meet the target. When all staff groups including health care scientists, professional and technical staff, and administrative and clerical staff are included the completion rate fell to 81%.

<table>
<thead>
<tr>
<th></th>
<th>Medical staff</th>
<th>Nursing staff</th>
<th>Allied health professional staff</th>
<th>Additional clinical services staff</th>
<th>All staff groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>95%</td>
<td>91%</td>
<td>94%</td>
<td>85%</td>
<td>81%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request - P38 Training)

Training completion by borough, which included all clinical and non-clinical staff groups showed a more mixed picture, with Bolton and Oldham not achieving the trust’s target.

<table>
<thead>
<tr>
<th></th>
<th>Bolton</th>
<th>Halton</th>
<th>Oldham</th>
<th>St Helens</th>
<th>Warrington</th>
<th>Wigan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>83%</td>
<td>90%</td>
<td>71%</td>
<td>93%</td>
<td>96%</td>
<td>92%</td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional information request – DR6/7 Training)

**Deprivation of Liberty Safeguards**

The trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

**Is the service caring?**

**Compassionate care**

Staff throughout the service treated people with kindness, dignity, respect and compassion. We observed staff interacting with children and families in a way which was empathetic and sensitive to their needs.

Staff were understanding and respectful of the cultural, social and religious needs of children, young people and families. For example, the public health and wellbeing team adapted their
education sessions for delivery in faith schools; for example, including the Islamic understanding and approach to the subjects.

We observed the interactions of members of staff with children and their families. We found that staff were engaging, friendly and responded to the needs of each individual.

During an audiology clinic, there were two audiologists present; one to focus on the child by using games as a form of distraction but also part of the assessment and a second audiologist to carry out clinical activity and discussion with the parents. At the end of this appointment it had not been possible to complete the hearing test fully and this was explained to the parents and staff took time to answer their questions fully.

We observed a home visit by the children’s community nursing team in Wigan. The nurse was compassionate in her approach to the new-born child’s parents and listened to their concerns. The nurse provided details of the local hospital outreach service who could provide additional support to the family, and ensured that appropriate healthcare professionals were updated after the visit.

<table>
<thead>
<tr>
<th>FFT results</th>
<th>Survey satisfaction results</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFT returns</td>
<td>Would recommend</td>
</tr>
<tr>
<td>Apr-18</td>
<td>646 98% 1% 99% 100% 100% 100% 100% 100% 100% 100% 661</td>
</tr>
<tr>
<td>May-18</td>
<td>892 98% 0% 99% 100% 100% 100% 100% 100% 100% 100% 981</td>
</tr>
<tr>
<td>Jun-18</td>
<td>908 92% 1% 97% 100% 100% 100% 100% 100% 100% 99% 973</td>
</tr>
<tr>
<td>Jul-18</td>
<td>578 96% 0% 99% 100% 100% 100% 100% 100% 100% 100% 594</td>
</tr>
<tr>
<td>Aug-18</td>
<td>605 96% 0% 99% 100% 100% 100% 100% 100% 100% 99% 622</td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request – DR42)

**Emotional support**

Staff ensured that people’s emotional health and wellbeing were considered as part of their care and treatment.

Parent groups were in place throughout the service so that further advice and support could be provided to parents who experienced challenges due to caring for their child’s needs.

The children’s community nursing teams were often involved in providing palliative care and support to children. The service supported children who were reaching the end of their life to die comfortably at home and provided support to their families as well.

Staff we spoke to found this a challenging aspect of care but felt privileged to be able to provide this support and care. Staff told us that when they were involved in emotional experiences such as this, their colleagues and managers were supportive and understanding. At Warrington we were shown a book of remembrance which included photographs of children who had passed away and staff spoke positively about having this to reflect on.

Staff in the 360° substance misuse team received a range of compliments about the care they provided. One service user wrote that the support provided by a staff member had enabled them to achieve their ambition of attending university and that the staff member had treated them like ‘one of your own’.
Staff in the Woodview community children’s nursing team told us they knew which children had an advocate for shared care. This enabled close working with the relevant social worker to ensure the children received appropriate and relevant support.

**Understanding and involvement of patients and those close to them**

Staff supported people to express their views and be involved in decision making about their care. Most staff could demonstrate how they gathered the views of children with complex needs to plan their care.

A staff member in the community nursing team told us of an example of supporting a child with complex needs to overcome the child’s fear of needles for undertaking blood tests. The staff member made multiple visits to the child’s home, a familiar environment, to get the child accustomed to the process of taking blood, to needles, and to demonstrate how the process worked using a ‘fake’ arm. The staff member could subsequently take the child’s blood sample, which had never been achieved previously.

The Wigan audiology service was in the process of developing a ‘Peach’ questionnaire and the use of the Talking Mat framework, which supports children to express their views in decisions about their lives. This was aimed at improving the service’s ability to capture ‘the child’s voice’ in its care plans.

Across the service staff told us about methods they would use to determine the preferences of children who were non-verbal such as the use of pictures. The Woodview community children’s nursing team acknowledged they had a high number of non-verbal children with complex needs.

Communication needs were assessed during each child’s initial assessment, and included asking parents what behaviours or non-verbal signs their child makes to express their emotions. Staff used this knowledge to work with each individual child to help them understand clinical interventions needed.

In Warrington, the children’s community nursing team told us about creating a care plan for a child with a visual impairment. They had got to know the child and their family well and collaboratively completed the care plan which included personal information which was specific to the child such as what their favourite meal was or the name they used to refer to their walking aid. This care plan had also been made using fabrics and raised stickers so that it was tactile and the child could recognise what it was.

The Bolton adolescent health team recorded the views of the young people they provided care to within the individual’s care plan, which included the young person’s expected goals and outcomes. As part of our inspection we observed a clinic in Warrington for children diagnosed with attention deficit hyperactivity disorder. We found the staff were child-focussed and were effective in seeking the opinions of each child who attended the clinic.

The Wigan speech and language therapy team developed a children’s feedback system that used pictures and pots to enable children to provide feedback by placing a counter in the relevant pot.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**
The service planned and provided services in a way that met the needs of local people. It ensured that arrangements were in place to accommodate children, young people and families with additional needs.

We found examples where the service had adapted and made adjustments to best serve the local population and those within its care. The 0-19 integrated team at Halton had held an engagement day with staff to determine how the newly formed integrated service would work.

Prior to tendering, the service had piloted clinics to ensure the way in which the service was delivered would meet people’s needs. The team used surveys to gather feedback from young people and parents and a pilot of a 0-6 months evening clinic had been in place since January because of feedback from parents. The team was also working closely with local colleges to establish an offer of school nursing services that would be of benefit to the young people who attended.

Introduction of immunisation teams who could deliver vaccination programmes in schools allowed school nurses to spend more time running drop in clinics, providing training to school staff and delivering additional sessions tailored to the needs of each school.

There had previously been a higher than anticipated number of appointments with the additional needs team at Warrington for which parents and children had failed to attend. The team had considered why this was happening and put an action plan in place. As part of the action plan, a text message reminder was now sent prior to appointments and the team were holding parent groups and teaching sessions.

Also within Warrington, nurses were holding morning drop-in sessions for children to attend for blood pressure checks which were needed regularly when children were prescribed medications for attention deficit hyperactivity disorder. This improved waiting times for prescriptions as children did not need to attend their GP for blood pressure checks.

A behaviour and sleep advisory clinic had been set up as part of the service provided by the specialist nursing team in St Helens as they had found there were significant numbers of families who needed additional support.

There were some examples where services were restrained by commissioning. For example, in Halton the school nurses were not commissioned to deliver behavioural management packages but there was still a need for this within the community. The service had adapted to this by allocating a nursery nurse, with the support of a qualified nurse, to provide short term intervention for parenting. The nursery nurse supported families by delivering a bespoke behavioural management package which had been set up by a previous team leader.

The school nursing team in Warrington had been commissioned to provide an enhanced sexual health clinic which was trialled for 12 months but was not well attended in that time. Despite poor uptake, the clinic was commissioned to continue however the school nursing staff we spoke to felt that their time and efforts could be better spent.

The school nursing service in Wigan did not have a recent service specification from its commissioners. This meant the service did not have up to date clearly defined standards for the services it was expected to deliver by its commissioners.

Across the service, staff told us that access to emotional health and wellbeing services was needed, particularly by those working with young people and adolescents where conditions such as anxiety and depression were becoming more commonplace. Some services had employed emotional health and wellbeing practitioners but this was not consistent across the boroughs.
The trust had a Transition for Children to Adults Services Policy in Halton and Warrington, which set out that preparations for transition to adult services for a child when they were 13 years of age. However, staff told us of concerns about the effectiveness of the transition process which staff described as ‘complex’ and ‘not smooth’. As such, provisions for children’s transition to adult services were not always as good as they might have been. Staff told us that some children remained within the service until they were in their twenties due to a lack of available adult services.

The additional needs nursing team in Warrington were consistently meeting their key performance indicator for safe transition to adult services. At the time of our inspection, safe transition was defined as the provision of a final appointment with children’s services, referral to adult services and a letter to the child’s GP and family.

Going forward, the Warrington team wanted to begin transition much earlier for children with attention deficit hyperactivity disorder at the age of 14 years so that parents and children could get used to children taking on more decision making for themselves. The team intended that subsequent final appointments with the children’s service would take place within the adult service setting with the intention of improving transition to adult services.

The looked after children team and the named nurse for children in care in the Wigan and Warrington boroughs had close working relationships with the local authorities, and caseloads for the teams were discussed with the local clinical commissioning groups.

Across both Halton and Warrington, we found that staff were uncertain of the criteria for referral to the complex case panel. Staff who were directly involved in the panel process were clear on this but expressed frustration that a large volume of referrals were out of scope for consideration at panel.

Staff working within the Woodview Child Development Centre in Halton told us it was common for delays to occur prior to cases being presented at the complex case panel because assessment reports had not been completed or received on time from all relevant professionals.

At Warrington, we spoke to the parents of a child who had been referred to complex panel. They had experienced a delay of three months because the speech and language therapy assessment report had not been shared on time.

Following our inspection, we compared the terms of reference for the complex case panels in both Halton and Warrington and found these to be the same. However, staff involved in the panel processes in the Halton and Warrington boroughs told us that their processes were completely different. As such, staff from the two boroughs had not worked together to streamline or make improvements to the process.

**Meeting the needs of people in vulnerable circumstances**

People received personalised care which was responsive to their needs. The service offered flexibility around when and where patients could access services. However, printed information was not always available in other languages.

The Bolton immunisation service planned longer sessions for children with special needs and disabilities. This included working with the relevant schools and parents and ensuring there were additional staff available to assist during the sessions.

The public health and well-being service worked with teachers to plan education sessions and to adapt the sessions to the needs of individual children, such as visual and communication aids.
Across the service we found examples of teams who were moving towards a case-loading model to improve continuity of care of children and families. This meant that children and families would not have to explain their medical and social history to a new person at each appointment and enable staff to more easily build a good rapport with people in their care.

We found that care was tailored to individual’s needs. We saw examples within the children’s community nursing team in Warrington of personalised care plans which had been written with children and their families or carers.

The care plans included clinical details but also the likes and dislikes of the child and anything else which was relevant such as how to tell when the child was feeling unwell or what their favourite meal was. One care plan had been made tactile for a child with a visual impairment. Staff told us of occasions when children had been admitted to hospital and these care plans had been an invaluable source of information to hospital staff.

While the ‘voice of the child’ was not always well documented within paper records, we observed staff carrying out appointments in a way which was child-focussed. During the clinic appointments we observed we found that staff spoke to children to find out what their opinion was of their treatment and took their preferences into account.

The children’s, young people and families’ services had access to face-to-face and telephone translation services for people whose first language was not English. Staff could request British sign language interpreters, for children who were deaf.

The Wigan audiology service had access to leaflets produced by the National Deaf Children’s Society, such as a patient information leaflet for glue ear in Polish and Bengali. Other leaflets available included child friendly leaflets such as ‘Ali gets hearing aids’ and ‘Ellie, Leila and Jack have tinnitus’.

However, despite a large eastern European population in Bolton and south Asian population in Oldham, none of the services we visited had access to written information in other languages.

The Bolton healthy lifestyles team developed individual gym exercise and healthy eating programmes for children and young people between the ages of 5 and 19, primarily from social deprived backgrounds. Children and young people could be referred to the team by their GPs, paediatrician, or through self-referral.

**Access to the right care at the right time**

People could not always access care and treatment in a timely way. Although referral to initial assessment times were within the service targets we found examples where children had faced lengthy delays and the validity of the data provided was uncertain as there were rudimentary systems in place to collate this information.

There was a lack of support or temporary intervention for families and children in the Woodview Child Development Centre, who were awaiting complex case review at panel. Healthwatch Halton published a summary report in July 2018 after having launched an online survey in December 2017 to gather information about Woodview Child Development Centre. 64% of respondents waited more than five months from referral to first appointment and one in five waited more than a year. Parents said they felt “lost in the system” with concerns about their child’s health and wellbeing “struggling to maintain normal life with nowhere to turn”.

The target set by the service was that the time, from referral to diagnosis through the panel process, should not exceed 20 weeks. However, some children at Woodview Child Development
Centre had experienced delays of more than a year from referral before their cases were reviewed by the panel.

A full investigation into the delays noted there was a single point of access to the services provided by the additional needs nursing team. All referrals were assigned to the team’s caseload, which stood at more than 900 children by the time the backlog in the process was identified. This meant a large volume of children had not progressed further than referral into the service and approximately 143 children referred with suspected neurological developmental problems had potentially had a delayed diagnosis and treatment up to a year or more.

At the time of our inspection, there was an action plan in place and a rapid improvement event had taken place at Woodview. Staff we spoke to were positive about the changes being made. These included reducing the caseload of the additional needs nursing team to 500 children; improved triaging of referrals into the service, including signposting referrers to more appropriate services or providers; and, increasing the number of complex case panels.

At the time of our inspection, the service had sent duty of candour letters to the families of all children involved. It had reviewed each of the cases and determined that harm had been caused in several cases as a result of delays in children’s assessments.

The same panel pathway was in place at Warrington; however, there was a process in place to maintain regular contact with parents and keep them updated as to progress through the pathway. At Warrington we also found that there was a resource pack of written information which could be sent to parents on a variety of different conditions and if the referrals were not appropriate for the panel process then parents would be signposted to another service.

We spoke to paediatricians across the service who told us they were now maintaining the 18-week referral to treatment target but that this was a struggle due to workforce. They expressed that additional work was needed to plan to meet the increasing demands on the service, including further liaison with the clinical commissioning groups to enable commissioners to understand the capabilities of the service. For example, the paediatricians did not have the clinical expertise to make a diagnosis of mental health conditions such as behavioural anxiety but felt this had previously been expected of them.

In Wigan, 68.6% of healthcare assessments and healthcare plans were completed within 20 working days of a child entering care. In St Helens the only plans not to be completed on time were caused by appointments not attended by the child.

Since our last inspection, there had been improvements to paediatric service provision in St Helens. Previously, the service had transferred 2000 patients from the local acute provider and at our last inspection we were not assured that there were appropriate measures in place to ensure these patients were reviewed when they needed to be.

Since then, the service had worked to triage and review every patient. There was a telephone clinic and triage pathway to improve efficiency for children who could be discharged or transitioned to adult services. A patient advisory group was set up and a long-term locum paediatrician was employed by the service.

The acute children’s community nursing team in Wigan were available Monday to Friday 8am to 8pm, at weekends between 8am and 6pm, and on bank holidays between 10am and 4pm. The team provided a same day visit service for referrals received before 4pm. Rotas were arranged to ensure there was a suitable staff skill mix to cover clinics and home visits and to accommodate urgent visit requests.
The complex children’s community nursing team provided a service Monday to Friday between 8am and 6pm. Referrals to the complex team were usually received from hospitals prior to a child’s discharge home. The team worked with families to understand and plan the level of support needed.

**Referrals**

The trust provided data on the median waiting time for patients waiting from referral to initial assessment for the services below. The trust identified the target waiting time as 126 days, the equivalent of 18 calendar weeks. The trust did not provide data on days from initial assessment to onset of treatment.

<table>
<thead>
<tr>
<th>Borough</th>
<th>Service</th>
<th>Median waiting time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wigan</td>
<td>Dietetics CYP</td>
<td>73.5</td>
</tr>
<tr>
<td>Wigan</td>
<td>OT CYP</td>
<td>33.4</td>
</tr>
<tr>
<td>Wigan</td>
<td>Paediatric LD</td>
<td>11.0</td>
</tr>
<tr>
<td>Wigan</td>
<td>Physio CYP</td>
<td>28.6</td>
</tr>
<tr>
<td>Wigan</td>
<td>SALT CYP</td>
<td>30.7</td>
</tr>
<tr>
<td>Wigan</td>
<td>Podiatry Biomechanics Paediatrics</td>
<td>25.4</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Audiology</td>
<td>17.6</td>
</tr>
<tr>
<td>St Helens Borough</td>
<td>Diagnostic Audiology (St Helens)</td>
<td>30.9</td>
</tr>
<tr>
<td>St Helens Borough</td>
<td>Paediatric Continence (St Helens)</td>
<td>21.0</td>
</tr>
<tr>
<td>St Helens Borough</td>
<td>Paediatric SLT (St Helens)</td>
<td>15.3</td>
</tr>
<tr>
<td>Knowsley Borough</td>
<td>Diagnostic Audiology (Knowsley)</td>
<td>26.6</td>
</tr>
<tr>
<td>St Helens Borough</td>
<td>Community Paediatrics (St Helens)</td>
<td>26.1</td>
</tr>
<tr>
<td>Halton Borough</td>
<td>Community Midwifery (Halton)</td>
<td>13.6</td>
</tr>
<tr>
<td>Halton Borough</td>
<td>Community Paediatrics (Halton)</td>
<td>39.0</td>
</tr>
<tr>
<td>Halton Borough</td>
<td>Diagnostic Audiology (Halton)</td>
<td>26.3</td>
</tr>
<tr>
<td>Halton Borough</td>
<td>Occupational Therapy (Halton)</td>
<td>29.1</td>
</tr>
<tr>
<td>Halton Borough</td>
<td>Paediatric Continence (Halton)</td>
<td>24.7</td>
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<td>Halton Borough</td>
<td>Physiotherapy (Halton)</td>
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</tr>
<tr>
<td>Halton Borough</td>
<td>Children with Additional Needs Nursing Service (Halton)</td>
<td>13.2</td>
</tr>
<tr>
<td>Warrington Borough</td>
<td>Audiology Services</td>
<td>14.5</td>
</tr>
<tr>
<td>Warrington Borough</td>
<td>Paediatric Community Medical Service</td>
<td>33.1</td>
</tr>
<tr>
<td>Warrington Borough</td>
<td>Paediatric OT</td>
<td>63.0</td>
</tr>
<tr>
<td>Warrington Borough</td>
<td>Paediatric Physio</td>
<td>46.8</td>
</tr>
<tr>
<td>Warrington Borough</td>
<td>Paediatric SLT Service</td>
<td>34.0</td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request – DR8)

**Learning from complaints and concerns**

Effective complaint handling was not embedded in the children, young people, and families' services. There was limited information on how to make a formal complaint. Historically, the service had not recorded verbal complaints or those which were not raised as formal complaints.

Healthwatch Halton published a summary report in July 2018 after having launched an online survey in December 2017 to gather information about Woodview Child Development Centre. Within the summary report Healthwatch recommended that the service improve the handling of complaints after parents had tried to raise formal complaints and received no response.
Staff we spoke to told us that anyone could raise a formal complaint using the complaints form, which was on the trust website. Staff did not understand they could escalate verbal complaints to formal complaints if needed.

As part of the provider information request which is submitted prior to our on-site inspection, we asked the trust to tell us the number of complaints received over a year period. The service reported a total of 17 complaints across the period. This compared with 189 compliments reported over the same period.

Service managers told us that there was work taking place to improve the format of evaluation forms (Talk to Us forms) which were used to gather patient feedback. It was felt that the forms were useful in gathering positive feedback but did not provide the opportunity for people to raise complaints or concerns.

Complaints

From April 2017 to March 2018 there were 17 complaints about community services for children. The trust took an average of 41.9 days to investigate and close complaints. Timescales for resolving complaints were individual and agreed with the complainant at the start of the investigation.

A summary of complaints within community services for children by subject is below:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>5</td>
</tr>
<tr>
<td>Quality of care</td>
<td>5</td>
</tr>
<tr>
<td>Child protection</td>
<td>2</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Staffing</td>
<td>1</td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Compliments

From April 2017 to March 2018 the trust received 655 compliments. Of these 189 related to community services for children, which accounted for 29% of all compliments received by the trust.

A breakdown by location is below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wigan</td>
<td>50</td>
</tr>
<tr>
<td>Oldham</td>
<td>41</td>
</tr>
<tr>
<td>Halton</td>
<td>31</td>
</tr>
<tr>
<td>Warrington</td>
<td>28</td>
</tr>
<tr>
<td>Bolton</td>
<td>28</td>
</tr>
<tr>
<td>St Helens</td>
<td>11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>189</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)
Is the service well-led?

Leadership

Managers at all levels in the service had the skills and abilities to run the service. Although facing several challenges within and across services and borough boundaries, the leaders were motivated to improve the service.

Children, young people and families’ services were delivered by the trust’s operations directorate across the six geographical boroughs. The directorate had two divisions with the easterly division covering Wigan, Oldham and Bolton, and the westerly division covering Warrington, Halton and St Helens. Both divisions were led by the chief nurse and operating officer, supported in the east division by director of children’s services (east), and in the west division by the borough director for Halton and St Helens and the borough director for Warrington.

The directorate, divisional leaders and clinical managers we spoke with understood the challenges facing their services. The leaders could describe the actions that had been taken, or were planned, to meet these challenges.

Staff we visited in the Wigan, Bolton and Oldham areas knew who their leaders were and the reporting path for their services. Most of the staff spoke positively about their leaders and local managers. Staff told us that senior leaders including the chief executive, chief nurse, medical director and a non-executive director had visited several of the services.

However, there were a few exceptions where staff told us their concerns about individual line managers, or the way transition from their previous employers had impacted on their roles, responsibilities and pay bands. In Oldham staff were concerned that the complexities of the local population demographic, which had seen a significant increase in the eastern European community, were not well understood by the service’s leaders; this had been compounded by a similar increase in the number of safeguarding cases.

Managers and senior staff we interviewed spoke positively about the support provided by the executive team and, in particular, the chief nurse who was described as very approachable and responsible. However, one staff member expressed their view that senior leaders ‘bypass’ administration teams during site visits.

Vision and strategy

The trust had a vision and strategy for what it wanted to achieve, that was complimented by individual operational strategies for each of the boroughs.

The Quality and Place: Transforming Health Together 2018-2023 strategy supported delivery of the trust’s mission ‘to improve local health and promote wellbeing in the communities we serve’, and the trust’s six values of being person-centred, encouraging innovation, open and honest, professional, locally led, and efficient.

Staff we asked across the services were aware of the strategy, but were not aware of any non-managerial consultation or input into its development. Managerial staff were not always able to explain how their work aligned to the service strategy.

Following the concerns raised in the Healthwatch report, staff in all the teams in the Woodview child development centre had recently been fully engaged in a ‘rapid review’ of the service to
identify and implement improvements in the services offered. Staff were aware of ‘listening into action’ programmes that had been delivered in their respective services.

There was a separate five year operational and strategic plan for each of the boroughs for the period of 2016/17 to 2020/21. The plans, which covered all community services, set out how the services in each borough aimed to meet the requirements set by their local clinical commissioning groups. However, staff in the Wigan school nursing service had not received an up-to-date service specification from their local clinical commissioning group.

**Culture**

There was a culture throughout the service which focussed on the delivery of patient-centred care. Staff spoke with passion about their roles and felt supported by their colleagues and managers.

Staff we asked, overall, told us they felt the culture within the children’s services had improved over the previous few months, particularly following the appointment of the trust’s Chief Nurse. Most staff spoke positively about their local managers across all the services we visited.

Managers acknowledged there had been a distinct improvement in the culture of the services in recent months. However, some staff expressed concern about the trust’s sickness and absence procedure and felt that at times the policy encouraged punitive rather than supportive actions by managers. Staff generally felt supported by their local line managers through periods of sickness; however, this did not extend to the human resources team, which staff felt were more stringent in their approach to managing sickness. This has increased anxiety levels and one staff member told us they were ‘worried about being off’.

The trust had a lone worker policy. Implementation of this varied by service, but primarily services required staff to ensure their appointment calendars were up-to-date and accurate and that staff rang the office to confirm when they had finished an appointment or completed their shift for the day.

The trust had a performance and development review process in place. Staff we asked confirmed they had attended one to one meetings with their managers (known as ‘My Space’) and had attended and been given the opportunity to input into their annual appraisal reviews, (known as ‘My Plan’).

At the time of the inspection, the trust reported compliance with the review process as follows. The St Helens and Halton boroughs had the lowest rate of compliance; however, staff we spoke with confirmed they had received their reviews which they felt were positive.

<table>
<thead>
<tr>
<th>Borough</th>
<th>% Compliant with performance and development reviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bolton</td>
<td>86</td>
</tr>
<tr>
<td>Halton</td>
<td>51</td>
</tr>
<tr>
<td>Oldham</td>
<td>80</td>
</tr>
<tr>
<td>St Helens</td>
<td>41</td>
</tr>
<tr>
<td>Warrington</td>
<td>60</td>
</tr>
<tr>
<td>Wigan</td>
<td>77</td>
</tr>
</tbody>
</table>

(Source: Post-inspection additional data request – DR31)

**Governance**

The service had governance arrangements which ensured staff were clear about their roles within the structure, what they were accountable for, and to whom. Each service, in each borough, had a
clear reporting structure, through clinical service managers to their interim director of operations. Leaders and managers across the service could describe the governance structure.

The monthly quality and safety subgroups meetings for each geographical directorate were structured with standing agenda items. These included review of organisational assurance reports, safety (which incorporated risks), and quality. The agenda also included a quarterly rolling programme of review of reports from clinical audit, infection prevention and control, information governance, medical devices, updates on the Commissioning for Quality and Innovation (CQUIN) programmes, medicines management, and performance against the safety thermometer.

The monthly finance, workforce and performance meeting reviewed individual services’ performance against key performance indicators, risks and incidents including those for escalation, budgets and finance, staffing and vacancy levels, mandatory training and appraisal levels, and safeguarding concerns.

The trust-wide Medication Incident Review Panel reviewed all medicines incidents, including those within the children, young people and families’ services. The panel shared lessons learnt, patient and medicines alerts and medicines recalls, and good practice.

Governance for the safeguarding teams was provided through the monthly safeguarding team assurance group.

Staff in all areas we visited told us that team meetings took place, which shared information and learning from alerts, incidents, risks, complaints and concerns.

Management of risk, issues and performance

The service had systems to manage performance and for identifying risks, escalating, planning to eliminate or reduce them. However, as not all open risks had control measures, gaps in controls, internal and independent assurances, and gaps in assurances identified, the risk management system was not always effective.

The children, young people and families service leaders could describe, understood and had oversight of the risks and issues affecting their respective services.

The division held a risk register, which included risks across all services within the division. Of the 182 open risks recorded, ten were classed as extreme risks, 84 were classed as high risks, 78 were moderate risks, and the remaining ten were low risks.

The extreme risks included those we expected to see, including demand against operational capacity risks, staff vacancies, safeguarding, records management, connectivity to the trust’s computer system, and delays in assessment (at Woodview) due to poor governance structures. High risks again reflected demand and capacity risks, including associated staff health and wellbeing risks, safeguarding, equipment, and performance against key performance indicator risks.

Each open risk identified controls and assurance measures, review dates, actions and action progress fields. All but seven of the open risks had a named action owner; however, we identified 18 open risks where no control measures, gaps in controls, internal and independent assurances, and gaps in assurances had been identified. Ten of these were classified as high risks, and included six related to safeguarding issues such as delay in the timely completion of health assessments, the lack of a safeguarding flag on the system, and issues relating to the completion of looked after children care leavers’ summaries. Following our inspection, the trust provided an
updated divisional risk register which demonstrated that the gaps we had identified had been addressed.

Risks were reviewed and managed through the division’s quality and safety subgroup meetings and the finance, workforce and performance meetings. High level risks were escalated through the clinical governance twice quarterly clinical governance committee and the quality and safety committee to the bi-monthly board meetings.

The service had a clinical audit plan to supplement the trusts annual clinical audit programme. This included division-wide audits such as record keeping, informed consent, and duty of candour. This was supplemented by service and location specific audits; for example, an audit on depression in children and young people: identification and management in the universal 5-19 service in Bolton and the 0-19 service in Warrington, and the speech delay disorder audit in children’s speech and language team in Wigan. At the time of the inspection these audits were planned for future start dates; this meant we could not review the results.

In the community paediatric services at Halton the system for recording the use of FP10 handwritten and electronic prescription pads was not robust. While the prescription pads and forms for printing from the online prescribing system were securely stored the use of these forms could not be accounted for. Although staff kept a log of the number of electronic forms used, the serial numbers were not recorded. Unused forms were returned to secure storage at the end of each day but this process was not recorded.

There was no record kept of the issue of handwritten FP10 forms. One hundred FP10 forms had been used since 24 July 2018 which was unusually high but staff told us that these forms were used by locum staff who did not have access to the electronic system.

A lack of process for recording the use of prescription pads and electronic prescribing meant that the service was unable to assure itself that prescriptions were being issued appropriately and responsibly.

Following the inspection, the trust developed a standard operating procedure for the management of FP10 prescription pads, which was supported by signed log sheets.

**Information management**

The service did not consistently collect, analyse, manage, share or use information well to support all its activities.

Staff across the services we visited held spreadsheets locally recording mandatory training and appraisal scheduling and completion information. This was because there was a common concern that the trust’s electronic information systems did not hold accurate data, including out-of-date and duplicate information. For example, the Oldham school nursing teams noted that the transfer of training data from the service’s previous provider had resulted in staff repeating mandatory training on-line courses before the course would have been due for renewal.

Where teams were based within the same building such as paediatrics, speech and language therapy and additional needs nursing teams staff reported good information sharing and multidisciplinary working. This was because staff could simply discuss this with the relevant practitioner face to face if they had concerns about a child.

However, we saw no evidence of this within the paper records we reviewed. It was indeterminable from each set of records which other professionals were involved in the care of each child.
increased the risk that staff assessing and treating a child in one speciality may not have all the relevant information they need to ensure the child received appropriate care.

Further, staff we spoke with across the services and the boroughs expressed inconsistent views on the effectiveness of information sharing and governance arrangements across borough boundaries.

Staff in the services where electronic working had been fully rolled out almost universally raised concerns about the trust’s IT infrastructure. Staff recognised that, in some instances, this related to a lack of signal in patients’ homes or remote locations. However, staff remained concerned about connectivity to, and responsiveness of, the trust’s systems at their base locations.

We were told that a separate ‘offline app’ was available to staff to be able to record relevant information in situations where they were unable to connect to the trust’s infrastructure. The app then refreshed the information on the main system when a signal was next available.

The relative newness of the system to some staff we spoke with was reflected in their inability to easily locate elements of the patients’ records. However, we were assured that staff (in full electronic working services) had access to the information they needed to undertake their role.

Staff in the Wigan audiology service had access to the main patient electronic record system alongside a separate audiology system, which had recently been updated and improved. This had enabled easier and more effective information sharing with other professionals and with parents.

We saw evidence of written consent being obtained from patients or their families to share information about them with other health professionals.

Where services had not yet converted from paper to electronic records, we found examples of multiple sets of paper records for individual children. There was no standard procedure for the sharing of information which may have been relevant to another professional involved in the care of each patient. For example, in the Woodview child development centre, dependent on an individual child’s needs and co-morbidities, they may have up to eight sets of individual paper records; one record held by each service speciality the child was being seen by.

**Engagement**

The service engaged with people who use the service and the public to gather views on the provision of services and promote integrated care services.

The Halton community nursing team was in the process of implementing an ‘experience based design’ approach to engaging with children and their parents. Staff used an experience questionnaire to capture children’s and parents’ views on their interaction with the service at all key stages. This included referral to the team, waiting for an appointment, receiving an appointment, checking in – first visit, ongoing care, ongoing contact with the service and leaving the service. The team aimed to use the information obtained in the questionnaires to improve the service it offered.

The Woodview community children’s nursing team engaged with the trust’s patient experience lead in the patient partners project. The project, which used focus groups to gather evidence, aimed to obtain an understanding of the experience of patients, their families and their carers.

The Bolton healthy schools team hosted a public engagement event in the town centre.

The 360° substance misuse team worked to raise funds for local charities at Christmas to enable the provision of gifts and clothes to disadvantaged young people and families who were accessing the
service. The team had its own dedicated website to engage with its service users, parents and carers, and other professionals. The website provided information about alcohol, drugs and new psychoactive substances, and provided a range of links and contact details for external support organisations.

The safeguarding, looked after children, and child in care teams in Wigan engaged well with the community and with the children in their caseload. The teams were in the process of raising donations as part of a sponsored climb of Mount Snowdon. The aim of the climb was to raise money to enable the teams to work more interactively with the children in their care. However, some staff members expressed concern that there had been little to no response, support, or funding from the senior management team for the event.

The teams had asked local young people to design their team logo, and were planning a community café event for October 2018. They had also worked with care leavers, a local food bank and the service’s dietitians to teach young people how to shop well, to use recipes, and to cook on a budget.

The service had implemented a ‘Leader in Me’ development programme for staff and managers, and had conducted ‘listening into action’ events to improve staff engagement.

In areas where the 0-19 service was relatively new staff were involved in planning how the service could best be delivered. However, staff in other areas told us they did not feel the team was fully integrated and that there was more emphasis on health visiting at team meetings and training days than on school nursing which impacted morale among the school nursing staff.

The trust recognised staff anxieties about future transfer of some of the children, young people and families’ services into a neighbouring healthcare provider trust. For example, the safeguarding and looked after child teams in Wigan. Staff were invited to information sharing events, with feedback shared at team meetings. Staff were given the opportunity to discuss their concerns with managers during one-to-one meetings.

Learning, continuous improvement and innovation

Learning, continuous improvement and innovation was not always shared or embedded consistently across services and borough boundaries.

Although the same complex case panel pathway was in place at Warrington, learning from and effectiveness of the process for this panel, which may have prevented the issues that arose at the Woodview children’s development centre in Halton, had not been shared.

The services we visited took an active role in the trust’s equipment ‘swap-shop’. Accessed via the trust’s intranet system, individual services could identify and advertise excess equipment or stationary that was no longer required and could be used by other services. This reduced wastage and costs for the service, and the trust.

The service worked with a regional university to develop and deliver training and qualifications in specialist community public health nursing. The modular nature of the course meant that staff could more easily manage their learning while working.

A child illness mobile application had been implemented in Oldham, which included a symptom tracker and contact numbers for local children’s health services including dental services.

The safeguarding, looked after children, and child in care teams were in the process of evaluating mobile phone applications to encourage improved communication with the young people in their care.
Accreditations

NHS Trusts can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The trust did not provide information for this section.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)
Community end of life care

Facts and data about this service
The trust provided the following information about community end of life care at Bridgewater Community Healthcare NHS Foundation Trust:

End of life care is provided in Wigan, Warrington and Halton Boroughs, each area commissioned through their respective CCG’s.

Community nursing services provide the majority of end of life care to patients and are supported by community matrons and specialist palliative care services within each borough.

Halton and Warrington commission a seven-day Specialist Palliative Care Teams from Bridgewater, and are based within the two hospices.

Wigan commission the local Hospice to provide a seven-day Hospice Specialist Nursing team. Each service is led by a Consultant in Palliative Medicine Wigan CCG commission a Specialist Allied Health Professional team who are based within the hospice.

(Source: CHS Routine Provider Information Request (RPIR) - CHS Context tab)

Is the service safe?

Mandatory training

Mandatory Training completion

The trust had not been able to provide data on mandatory training for specialist end of life care training. It had not been possible to report on the percentage compliance in this area as the service did not hold an eligible staff group list to measure activity against. The service provided a snapshot of the education and training that was taking place to support end of life care.

Training in this area had been identified at local service level and submitted through the annual training needs analysis by service managers. The end of life focus group work to develop a trust wide end of life skills profile, competence requirements and training needs analysis was planned for the autumn of 2018.

The snapshot showed that between January 2015 and September 2018, 556 staff attended internally delivered courses in end of life care, 29 accessed externally funded training, and 251 attended the Sage and Thyme communication skills training.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust, for all staff groups from April 2017 to March 2018 are in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
</table>

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<table>
<thead>
<tr>
<th>Information Governance</th>
<th>2,632</th>
<th>2,883</th>
<th>91.3%</th>
<th>90.0%</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent Wrap 3</td>
<td>636</td>
<td>719</td>
<td>88.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>1,768</td>
<td>2,114</td>
<td>83.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1,768</td>
<td>2,114</td>
<td>83.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Risk Assessment</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Secure transfer of personal data</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Lone working &amp; security</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>634</td>
<td>769</td>
<td>82.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>634</td>
<td>769</td>
<td>82.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Customer Care</td>
<td>633</td>
<td>769</td>
<td>82.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent</td>
<td>2,231</td>
<td>2,883</td>
<td>77.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - refresher</td>
<td>1,637</td>
<td>2,232</td>
<td>73.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Record Keeping</td>
<td>1,445</td>
<td>2,114</td>
<td>68.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>229</td>
<td>336</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - initial*</td>
<td>1,400</td>
<td>2,100</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>1,349</td>
<td>2,114</td>
<td>63.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Non- Clinical staff*</td>
<td>391</td>
<td>613</td>
<td>63.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Clinical Staff</td>
<td>1,832</td>
<td>2,883</td>
<td>63.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>1,620</td>
<td>2,883</td>
<td>56.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - People</td>
<td>300</td>
<td>628</td>
<td>47.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

*Training completion data for these courses is provided for the previous year as this course is not undertaken annually.

The 90% target was met for one of the 23 mandatory training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

**Safeguarding**

**Safeguarding Training completion**

Data for 31 July 2018 showed the number of specialist palliative care staff trained in Halton, Warrington and Wigan for safeguarding Level 2 adults was 100% and for level 3, 58% (10 out of 14 staff were trained). For level 2 children safeguarding training the figure was 94%.

Staff understood the process of safeguarding and were aware of who to contact if they needed support from the trust or local authority.

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.
Each authority had their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community end of life care made no safeguarding referrals from April 2017 to March 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Cleanliness, infection control and hygiene
Staff undertaking community visits had adequate supplies of gel hand sanitiser and personal protective equipment. We observed community nurses washing their hands following care interventions.

Staff had received training in aseptic techniques. 83.6% of staff had received infection prevention training.

Environment and equipment
One brand of syringe driver was used across the hospital and community, which ensured a consistent approach to the care of patients requiring a subcutaneous infusion (a subcutaneous infusion is an injection of fluid under the skin). All clinical staff received training in the use of syringe drivers. Records showed syringe drivers were regularly serviced by an external company and we observed this happening on site.

Checklists showed that syringe pumps were checked daily for patients in the community. This included the correct delivery rate and site condition. Checklists were signed and dated by nurses when the syringe pump was started and at any subsequent site change. Medical staff or the pharmacist was contacted where necessary.

Safety notices about medical devices were shared with staff through team meetings. There was access to an equipment store. Patients and staff said equipment was available quickly. We observed one patient had received a specialist bed within two hours of the request.

Assessing and responding to patient risk
Records showed that a range of risk assessments were undertaken for patients at the end of their life. For example, an assessment for pressure ulcers, malnutrition universal screening tool and falls assessment. We noted assessments were regularly reviewed where appropriate.

Patients were cared for in their preferred place of care where possible. Where a patient deteriorated appropriate transfer was made either to a hospice or hospital.

We observed a district nursing handover where ongoing treatment and any risks were discussed and priority was given to end of life care patients out of hours.

There was a coordinated approach with the specialist palliative care team if additional advice and support was needed particularly around symptom management.

In the event of a rapid discharge, district nursing staff could access anticipatory medication out of hours from a supply kept with the out of hours GP service.
**Staffing**

**Planned v Actual Establishment**

Details of staffing levels within community end of life care by staff group as at 30 April 2018 are below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>2.8</td>
<td>1.9</td>
<td>146.8%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>5.6</td>
<td>5.6</td>
<td>100.0%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>9.0</td>
<td>9.0</td>
<td>100.0%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>4.5</td>
<td>5.1</td>
<td>89.0%</td>
</tr>
<tr>
<td>Public Health and Community Health Services</td>
<td>2.5</td>
<td>3.5</td>
<td>71.6%</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>24.4</strong></td>
<td><strong>25.1</strong></td>
<td><strong>97.3%</strong></td>
</tr>
</tbody>
</table>

Medical and dental staff were over-established; however, the planned staff numbers are low for both of this staff group.

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

The specialist palliative care consultant received 15 hours of administrative time which meant they had to undertake administrative tasks in addition to their day to day role. There was succession planning and funding for additional administrative support was being reviewed.

**Vacancies**

The trust did not provide a target for vacancy rate. From April 2017 to March 2018, the trust reported an overall vacancy rate of 12.3% in community end of life care. Across the trust overall vacancy rates for nursing staff were 0.0%; for medical staff were 36.2% and for allied health professionals were 1.4%.

A breakdown of vacancy rates by staff group in community end of life care at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total vacancies (12 months)</th>
<th>Total WTE establishment (12 months)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>12.6</td>
<td>34.8</td>
<td>36.2%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>15.8</td>
<td>79.7</td>
<td>19.8%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>3.2</td>
<td>19.2</td>
<td>16.7%</td>
</tr>
<tr>
<td>Public Health and Community Health Services</td>
<td>2.4</td>
<td>44.6</td>
<td>5.4%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>0.7</td>
<td>48.4</td>
<td>1.4%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>0.0</td>
<td>55.2</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>All staff groups</strong></td>
<td><strong>34.7</strong></td>
<td><strong>281.9</strong></td>
<td><strong>12.3%</strong></td>
</tr>
</tbody>
</table>
Turnover

From August 2017 to March 2018 the trust reported an average turnover rate of 219.5% in community end of life care. It is recommended that these data are re-verified on inspection.

A breakdown of turnover rates by staff group in community end of life care at trust level for the year ending March 2018 is below:

Community end of life care total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total leavers</th>
<th>Average monthly staff establishment</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health and Community Health Services</td>
<td>0.7</td>
<td>0.3</td>
<td>240.0%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>1.0</td>
<td>0.5</td>
<td>207.1%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>1.7</td>
<td>0.8</td>
<td>219.5%</td>
</tr>
</tbody>
</table>

Sickness

The trust set a target of 3.8% for sickness rates. From April 2017 to March 2018 the trust reported an overall sickness rate of 5.8% in community end of life care. This did not meet the trust’s target. Across the trust overall sickness rates for nursing staff were 9.6%; for medical staff were 2.7% and for allied health professionals were 6.9%.

A breakdown of sickness rates by staff group in community end of life care at trust level is below:

Community end of life care total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total sickness absence (days)</th>
<th>Total establishment (days)</th>
<th>Sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>0.0</td>
<td>474.5</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff – Hospital</td>
<td>21.6</td>
<td>809.1</td>
<td>2.7%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>15.4</td>
<td>525.6</td>
<td>2.9%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>109.9</td>
<td>1,592.1</td>
<td>6.9%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>132.6</td>
<td>1,387.0</td>
<td>9.6%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>279.5</td>
<td>4,788.4</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

Nursing – Bank and Agency Qualified nurses
The trust reported no bank and agency usage between April 2017 and March 2018 within community end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

**Nursing - Bank and Agency Nursing assistants**

The trust reported no bank and agency usage between April 2017 and March 2018 within community end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

**Medical locums**

The trust reported no medical locum usage between April 2017 and March 2018 within community end of life care.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

**Suspensions and supervisions**

During the reporting period from May 2017 to May 2018, community end of life care reported that there no cases where staff have been suspended.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

**Quality of records**

The service used electronic and paper records which were held in a patient’s home. We saw improvement in the quality of records compared to the last inspection in all the records we reviewed. We found evidence of good comprehensive assessments.

The records covered core issues such as the preferred place of care and death, psychological, spiritual and emotional support and communication with patients and families.

Medication prescribing was included and followed up by a letter to the GP which was added to the electronic system. There was a section for special notes which identified whether a Do Not Attempt Cardiopulmonary Resuscitation order was in place.

An Independent Plan of Care was kept with the patient. The plans we looked at contained capacity assessments except for one plan along with a clear record of care.

All notes we reviewed were legible, signed and dated appropriately.

There was a clear pathway to follow for district nurses applying the end of life care plan in the last 12 months, last weeks and days of life. At the initial assessment staff completed the end of life checklist recording patients’ needs and wishes.

There was an audit by the Warrington team which sampled 19 individual plans of care between April to June 2018. The audit covered 23 specific areas of good practice in managing the end of life process. The audit showed positive results across nearly all indicators including management of pain, ongoing assessment and communication with families.

A working group was set up in April 2018 with the trusts IT department and community nurses to improve the care planning within the trusts electronic recording system to support patients...
approaching end of life. The improvements so far included improved layout, instruction and guidance on filling in data and process maps to inform staff about best practice in the management of end of life care.

**Medicines**

There were improvements since the last inspection in the management of medicines. At our last inspection we found no consistent medicines management for end of life care services across the trust.

In response, the trust provided a best practice briefing to all end of life staff in the administration of opioids. The trust developed an opioid administration flow chart to ensure consistency of care in the provision of medication to patients.

Following the last inspection, the pharmacy team had completed a piece of work to review the management of medicines for patients at the end of life. The team engaged with partner organisations to produce standard documents for prescribing and administering medicines.

NHS Improvement had undertaken training with the trust in respect of a pilot programme in the administration of medicines at the end of life which 20 staff had completed.

The service had worked with the hospice and its commissioners to develop the Prescribing Guidelines for Symptom Management in the Dying Patient. The guidance was developed to support safe and effective prescribing of medication. There were several algorithms for different medicines to manage pain, nausea and agitation. There was a standard operating procedure which staff followed for controlled drugs.

The trust had appointed a medicines safety officer who was following up all medication related incidents. Trends in medication incidents had improved.

**Safety performance**

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

The trust reported no patient safety thermometer data from June 2017 to May 2018 for teams within community end of life care.


**Incident reporting, learning and improvement**

Never events
Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018 the trust reported no never events within community end of life care.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents in community end of life care, which met the reporting criteria, set by NHS England from July 2017 to June 2018.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents (SIRI) – Trust data**

From April 2017 to April 2018, trust staff within community end of life care reported no serious incidents.

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Staff used an electronic system to report incidents and this could be done remotely.

At our last inspection we found that the trust had not reported incidents in end of life separately from other services such as district nursing. The lack of an independent system for reporting incidents led to the service being unable to identify learning from incidents in end of life care. At this inspection we found there was recording of incidents and examples of learning from incidents.

The service published a report which identified incidents relating to end of life care. Between July 2017 and August 2018 there was an average of 13 incidents per month relating to end of life care. The most common type of incidents reported to involve end of life patients, were pressure ulcers.

There was a total of 18 incidents identified as relating to issues regarding the management of end of life. The causes of these incidents were symptom management, controlled drugs, Do Not Attempt Cardiopulmonary Resuscitation, preferred place of death and advance care plan.

An incident was reported by the Warrington team about no access to medication out of hours. This led to the development of a service level agreement with the hospital and a standard operating procedure for access to the hospitals on call pharmacist, a driver could collect the prescription in a sealed bag and transport the medicines to the patient.

There were monthly reports for incidents relating to end of life medicines management. Reports showed category of incident, action taken and supporting evidence. There was a section detailing incidents and notifying lessons learnt.
Is the service effective?

Evidence-based care and treatment

The care provided by staff was based on the Gold Standard Framework. The framework was a model of good practice that enabled a 'gold standard' of care for all people who were nearing the end of their lives.

The trust worked towards national guidance which focussed on the care of dying adults in the last days of life. The individual plan of care incorporated best practice in supporting patients and families through the last days of life.

There was a system for clinical audits in end of life care within district nursing teams which were based on the national End of Life Five Priorities of Care.

Audits across the district nursing boroughs noted several areas for improvement. This included individualised plan of care training for earlier recognition, training in mental capacity particularly with end of life patients, development of pain management tools, training on how to give psychological support to carers and families, support after death and recording when support after death was not needed or wanted.

All improvements were underway and were being driven and directed by the trust End of Life Care Steering Group. For example, education and development workstreams had been set up to review and update all associated documentation.

The trust had developed several end of life care champions whose role was to maintain their own knowledge base whilst sharing good practice with peers. The role included access to training and promoted the appropriate use of plans of care.

Nutrition and hydration

Food and drink was assessed as part of the clinical assessment process and recorded for each patient. For patients whose care was being supported by the Independent Plan of Care a regular assessment of food and drink was performed and this included involvement from the Macmillan team.

District nurses completed a Malnutrition Scoring Tool as part of their risk assessment during their first visit. We observed discussions with patients about their dietary intake.

Records showed patients were referred to dieticians and a swallowing care plan was started for patients who had difficulty in swallowing.

Pain relief

Patients said their pain was well managed and that staff were accessible to manage pain needs quickly. Staff carried out pain assessments during their visits to patients.

There was clear guidance on symptom management and prescribing of anticipatory medicines for end of life patients which followed National Institute of Health and Care Excellence guidance NG31 (Care of dying adults in the last days of life).

There were tools to support staff which identified suggested medicines and doses to manage pain, restlessness, nausea and excess secretions as required and for administering symptom relief by continuous sub-cutaneous infusion. Advice and guidance was available from the specialist palliative care team.
Patient outcomes

Audits – changes to working practices

The trust has participated in one clinical audit in relation to this core service as part of their Clinical Audit Programme, details are in the table below.

<table>
<thead>
<tr>
<th>Audit name</th>
<th>Area covered</th>
<th>Key Successes</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Audit of End of Life Care Bundle - Halton Haven</td>
<td>Halton Specialist Palliative Care Service</td>
<td>100% compliance with 17 out of 19 standards.</td>
<td>Those patients who died within the community, a joint audit project with the district nursing service would give a better view of the patient’s pathway. The End of Life Steering Group is working on an integrated audit in each of the boroughs. The care bundles are a requirement of Halton CCG.</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

Between April to September 2018, where applicable 100% of patients received medication by a syringe driver administered within 4 hours of recognition of need in Warrington and 97% in Halton.

100% of patients in Warrington had their initial assessment within the priority timescales and 85% in Halton. Where results were lower this was because there had been a rapid deterioration for the patient or fast track discharges to the hospice or admission to hospital.

An audit of 19 individual plans of care was undertaken in Warrington from April to June 2018. The audit covered 23 specific areas of good practice in managing the end of life process. The audit showed positive results across nearly all indicators including management of pain, ongoing assessment and communication with families.

As part of the trusts 2017/2018 audit plan, an external audit undertook a review of the trust’s progress against some of the issues raised around end of life care following our last inspection. The audit showed significant assurance.

Competent staff

Syringe driver training was provided in house. New staff worked with experienced staff to learn how to manage syringe drivers in practice. Staff completed competency assessments and observations before they undertook the task on their own.

There were several specialist training programmes which staff completed. This included bowel and bladder care, podiatry awareness, key concepts of cancer care and catheter training. We received data showing that staff had access and undertook training in recognising dying, agitation at end of life and managing pain.

The trust internally delivered courses for staff and between January 2015 to Sept 2018 over 556 individuals had been trained in specific areas of end of life care.
251 staff caring for end of life patients had been trained in Sage and Thyme communication skills between January 2015 to Sept 2018, however there was currently a lack of facilitators to develop this further.

The trust provided information showing that 29 practitioners and doctors had accessed externally funded courses between January 2015 to September 2018. The associate director for end of life care was reviewing available funding to improve education programmes for advanced communication skills.

The Warrington Specialist Palliative Care team delivered education to the public, district nurses, care home staff, medical students and doctors in training and provided clinical placements. The placements varied from one-hour to 10-week placements.

The specialist palliative care team completed training to enhance their role. Staff at Warrington said they attended journal club sessions, audit meetings and received updates on regional standards and guidelines. Staff also attended weekly clinical meetings.

Student nurses worked with the district nursing teams. They reported good opportunities for development and learning and were positive about the training they had received.

Clinical supervision was being reviewed and was included on local risk registers as an area for development. Formal clinical supervision for palliative care in Halton Macmillan service occurred every six weeks throughout the year. Informal supervision occurred twice weekly with the hospice consultant. Formal clinical supervision for the palliative care team in Warrington Macmillan team was to start this month. Informal clinical supervision occurred twice weekly with the hospice consultant. Staff at Warrington said a clinical session with a neurologist was arranged.

**Appraisal rates**

Specialist palliative care teams reported that they had received an appraisal in the last year.

**Multidisciplinary working and coordinated care pathways**

Records showed there was a co-ordinated approach to ensure patients received good care at the end of life. Staff worked with other agencies to assess and plan ongoing care.

There was access to the specialist palliative care team seven days a week 8.30am to 4.30pm. Out of hours staff could contact the hospice. There was access to a consultant in palliative care.

Staff could access specialist teams for long term conditions such as respiratory matrons, heart failure nurses, stoma nurses and the tissue viability team.

Physiotherapists, occupational therapists, dieticians and speech language therapists worked closely with the palliative care team and district nurses.

Records showed referrals to the MacMillan team to provide patients with psychological support and symptom review.

Staff attended Gold Standards Framework meetings working with primary care to plan and monitor care for patients nearing the end of their lives. Nurses and managers told us they were actively involved in these meetings and they supported a team ethos to the management of patients.
District nurses told us they had good working relationships with community nurses and hospices who were accessible and supportive.

**Health promotion**
Records showed patients were encouraged to be as independent as possible and to lead their lives in the way they would wish. Staff signposted patients to other agencies such as mindfulness, complimentary therapies and cancer rehabilitation sessions.

During the home visits we saw nurses took an active interest in the patient and their relative’s social activities and made suggestions where patients could continue to engage in social activities even when the symptoms of their illness may have restricted them.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**
The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the specialist palliative care teams across Halton, Warrington and Wigan was 100% as at 31 July 2018.

**Deprivation of Liberty Safeguards**
The trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

We observed that consent was obtained from patients before any interventions were carried out.

The Care of the Dying Quality Indicators for April to September 2018 showed patient consent was obtained for the preferred place of care and the individualised plan of care to be discussed with relatives and carers.

There was evidence of Do Not Attempt Cardiopulmonary Resuscitation in case notes and these were completed either by a GP or when patients were in hospital, by a consultant. The newly appointed Gold Standards Framework facilitator was working with GPs to improve this area.

**Is the service caring?**

**Compassionate care**
We visited patient’s homes, observed care and spoke with patients and their families who had been admitted to the hospice by the specialist palliative care team. Patients spoke highly of the district nurses and specialist palliative care staff. We observed compassionate care throughout all our visits.

Staff reassured patients during difficult conversations. We observed they held the patients hand and there was open, honest communication about end of life care and dying, in terms of what would happen and the care that patients would receive.
We saw compassionate care being given to families, staff offered support where required. We saw how family members were supported in understanding and managing symptoms by being involved in discussions during assessment of the patient at home.

Feedback from patients and families was very positive and indicated that staff treated people with dignity, respect and kindness during all interactions.

**Emotional support**

Patients and their families were encouraged to call the nursing team for emotional support whenever it was needed.

Staff were assigned as key workers which ensured there was continuity of care. Staff were knowledgeable about what was important to patients and their families and actively explored and respected their emotional and spiritual needs, including after a patient had died.

We observed staff sat with patients in their home and gave appropriate and timely support so they could cope emotionally with their care and treatment. Staff ensured that patients maintained their independence if possible and encouraged them to manage their own health, care and wellbeing.

We saw examples where immediate referrals were made following an assessment to provide patients with psychological support. Patients could access day therapy and counselling. There were family support services and bereavement counselling. Records showedbereavement follow up care and referral to other support services if needed.

Nurses in every team went above and beyond allotted hours to support patients and families particularly in the last few days before patients died.

**Understanding and involvement of patients and those close to them**

Patients told us they were offered options to support them at home, enabling them to make choices about their preferred place of care.

Patients were involved and understood their care and spoke openly about their condition. Patients informed us they had received good information from the nursing and special palliative care teams about their condition and its management.

We observed district nurses asking appropriate questions and they listened carefully then repeated what the patient and the family had said to ensure they had understood the patient’s needs correctly.

Those patients receiving care at the hospice informed us they had made the choice to attend to receive symptom and pain assessment and were fully informed about their treatment plans.

Staff spoke to patients and their family about the support available particularly out of hours and the various agencies that could provide support.

We observed actions following a visit were clearly communicated to the patient, for example changes to medication, GP visits, dietetic referral and discussion about Do Not Attempt Cardiopulmonary Resuscitation.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**
There was partnership working with the various integrated clinical networks and palliative end of life committees across four boroughs. Education and audit was managed locally and fed into the Greater Manchester strategic clinical network and Northwest Coast strategic clinical network. This ensured that services were planned to meet peoples end of life care needs.

There was joint working with local councils and charitable agencies to provide hospice care, access to allied healthcare professionals and Marie Curie and Macmillan nursing teams.

There was no palliative care consultant cover 24 hours, seven days a week. Discussions around this provision was continuing. There were two palliative care consultants with one being employed by the hospice in Wigan. Posts were shared between the hospice and community.

In some boroughs staff had a ‘duty day’ to be available for telephone advice and review any outstanding referrals.

**Meeting the needs of people in vulnerable circumstances**

There were several information leaflets available for patients and families which explained the role of district nurses, list of contacts including out of hours and access to support services.

A communication booklet for care in the last days and hours of life was provided. This enabled patients, family and healthcare staff to have ongoing communication about what was important to them and any questions or comments. Easy read versions were available.

Records showed staff discussed the preferred place of care with patients. We observed staff made provisions to ensure patients could be cared for at home if they wished.

There was access to multidisciplinary teams such as dieticians, speech and language therapists, physiotherapists and occupational therapists. Patients could access the Hospice at Home team and day and night sitters.

Staff told us of examples where they had planned and delivered services to take account of patient’s complex needs. Where patients had mental health problems we saw a co-ordinated approach with the GP, community matron, specialist palliative care team and mental health team. This enabled all reasonable adjustments to be made for patients to be cared for in their preferred place.

Records showed patients were offered day therapy at the Vitality Centre. The centre was provided by the hospice. Patients and their family could attend complimentary therapies, mindfulness and counselling. There were demonstrations and talks on relevant topics, patients could meet with others on a similar journey.

District nursing staff were trained in the verification of expected death, this enabled the recording process to be completed without delay and distress to relatives.

**Access to the right care at the right time**

**Referrals**

The trust has identified the below services within Wigan borough in the table as measured on ‘referral to initial assessment’.

For community end of life care at Wigan the referral to initial assessment target was met. The trust did not provide data on days from initial assessment to onset of treatment.
### Name of hospital site or location

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Days from referral to initial assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Local Target (days)</td>
</tr>
<tr>
<td>Wigan Borough</td>
<td>Cancer &amp; Palliative Care MDT</td>
</tr>
</tbody>
</table>

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

Patients could refer themselves directly to the specialist palliative care team. The team also accepted referrals from carers and healthcare professionals. A specialist nurse was allocated to work with patients and their GP practice. Once symptoms were well managed patients were discharged into the care of their GP and the community nurses.

There was district nursing support 24 hours a day seven days a week. The specialist palliative care team was available for referrals between 8.30am-4.30pm seven days a week. Out of hours advise and care was provided by the hospice, GP or district nursing teams.

Patients and families were given 24 hours a day contact numbers so they could request help and advice quickly.

District handover meetings were held each day. We observed handovers which discussed and triaged patients according to need. District nurses prioritised end of life care patients within their caseloads. Patients had a link worker which ensured continuity of care.

Warrington Community Palliative Care had conducted a referral audit of 33 patients in 2017, to review the time taken to see routine and urgent referrals. Urgent referrals were to be contacted within two working days of contact and routine referrals within seven working days. All urgent referrals were contacted within the time frame and 91% of all referrals were seen within the allocated time limits.

The Care of the Dying Quality Indicator Audit April to September 2018, showed that 100% of patients had achieved their preferred place of care in Warrington and 53% in Halton.

### Learning from complaints and concerns

#### Complaints

From April 2017 to March 2018 there were two complaints about community end of life care. The trust took an average of 49.0 days to investigate and close complaints, this was not in line with their complaints policy, which states complaints should be dealt with within 25 working days.

A summary of complaints within community end of life care by subject is below:

#### Community end of life care total

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>1</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

Staff encouraged patients and relatives to speak to them about concerns. If a patient or relative wanted to make a formal complaint staff told us they would consider local resolution in the first instance.
Compliments
From April 2017 to March 2018 the trust received 655 compliments. Of these 15 related to end of life care, which accounted for 2.3% of all compliments received by the trust. All compliments were for services in the Wigan area.

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)
Is the service well-led?

Leadership

The chief nurse was the executive end of life care lead. An associate chief nurse responsible for end of life care reported to the chief nurse. Compared to the last inspection there were clear lines of reporting and accountability for end of life care.

The consultant in palliative care said they had good links to the medical director and executive team with good working relationships. There was an appraisal process for medical staff with the medical director being the responsible officer.

Nurses were aware of the leadership structure and felt supported by local leadership. Managers in the service felt supported by senior managers and were aware of the previous weaknesses in the service and the actions which had been put in place to address concerns. The managers told us that leadership had improved since our last inspection.

Vision and strategy

At our last inspection the trust had no vision or strategy for end of life care services. The lack of a strategy impacted on the services rating and the trust were asked to develop an action plan which included the development of a strategy.

At this inspection we found the trust had implemented a new End of Life Care Strategy 2017/2019 which had been developed with consultation from staff and external partners as part of an end of life steering group.

The structure and provision of care outlined by the strategy was based on national guidance, Ambitions for Palliative and End of Life Care [Aimptions] (2015) and One Chance to get it right (5 Priorities) [2014]. The strategy brought awareness of end of life care to trust staff, and provided information how care should be addressed, and the tools, education, training and support which staff required to deliver care.

The strategy took account of the North-West End of Life Care Model. The model supported the assessment and planning process for patients from the diagnosis of a life limiting illness or those who may be frail. The model had five phases and the Good Practice Guide identified key elements of practice within each phase to prompt the assessment process as relevant to each setting.

Culture

We observed good relationships within teams. Staff said they felt supported. There was good multi-disciplinary working with other agencies. Staff were proud to be part of their team and working for the trust. Staff reported managers were very supportive and approachable.

Staff said they had been listened to by managers and had seen improvement in the service since our last inspection. One of the key areas noted by staff was their previous concern around staffing. Whilst staff told us they were extremely busy all of those we interviewed said staffing had improved the culture within their services.

There was good communication and staff said they received newsletters and messages from the associate director for end of life care. Student nurses on placement gave a good rating for the mentoring, training and opportunities they had received.
Staff in Warrington had away days every six months with the palliative care consultants. Minutes showed areas reviewed were objectives from the end of life care strategy, risk register, caseloads and new initiatives.

There were lone worker policies. Any concerns were recorded on the electronic system. At weekends staff contacted the out of hours service to sign in and out.

**Governance**

Governance processes had improved since the last inspection. The trust conducted an end of life care scoping document after our inspection which reviewed end of life provision across the trust. The trust operated over a large geographical area and across several commissioning areas and the scoping document assisted in developing a consistent strategy and shared learning. It also looked at any gaps in service provision.

The trust set up and end of life care steering group which was chaired by a non-executive director. Membership included specialist representatives from the medicines management team, specialist palliative care representatives and allied healthcare professionals. Meeting minutes showed input from areas such as falls, district nurse co-ordinators and MacMillan nurses. The group fed into the Clinical Governance Sub Committee and the Quality and Safety Committee and up to the Board.

Each locality had an end of life care champion who attended the steering group and gave feedback to their teams.

**Management of risk, issues and performance**

Minutes from the end of life steering group showed operational activity and assurance was evidenced and shared with departmental teams.

The end of life care implementation plan showed progress against each action. Out of twenty actions most were complete with a few progressing. The plan was linked to the Ambitions for Palliative and End of Life Care Framework and the trust’s End of Life Care Strategy.

The trust had carried out an external governance review of end of life care 2017/2018 which showed progress against the CQC actions identified at the last inspection. The review showed significant assurance.

End of life medicines management reports were produced each month and reported to the end of life care steering group. Complaints were reported and monitored by the patient experience team and included in a monthly patient experience report.

Each borough had a district nurse care of the dying quality indicators audit. This covered several key metrics such as preferred place of care, individualised care plans and symptom management.

In Wigan the palliative and end of life committee met every two months. Membership included the clinical manager, associate director of nursing and allied health care professionals. The committee reviewed the actions in the implementation plan, risk and performance.

There was an end of life care risk register. There were no high risks which required escalation to the board.

**Information management**
The service used an electronic system which was linked to GP practices. This provided a co-ordinated approach to care for end of life patients. Information could be scanned so that GPs were aware of the treatment pathway.

Staff said they had no problems with connectivity or access issues with the current system.

Guidelines were available for staff to access.

**Engagement**

Whilst we saw numerous cards and thank you letters there was no formal feedback recorded by the service. The rationale for this was that loved ones would find it difficult and challenging to receive patient surveys at the time of a patient’s death.

The service was carrying out a patient survey of care at the end of life and feedback from the patient’s next of kin / carers was being sought on cases from August 2018.

District nurses would ask families if they consent to be contacted regarding the service provided. The questionnaire covered care in the last three days of life and included individual needs, communication, access to services, pain relief and nutrition.

There was good engagement with staff within the specialist palliative care team. Knowledge was shared at regular team meetings locally but this was less evident across boroughs. Workshops were held for staff to contribute to the end of life care strategy and implementation plan.

**Learning, continuous improvement and innovation**

The service was part of a collaborative to provide creative and innovative ways to present improvement work. The project team included the end of life care lead, district nurses, allied healthcare professionals, specialist palliative care nurses, quality matrons and education leads.

The service produced a story for sharing the CQC inspection journey. The improvements were presented as a speaking story book and demonstrated how, a group of individuals across the organisation became a stronger team and continued to share experiences and support in the interest of patients and families they cared for.

The Warrington district nursing team were involved in the Advance Quality Alliance – Improving the quality of health and care initiative. Staff attended meetings regarding person centred approaches to improve how staff talk and listen to people to support them with their treatment.

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**Community dental services**

**Facts and data about this service**

The trust provided the following information about community dental services at Bridgewater Community Healthcare NHS Foundation Trust:

The Community Dental Service is commissioned by NHS England to provide specific and specialised dental services across both Cheshire and Merseyside and Greater Manchester in the following areas:

- Special Care Dentistry
• Paediatric Exodontia
• Minor Oral Surgery

It operates across 18 clinic sites within eight boroughs. Equally to deliver the service it works in partnership with seven hospitals to deliver treatment under general anaesthetic.

It also works in partnership with Bridgewater’s Health and Justice service and a Manchester mental health trust to provide dentistry in five prisons and one secure unit. It provides epidemiology services in several boroughs in Merseyside and Greater Manchester as well as Oral Health Promotion for Stockport and Trafford.

(Source: CHS Routine Provider Information Request (RPIR) - CHS Context tab)

Is the service safe?

Mandatory training

Mandatory Training completion

The trust was unable to provide data on mandatory training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust, for all staff groups from April 2017 to March 2018 are in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>2,632</td>
<td>2,883</td>
<td>91.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Wrap 3</td>
<td>636</td>
<td>719</td>
<td>88.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>1,768</td>
<td>2,114</td>
<td>83.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Medicine management training</td>
<td>1,768</td>
<td>2,114</td>
<td>83.6%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Risk Assessment</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety 2 years</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Health and Safety (Slips, Trips and Falls)</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Secure transfer of personal data</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Lone working &amp; security</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Manual Handling - Object</td>
<td>634</td>
<td>769</td>
<td>82.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>634</td>
<td>769</td>
<td>82.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Customer Care</td>
<td>633</td>
<td>769</td>
<td>82.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Prevent</td>
<td>2,231</td>
<td>2,883</td>
<td>77.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - refresher</td>
<td>1,637</td>
<td>2,232</td>
<td>73.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Clinical Record Keeping</td>
<td>1,445</td>
<td>2,114</td>
<td>68.4%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>229</td>
<td>336</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution - initial*</td>
<td>1,400</td>
<td>2,100</td>
<td>66.7%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>1,349</td>
<td>2,114</td>
<td>63.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Non Clinical staff*</td>
<td>391</td>
<td>613</td>
<td>63.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Resuscitation - Clinical Staff</td>
<td>1,832</td>
<td>2,883</td>
<td>63.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>1,620</td>
<td>2,883</td>
<td>56.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 90% target was met for one of the 23 mandatory training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Mandatory training for staff included immediate life support for those providing intravenous sedation, paediatric immediate life support for those providing inhalation sedation, information governance, infection prevention and control and fire safety. Training was a mix of online training and study days. Staff told us they had good access to training and were provided with protected time to complete the training.

Staff were encouraged to complete mandatory training, and this was actively monitored at a local level and at a regional level. Managers received regular updates about the staff compliance with mandatory training. This enabled them to prompt staff to complete training if they had not done so. We were shown this system and staff confirmed they were actively encouraged to complete training. Staff also informed us that they were sent e-mails to notify them of when their training was due to be completed again.

Updated records as of September 2018 demonstrated that the overall compliance for the dental core service was 90%.

Safeguarding
Safeguarding Training completion

The trust was unable to provide data on safeguarding training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust from April 2017 to March 2018 is in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>2,719</td>
<td>2,883</td>
<td>94.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>2,699</td>
<td>2,883</td>
<td>93.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>756</td>
<td>811</td>
<td>93.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>229</td>
<td>336</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for three of the four safeguarding training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse.
Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community dental services made one safeguarding referral of an adult and one safeguarding referral of a child from April 2017 to March 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

A trust safeguarding policy existed and staff were familiar with how to access this. The trust had a dedicated safeguarding team for adults and children to provide advice and support to the dental team. Staff were fully aware of the trusts safeguarding teams and spoke highly about the advice and support which they provided when required. Contacts for both the trust’s safeguarding team and local safeguarding teams were readily available at each clinic for staff to reference if needed.

As part of mandatory training all staff were required to complete level two safeguarding training. Clinicians were required to complete level three safeguarding training. Updated records as of September 2018 showed that 96% and 92% of staff had completed level two adult safeguarding training and level two children safeguarding training respectively.

Staff were knowledgeable about safeguarding issues and we were shown examples of safeguarding referrals which had been raised. These had been dealt with appropriately and logged as significant events. A system and process was in place to highlight patients who were subject to a child protection plan.

Safeguarding examples were shared across with core service through the “lessons learned” newsletter on the dental hub on the trust’s intranet. Staff were also aware of other forms of abuse such as human trafficking and Female Genital Mutilation. They told us that they would listen out for key phrases which patients may say which would raise concerns about certain safeguarding issues.

As part of the safeguarding policy there were details of how the service dealt with children or vulnerable adults who were “not brought” to appointments. In the first instance the parents or careers would be informed of their attendance. If this continued, then the safeguarding team would be contacted for advice and for children the school nurse would be contacted to inform them that the child had not been brought for dental appointments.

Cleanliness, infection control and hygiene

The service had a dental infection control and decontamination policy. This was readily available on the dental hub on the trust’s intranet.

The service used a system of local decontamination at each clinic (except for Seymour Grove) for the reprocessing of contaminated dental instruments and equipment.

The clinics where local decontamination was carried out was done so in line with guidelines issued by the Department of Health - Health Technical Memorandum 01-05: Decontamination in primary care dental practices.

Staff demonstrated the arrangements for infection control and decontamination procedures. They demonstrated and explained in detail the procedures for the cleaning of dental equipment. Used
dental instruments were decontaminated using a washer disinfector at each site. After decontamination they were sterilised using vacuum autoclaves.

Sterilised instruments were stamped with a date they were sterilised and a use by date of a year from the day they were sterilised. We saw evidence that the dental nurses maintained the daily, weekly and quarterly test sheets for the equipment used in decontamination of dental equipment. This included autoclaves and the washer disinfectors. We noted at The Bath Street Health and Wellbeing Centre that the cleaning efficacy test (soil test) had not been recorded. We were told this had been done but had not been recorded. We were assured that this would be recorded in future.

Sterilised dental instruments were appropriately stored in “clean” rooms until they were needed. The service carried out monthly instrument checks to ensure they did not pass their “use by” date.

At Seymour Grove an offsite decontamination unit was used for the reprocessing of contaminated dental instruments and equipment. Instruments were kept moist until they were ready to be sent to the offsite decontamination unit for reprocessing. This prevented any debris on the instruments from hardening which would make removal more difficult.

Infection prevention and control audits were carried out every six months as described in HTM 01-05. The latest audits showed that they were meeting the required standards. Where issues had been identified then an action plan had been formulated to address the issues. Six monthly hand hygiene audits were also carried out. The latest audit demonstrated that staff were fully compliant with current guidance.

Hand washing facilities, liquid soap and alcohol hand gel were available throughout the clinic areas. Personal protective equipment such as gloves and masks were readily available throughout the clinics. We observed staff followed the “arms bare below the elbow” guidance.

The service had systems in place to comply with the European Directive for the safer use of sharps. These included the use of safer sharps systems at all locations and disposable matrix bands. The trust had a generic sharps risk assessment which was not dental specific. We asked if there was a dental specific sharps risk assessment. Staff in the Greater Manchester area were unable to show us a dental specific sharps risk assessment. However, in the clinics we visited in the west sector they had a dental specific sharps risk assessment.

Arrangements for the safe storage of clinical waste could be improved. For example, at Ashton Primary Care Centre and Seymour Grove we noted that clinical waste bins were unlocked in areas which were accessible to the public. We highlighted this to staff on the day of inspection and were assured this would be investigated to ensure that all clinical waste was stored securely prior to collection.

Processes were in place to reduce the risks associated with Legionella. These included the regular flushing of the dental unit water lines and the use of a water conditioning agent. We saw Legionella risk assessments had been carried out. Monthly water temperature testing was carried out at by an external contractor.

We looked at the monthly temperature readings. Some of these related to thermostatic mixing valves fitted to taps. The temperatures were in accordance with the risk assessment. However, there was no temperature testing of the water supply feeding the valves. Staff told us they would consult with the external contractor about this.

We saw cleaning schedules for the clinics. The clinics were clean and tidy when we inspected them.
Environment and equipment

We observed that dental equipment was clean and well maintained. Staff told us there was sufficient equipment to support safe and effective care. These included dental handpieces and other dental instruments.

We reviewed evidence of servicing and maintenance of equipment at all locations. Equipment involved in the decontamination and sterilisation of dental instruments had been serviced and maintained appropriately. A process was in place to ensure staff were aware when equipment required servicing or validation.

We found that at each site we inspected equipment was present for dealing with medical emergencies. This included an automated external defibrillator emergency medicines and oxygen. There were also separate medical emergency kits for staff to take on domiciliary visits.

Emergency medicines and equipment were in line with guidelines issued by the British National Formulary and the Resuscitation Council UK.

A radiation protection folder was maintained at each location which we visited. This included records in relation to dental X-ray equipment and registration with the Health and Safety Executive as required with the Ionising Radiation Regulations (IRR 2017). A radiation protection advisor (RPA) and radiation protection supervisor (RPS) had been appointed. There was good evidence of liaison between the RPA and RPS at all locations. Local rules were available for each X-ray machine.

At Kingsgate house we noted there was no current routine test for the X-ray machines. This took time to locate as it had been sent to a different e-mail account. This test demonstrated the X-ray machines were safe to use. At Ashton Primary Care Centre, we saw the latest routine test had identified that one of the machines was producing three times more radiation than the reference level. The service did not use this machine, but the location was shared with another provider. The other provider was approached on the day of inspection who confirmed that they did not use the machine either. We were told that steps would be taken to prevent use of this machine.

The dentists told us when X-rays were taken they were justified, reported on and quality assured every time. Dental care records which we reviewed supported this. This ensured that the service was acting in accordance with the Ionising Radiation (Medical Exposure) regulations IR(ME)R and protected staff and patients from receiving unnecessary exposure to radiation.

The service carried out domiciliary visits for when patients could not attend the clinic. These visits were carried out in line with guidance from the British Society for Disability and Oral Health. A formal policy was not available for carrying out these visits. We were told a policy was currently being written by a domiciliary working group. A risk assessment was carried out on the premises which they were visiting. We saw evidence of completed risk assessment forms.

Assessing and responding to patient risk

Throughout our inspection, we looked at examples of dental treatment records. We found that the clinicians always recorded patient safety alerts. For example, medical histories were always taken by the clinicians and updated when patients attended for treatment. These medical histories included any allergies and reactions to medication such as antibiotics.

Staff described to us the use of Local Safety Standards for Invasive Procedures (LocSSIPs). These were used for extractions to reduce the chance of wrong site surgery. We saw evidence of completed LocSSIPs in dental care records.

Staff ensured that patients and carers received appropriate pre and post-operative instructions about treatments. This minimised the risk of the patient suffering from post-operative complications such as post extraction haemorrhage or infections. Patients and carers were also provided with pre and post-operative information conscious sedation and general anaesthesia. These leaflets were also available on the trusts website.
There was a process in place for patients who became acutely unwell during dental treatment. If a patient required emergency resuscitation, this would be carried out by trained members of staff and the patient would be transferred by an emergency 999 ambulance if required. The trust had a policy relating to sepsis. This outlined the signs and symptoms and sepsis and the treatment which would be required. There were flow charts in each surgery with information about sepsis. Staff were aware of the issues relating to sepsis and had discussed these at staff meetings.

The dentists used rubber dams in line with guidance from the British Endodontic Society when providing root canal treatment.

Mercury and blood spillage kits were readily available at all locations which we visited.

The service had a process for receiving national patient safety alerts such as those issued by the Medicines and Healthcare Products Regulatory Agency. Where relevant, these alerts were shared with all members of staff at staff meetings.

**Staffing**

**Planned v Actual Establishment**

Details of staffing levels within community dental services by staff group as at 30 April 2018 are below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Actual staff (WTE)</th>
<th>Planned staff (WTE)</th>
<th>Fill rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>2.0</td>
<td>1.0</td>
<td>200.0%</td>
</tr>
<tr>
<td>Qualified nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>20.6</td>
<td>21.1</td>
<td>98.0%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>67.7</td>
<td>71.0</td>
<td>95.4%</td>
</tr>
<tr>
<td>Public Health and Community Health Services</td>
<td>32.8</td>
<td>34.6</td>
<td>94.8%</td>
</tr>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>0.8</td>
<td>1.4</td>
<td>56.8%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>123.9</td>
<td>129.1</td>
<td>96.0%</td>
</tr>
</tbody>
</table>

Qualified nursing and health visiting staff were over-established, with low fill rates medical and dental staff (although planned staff numbers are low for both staff groups).

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

**Vacancies**

The trust did not provide a target for vacancy rate. From April 2017 to March 2018, the trust reported an overall vacancy rate of 16.6% in community dental services. No medical and dental or nursing staff were included within the vacancies dataset for community dental services.

A breakdown of vacancy rates by staff group in community dental services at trust level is below:

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total vacancies (12 months)</th>
<th>Total WTE establishment (12 months)</th>
<th>Annual vacancy rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>24.0</td>
<td>120.0</td>
<td>20.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>77.0</td>
<td>442.4</td>
<td>17.4%</td>
</tr>
</tbody>
</table>
Public Health and Community Health Services 101.4 610.2 16.6%
Support to doctors and nursing staff 54.2 331.6 16.3%
Support to ST&T staff 5.8 79.2 7.3%
All staff groups 262.3 1,583.4 16.6%

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

Turnover

From August 2017 to March 2018 the trust reported an average turnover rate of 22.2% in community dental services. No medical and dental or nursing staff were included within the turnover dataset for community dental services.

A breakdown of turnover rates by staff group in community dental services at trust level for the year ending March 2018 is below:

Community dental services total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total leavers</th>
<th>Average monthly staff establishment</th>
<th>Annual turnover rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>0.6</td>
<td>0.1</td>
<td>600.0%</td>
</tr>
<tr>
<td>Public Health and Community Health Services</td>
<td>3.6</td>
<td>7.4</td>
<td>48.8%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>2.2</td>
<td>21.3</td>
<td>10.3%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>6.4</td>
<td>28.8</td>
<td>22.2%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

Sickness

The trust set a target of 3.8% for sickness rates. From April 2017 to March 2018 the trust reported an overall sickness rate of 4.2% in community dental services. No medical and dental or nursing staff were included within the turnover dataset for community dental services.

A breakdown of sickness rates by staff group in community dental services at trust level is below:

Community dental services total

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total sickness absence (days)</th>
<th>Total establishment (days)</th>
<th>Sickness rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS infrastructure support</td>
<td>43.0</td>
<td>1,381.5</td>
<td>3.1%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>779.7</td>
<td>21,273.3</td>
<td>3.7%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>274.8</td>
<td>6,106.1</td>
<td>4.5%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>293.4</td>
<td>4,601.2</td>
<td>6.4%</td>
</tr>
<tr>
<td>All staff groups</td>
<td>1,390.9</td>
<td>33,362.1</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)
Nursing – Bank and Agency Qualified nurses

The trust reported no bank and agency usage between April 2017 and March 2018 within community dental services.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Nursing - Bank and Agency Nursing assistants

The trust reported no bank and agency usage between April 2017 and March 2018 within community dental services.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

Medical locums

The trust reported no medical locum usage between April 2017 and March 2018 within community dental services.

(Source: Universal Routine Provider Information Request (RPIR) – P21 Medical Locum Agency)

Suspensions and supervisions

During the reporting period from May 2017 to May 2018, community dental services reported that there no cases where staff have been suspended.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

Staffing levels at each location we visited were appropriate and we found the teams worked well together. The service rarely used bank or agency staff. We were told that in the event of sickness there was resilience in the workforce which meant that staff could be moved to work at other locations to cover sickness. If a dentist was on leave who worked at a single surgery location, then any patients requiring emergency treatment would be seen at a different local clinic.

 Appropriately trained nurses supported the dentists carrying out sedation on each occasion. This was also recorded in the dental care records with details of their names. The measures in place ensured that patients were treated safely and in line with current standards of clinical practise.

 The appointment diaries at each location we visited showed that sufficient time was booked for patient assessment and treatments. Appointment times could be tailored to patient need and the complexity of the treatment being provided.

Quality of records

Dental care records were mainly computerised. Computers were password protected and backed up to secure storage to keep patient details safe. Staff carrying out domiciliary visits would record their notes on paper and then copy them over to the computer system when they returned to the clinic.

Staff told us that the computer systems were often very slow and took time to load up patient records. Managers were aware of this and we were told this had been on the divisional risk register. We were told that a new server had been bought which would speed up the computer system.
Audits of record keeping were carried out. The latest audit showed that the clinicians were meeting nationally recognised guidance.

The dental care records were looked at were well-maintained and provided comprehensive information on the individual needs of patients such as, an oral examination, medical history, consent and agreement for treatment. All records were clear, concise and accurate and provided a detailed account of the treatment patients received.

**Medicines**

Medicines used in the provision of intravenous sedation (Midazolam) were stored securely in locked wall mounted metal cabinets. A controlled drug log was maintained by staff. This showed the amount used on each patient and the volume which was disposed of. Midazolam was disposed of safely using denaturing kits.

Medical gasses used for the provision of inhalation sedation were stored away from the clinical area and pipe in. There was a process in place to ensure a continued flow of these gasses. Staff checked these gasses every morning to ensure the cylinders had not been tampered with. At locations where the medical gasses were not piped in the cylinders were stored in an upright position to prevent them from tipping over.

NHS prescription pads were stored securely at all times. A log was maintained for the prescription pads. This enabled the service to actively monitor the use of prescriptions and ensure none had been taken.

Audits of prescribing were carried out every year. The most recent audit demonstrated that the dentists were following nationally recognised guidance. When the dentists were unable to follow guidance when prescribing the reason was always documented in the dental care records.

**Safety performance**

There had not been any never events at the community dental services in the previous 12 months. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. An example of a never event in dentistry is a wrong tooth extraction.

Staff were familiar with the concept of a never event and described to us the process for reporting these.

**Incident reporting, learning and improvement**

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From July 2017 to June 2018 the trust reported no never events within community dental services.

(Source: Strategic Executive Information System (STEIS))

**Serious Incidents**
Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community dental services, which met the reporting criteria, set by NHS England from July 2017 to June 2018.

(Source: Strategic Executive Information System (STEIS))

Serious Incidents (SIRI) – Trust data

From April 2017 to April 2018, trust staff within community dental services reported no serious incidents.

(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)

Staff recorded significant events, incidents and accidents on the trusts electronic reporting system. We were shown evidence of significant events which had been reported. These were investigated, and action taken to prevent re-occurrence. Staff gave a good example of a patient who became aggressive during an appointment. As a result, all staff were warned to be wary of potentially dangerous patients. In addition, a working group had been put together which aimed at reducing the likelihood of violence towards staff.

Since the inspection in June 2016 staff told us the process to share learning from significant events had improved. We were shown the “lessons learned” newsletter. This contained details of significant events which had occurred, and actions taken to reduce the likelihood of them re-occurring. Staff were familiar with these newsletters and confirmed that they read them. Significant events were also part of the standing agenda for team meetings.
Is the service effective?

Evidence-based care and treatment

The dentists used national guidelines to ensure patients received the most appropriate care. This included the guidance produced by the British Society for Disability and Oral Health, the Faculty of General Dental Practice and the National Institute for Health and Care Excellence. Dentists we spoke with were knowledgeable about these guidelines and the standards that underpinned them.

The dentists providing conscious sedation were aware of the standards set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists ‘Standards for Conscious Sedation in the Provision of Dental Care’ 2015.

The dentists used rubber dam when carrying out root canal treatment in line with guidance from the British Endodontic Society.

Nutrition and hydration (only include if specific evidence)

Patients undergoing general anaesthesia were given appropriate information by staff of the need to fast before undergoing their procedure. The patient, parent or carer were given a pre-operative instruction sheet emphasising the importance of fasting prior to the procedure.

Patients undergoing inhalation sedation were encouraged to have a light meal prior to the procedure.

Pain relief (only include if specific evidence)

The dentists assessed patients need for different levels of anaesthesia on an individual basis. For example, for very young patients when treatment under local anaesthesia was not possible a general anaesthetic was preferable.

We were told that the dentists would always initially attempt to provide treatment prior to undergoing a general anaesthetic. If the patient was unable to tolerate treatment with local anaesthetic alone then they would be placed on the list to have a general anaesthetic.

We were told that many children tolerated treatment with inhalation sedation who had initially been referred for a general anaesthetic.

In situations where patients were anxious about dental treatment conscious sedation could be used. This took the form of inhalation sedation or intravenous sedation.

Local anaesthesia was used for the relief of pain during dental procedures such as fillings or extractions. We were told that topical anaesthetic was routinely used prior to administering a local anaesthetic.

Patient outcomes

Audits – changes to working practices

The trust has participated in one clinical audit in relation to this core service as part of their Clinical Audit Programme, details are in the table below.
<table>
<thead>
<tr>
<th>Audit name</th>
<th>Area covered</th>
<th>Key Successes</th>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Re-audit of Mental Capacity Act (MCA) within Dental Network</td>
<td>All dental services within Bridgewater Trust</td>
<td>If a patient lacks capacity to consent to treatment and is “unfriended”, referral should be made to an IMCA (Independent Mental Capacity Advocate) - maintained 100% compliance with this standard over 2 cycles of audit.</td>
<td>The Trust Dental Advisor reviewed the findings to address specific cases with staff involved. The audit requires a redesign which will be undertaken by the clinical audit team with input from both Dental and Trust Safeguarding Team. Clear instructions on when written consent forms are mandatory needs to be communicated to all dentists to ensure uniformity.</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

Quality assurance processes were embedded within the culture of the service to improve patient outcomes and ensure quality and safety were not compromised.

We saw audits of X-rays, dental care records and infection prevention and control. These audits had action plans associated with them which were disseminated to all staff.

In addition to these there had been audits carried out in relation to the use of the reversal agent used in intravenous sedation, compliance with the NICE guidance on the extraction of wisdom teeth and the appropriateness of referrals for inhalation sedation. The results of these audits showed that the clinicians were performing well and following NICE guidance. The sedation audit showed that the reversal agent was not used in the last year.

Results of audits were displayed on the dental section of the trusts intranet page and discussed with clinicians during team meetings.

The service also carried out patient reported experience measures. This took the form of a patient satisfaction survey which was linked to the NHS friends and family test. The latest results of this survey showed high levels of satisfaction with the service being provided.

**Competent staff**

**Clinical Supervision**

The trust reported no clinical supervision applications for community dental services.

(Source: CHS Routine Provider Information Request (RPIR) – CHS4 Clinical Supervision)

**Appraisal rates**

**Community dental services total**

From April 2017 to March 2018, 89.8% of permanent non-medical staff within the community dental services core service had received an appraisal compared to the trust target of 90%. The staff categories in the table below for community dental services are not consistent with other datasets on staffing and sickness/vacancy/turnover rates.
<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number of staff appraised</th>
<th>Sum of Individuals required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Non-Medical Staff</td>
<td>28</td>
<td>28</td>
<td>100.0%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>88</td>
<td>95</td>
<td>92.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical &amp; Dental Staff - Hospital</td>
<td>42</td>
<td>53</td>
<td>79.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
<tr>
<td>All staff groups</td>
<td>158</td>
<td>176</td>
<td>89.8%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

Two of the three staff groups within the core service met the appraisal targets.

A breakdown of appraisal rates for medical and dental staff by dental network area is below:

Staff were encouraged to complete additional professional training to assist with the ever-increasing complexity of patients.

Many dental nurses had completed extended duty training. These included radiography, special care dental nursing, conscious sedation and oral health education. The dental nurses could utilise these extended duties.

Some of the dentists were on the General Dental Council’s specialist register. These included special care dentistry, paediatrics and oral surgery.

The service used dental therapists to carry out some treatments. Dental therapists are qualified dental professionals who can carry out treatments such as fillings and extraction of deciduous teeth. Many of the dental therapists were trained to carry out inhalation sedation. The dental therapists played a vital role in the service.

Staff we spoke with said they had annual appraisals and felt these were beneficial and had led to extra training or courses. We saw evidence of personal development plans.

**Multidisciplinary working and coordinated care pathways**

Multidisciplinary working was used throughout the service. Multidisciplinary team meetings were held as part of best interest decision making or for patients with complex medical needs.
Staff described to us examples of when they liaised with patients GPs, consultants, psychiatrists and carers to ensure and medical conditions were highlighted prior to a general anaesthetic. This would also enable any other procedures to be carried out under general anaesthetic. These could include podiatry, gynaecological procedures or a well man check.

Referrals were received into the service via an online referral pathway or a paper referral. Referrals were initially triaged by dental nurses to ensure they were appropriate to the service. Patients were then contacted to book an initial consultation appointment with a dentist. Once a course of treatment had been completed the patient was discharged back to their own dentist for continuing treatment. A discharge letter was sent to the referring dentist.

Health promotion

Dental staff used the Department of Health’s ‘Delivering Better Oral Health’ toolkit 2013 when providing preventative advice to patients on how to maintain a healthy mouth. This is an evidence-based tool kit used for the prevention of the common dental diseases.

We saw evidence that oral hygiene advice, dietary advice and smoking cessation advice was given to patients. In addition, high fluoride toothpaste was prescribed to patients who were at high risk of tooth decay. There were numerous oral health promotion leaflets relevant to the local community at each location we visited. This included advice about the use of chewing tobacco.

The service had a dedicated oral health promotion team who visited local nurseries and schools including special care schools. They also trained health visitors and staff at care homes in how to improve the oral health of their patients or residents.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty training completion

The trust was unable to provide data on mental capacity act training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust from April 2017 to March 2018 is in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Capacity Act Level 1</td>
<td>2,402</td>
<td>2,883</td>
<td>83.3%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was not met for this course at the trust as a whole.

(Source: Universal Routine Provider Information Request - P38 Training)

Deprivation of Liberty Safeguards

The trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority.

(Source: Universal Routine Provider Information Request (RPIR) – P13 DoLS)

Staff understood the importance of obtaining and recording patients’ consent to treatment. Staff described to us the process which they went through to obtain informed consent. This included informing the patients or carers about the different options available and the risks and benefits
associated with each treatment option. We saw good evidence that dentists documented the consent process in the patient records and utilised NHS consent forms (1, 2, 3 or 4) as appropriate. Patient comments confirmed that they were fully involved in the consent process.

Where patients were undergoing treatment under conscious sedation then consent was always obtained at a pre-assessment appointment following standards set out by the Royal Colleges of Surgeons and the Royal College of Anaesthetists ‘Standards for Conscious Sedation in the Provision of Dental Care’ 2015. This was then re-confirmed on the day of treatment.

Staff had a strong understanding of the legal requirements of the Mental Capacity Act 2005. They told us that the assessment of a patient’s capacity begun when the patient walked in the door. Mental capacity assessment forms were used to ensure there was a consistent approach to determining if a patient had capacity to consent to treatment.

We were shown and given examples of when best interest decision meetings had been carried out with the assistance of an Independent mental capacity advocate. Updated records showed that 85% of staff had completed Mental Capacity Act training.

Staff were familiar with the concept of Gillick competence in respect of the care and treatment of children under 16. Gillick competence is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

**Is the service caring?**

**Compassionate care**

We observed staff treating patients with dignity and respect. Staff told us they adopted a holistic approach to patient care which focussed on the medical, physical and social needs of patients. Patients told us that staff were compassionate, considerate, professional and friendly.

Privacy and confidentiality was maintained in the reception area. The layout of reception and waiting areas provided privacy when reception staff were dealing with patients. If a patient asked for more privacy they would take them into another room.

The reception computer screens were not visible to patients and staff did not leave patients’ personal information where other patients might see it. Surgery doors were kept closed whilst treatment was being carried out and signs were placed on the door when they wished not to be disturbed due to patient anxiety.

Staff respected peoples’ individual preferences, habits, culture, faith and background.

**Emotional support**

Staff were clear on the importance of emotional support needed when delivering care. It was clear that staff considered patients emotional needs and made adjustments as necessary. Patient feedback highlighted that staff provided emotional support to patients in a kind and caring manner.

Staff provided us with case studies of where they had provided emotional support to patients. These included arranging appointments during their lunch hours to ensure the patient was not kept waiting in a busy or noisy environment, getting to know the patient well including their likes and dislikes (such as liking football or disliking load noises) and introducing children to the dental equipment in an age appropriate manner.
Staff told us they used the dental passports. These are forms filled in by patients or their carers. They included information about the patient’s likes, dislikes and how they like to be spoken to. Staff told us this was very useful as it was a good reminder of how to treat certain patients.

Appointment times and lengths were tailored to individual needs. For example, we were told that nervous patients would normally prefer early or late appointments. These were arranged, and staff ensured these patients were not kept waiting. Staff told us that they had sufficient time to treat patients.

**Understanding and involvement of patients and those close to them**

Patients and their families were appropriately involved in and central to making decisions about care options and the support needed.

The dentists described to us the methods they used to help patients understand treatment options discussed. These included drawing pictures for patients and using models to help them fully understand treatment being proposed. There were also information leaflets (including child friendly) about treatments in the waiting area and in the surgeries, which could be given to patients.

Our observations of interactions between staff and patients confirmed that staff communicated with patients in a manner that helped them to understand their care and treatment. Feedback from patients indicated that they were fully involved in the treatment decisions.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The dental service was commissioned by NHS England. Services were planned to meet the needs of people who could not access primary dental care services. These included patients with medical, physical or social issues and patients with dental anxiety.

Reasonable adjustments had been made at all the locations which we visited. This included step free access, automatic doors, accessible toilets, knee break chairs and lowered reception desks. The service also had access to wheelchair tippers and bariatric chairs at some locations. Access for wheelchair users at Seymour Grove was not ideal due to the layout of the premises, small surgeries and narrow doorways. We were told that wheelchair users were signposted to other local clinics if required.

Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas, written in languages other than English, informing patients translation service were available.

Domiciliary visits were carried out by the service. These visits were reserved for patients who could not access the service due to medical, physical or social issues.

There were adequate seating facilities in the waiting areas at all clinics.

Services were available Monday to Friday from 8:30am to 4:30pm. Not all clinics provided treatment during these hours. Patients requiring emergency treatment when a clinic was closed were signposted to a different clinic which was open. We were told that any patients requiring emergency care would be seen the same day.

**Meeting the needs of people in vulnerable circumstances**
The whole service was configured to reflect the needs of vulnerable people. It was a referral service providing either continuing care or a single course of treatment to children or patients with special needs due to physical, mental, social and medical impairment.

Domiciliary visits were carried out by the service. These visits were reserved for patients who could not access the service due to medical, physical or social issues.

We were told in the Halton and St Helens area they had identified certain groups of patients who were considered vulnerable. These included travellers, asylum seekers and the homeless. They had identified and developed links with local services or charities who helped these vulnerable groups. We were shown a list of services and charities whom they had identified. They were currently looking at developing these links with these services and charities to ensure these vulnerable groups could access dental treatment in a timely manner.

### Access to the right care at the right time

#### Accessibility

The trust provided the following information about the largest ethnic minority groups in the six main catchment areas covered by the trust.

<table>
<thead>
<tr>
<th>Ethnic minority group - Bolton</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>Asian/Asian British: Indian</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian/Asian British: Pakistani</td>
</tr>
<tr>
<td>Third largest</td>
<td>White Other</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Black/Black British African</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic minority group – Halton</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Other</td>
</tr>
<tr>
<td>Second largest</td>
<td>White Irish</td>
</tr>
<tr>
<td>Third largest</td>
<td>Mixed White &amp; Black African</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Mixed White &amp; Asian</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic minority group – Oldham</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>Asian/Asian British: Other</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian/Asian British: Pakistani</td>
</tr>
<tr>
<td>Third largest</td>
<td>Asian/Asian British: Bangladeshi</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>White Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic minority group – St Helens</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Other</td>
</tr>
<tr>
<td>Second largest</td>
<td>White Irish</td>
</tr>
<tr>
<td>Third largest</td>
<td>Chinese</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Ethnic minority group – Warrington</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Other</td>
</tr>
<tr>
<td>Second largest</td>
<td>Asian/Asian British: Indian</td>
</tr>
<tr>
<td>Third largest</td>
<td>White Irish</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian/Asian British: Pakistani</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic minority group – Wigan</th>
<th>Percentage of catchment population</th>
</tr>
</thead>
<tbody>
<tr>
<td>First largest</td>
<td>White Other</td>
</tr>
<tr>
<td>Second largest</td>
<td>White Irish</td>
</tr>
<tr>
<td>Third largest</td>
<td>Black/Black British African</td>
</tr>
<tr>
<td>Fourth largest</td>
<td>Asian/Asian British: Indian</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request – P48 Accessibility)

Referrals

The trust reported no referral to treatment data for community dental services.

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

General dental practitioners and other health professionals could refer patients for short-term specialised treatment as well as long term continuing care to the community dental service. Once a course of treatment had been completed the patient was referred back to primary dental care for ongoing care with their own dentist if appropriate.

Internal referral systems were in place, should the dental service decide to refer a patient on to other external services such as local maxillofacial services. The service reported that there were no delays with internal referrals.

We were told and saw evidence of dedicated slots in the dentist’s diaries which were used to ensure patients who were referred in were seen for an initial consultation within ten working days. These were called “golden slots”. They currently had a 94% compliance with seeing patients within ten working days. There was currently a waiting list of between three and six weeks for children requiring treatments under general anaesthetic and 13 weeks for special care adults requiring a general anaesthetic.

We were told that because of a significant event at Whiston Hospital in February 2018 that treatment under general anaesthetic had to be suspended. This had resulted in a build-up of the waiting list for children requiring a general anaesthetic. The service worked closely with other hospitals to reduce the waiting list. As of August 2018, the waiting list had been reduced to the normal level. We were told this work had been acknowledged by the board for their effort to reduce the waiting list.

Learning from complaints and concerns

Complaints

From April 2017 to March 2018 there were four complaints about community dental services. The trust took an average of 33.5 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 25 working days.
A summary of complaints within community dental services by subject is below:

### Community dental services total

<table>
<thead>
<tr>
<th>Subject</th>
<th>Number of complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitude of staff</td>
<td>1</td>
</tr>
<tr>
<td>Medication</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Waiting times</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
</tr>
</tbody>
</table>

*(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)*

### Compliments

From April 2017 to March 2018 the trust received 655 compliments. Of these 53 related to community dental services, which accounted for 8.1% of all compliments received by the trust as a whole.

*(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)*

The trust had a complaints policy and procedure which was readily available for staff to reference. The service had a low level of complaints. The service aimed to deal with informal complaints in house initially. If a patient was not satisfied with the response, then they were signposted to the Patient Services (formerly PALS) team. The patient services team would acknowledge the complaint and allocate it to a senior member of staff not involved in the complaint to investigate. We saw an example of a complaint which had been responded to. This gave a detailed, open and honest response to the patient. We were told that learning from complaints was discussed at team meetings to disseminate learning and prevent future issues.

There were details of how patients could make a complaint displayed in the waiting area, in the patient information leaflet and the trust’s website.

### Leadership

Leaderhip was provided by the professional lead for dentistry and the assistant director of operations. They were supported by a team of managers and acting clinical directors. The professional lead for dentistry had overall responsibility for the clinical leadership for the service. Clinical leadership in the Cheshire and Merseyside area was strong as the professional lead for dentistry and acting clinical directors were based there. Due to the geographical size of the service and the lack of clinical director in the Greater Manchester area there was a gap in clinical leadership. This had led to a lack of clinical command in the Greater Manchester area and effect of this had been noted by some members of staff who had started to feel professionally isolated. The assistant director of operations was aware of this issue and was currently in the process of recruiting one of the dentists to a permanent clinical director post.

The majority of staff told us that they felt supported and valued by management. Due to the geographical size of the service coverage of all clinics posed a challenge for the management.

Several staff members had individual roles such as infection prevention and control. This led to a culture of individual responsibility and accountability within the service.
Vision and strategy

The service had a short term, medium term and long-term vision and strategy. The current strategic risk was that the services were due to be re-tendered by NHS England. The assistant director of operations was putting together a business plan to continue to provide services.

Other visions and strategies were to maintain good estates, providing safe and high-quality care, improve their oral health of the local communities and a more joined up IT system.

The trusts values were “Person centred”, “Encouraging innovation”, “Open and honest”, “Professional”, “Locally led” and “Efficient”. Staff were encouraged to be aware and embed these values in their work. They also formed part of their appraisal process.

Culture

Morale at the service was generally good. Staff were proud and passionate about the work they did, and it was clear they were dedicated to their individual roles. They continuously strived to provide high quality treatments in a caring and compassionate manner for their patients.

Staff were aware of their responsibilities to raise concerns if the need arose. They were aware of the whistleblowing process and could easily access the policy. They were aware of the freedom to speak up guardian and could access their details on the trusts intranet.

Staff were aware of the need to be open and transparent with patients in line with the duty of candour. We were given examples of when staff had applied with duty of candour in response to certain situations and circumstances.

Governance

There were effective governance procedures in place to enable the smooth running of the service. Policies and procedures were readily available on the trusts intranet page and were updated regularly to ensure they reflected current guidance and legislation. Policies included infection prevention and control, safeguarding and conscious sedation. We were told that a policy relating to the provision of domiciliary visits was currently being developed. Staff demonstrated to us how to locate policies.

Quality assurance processes were embedded within the culture of the service. Audits were regularly carried out. These included dental care records, X-rays, infection control and hand hygiene. Results of these audits demonstrated a high level of compliance. Where issues had been identified these were disseminated to staff. Results of audits were also displayed on the dental section of the trusts intranet page.

Managers attended monthly clinical governance meetings where matters of governance were discussed. The assistant director of operations told us that they had a good line of sight to the trust board. We were told that the band 5 nurses held three monthly meetings where ideas were shared, issues discussed and patient experiences including case presentations were discussed.

Management of risk, issues and performance

The service maintained a risk register which was regularly reviewed by manager s. This was used to monitor known risks associated with the service and put in place actions to reduce the risks. Staff were fully aware of the risk register and it was discussed during staff meetings. We reviewed
the current risk register and saw entries relating to equipment, access to general anaesthetic theatre space and IT systems.

Risk, issues and performance were discussed at the monthly clinical governance meetings, the quality and safety group and the performance group.

**Information management**

The service collected, analysed, managed and used information well to support all its activities.

Staff had completed training in information governance and were aware of the importance of protecting patients’ personal information. For example, staff locked computers when they moved away from their workstations, reception computer screens were not visible to patients and staff did not leave patients’ personal information where other patients might see it.

Dental care records were mainly computerised. Computers were password protected and backed up to secure off-site storage.

**Engagement**

Several of the clinicians providing care had representation on the local managed clinical network. These included paediatric dentistry, special care dentistry and oral surgery. Managed clinical network are groups of professionals from primary, secondary and tertiary care who work together to ensure the equitable provision of high quality effective services. These networks enable the clinicians to engage with general dental practitioners and other providers of secondary care about how services can be improved.

In addition, one of the dentists also attended the local dental committee meetings. We were told this was useful to enable them to keep close links with the dentists working in primary care.

The assistant director of operations also met with the NHS England local area teams who commission the services. These meetings were to discuss performance of the service and any issues identified.

Patients were encouraged to complete the NHS Friends and Family Test. This is a national programme to allow patients to provide feedback on NHS services they have used.

**Learning, continuous improvement and innovation**

**Accreditations**

NHS Trusts can participate in several accreditation schemes whereby the services they provide are reviewed and a decision is made if to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed to continue to be accredited.

(Source: Universal Routine Provider Information Request (RPIR) – P66 Accreditations)

Staff told us how many of the dental nurses had undergone additional training in subjects such as dental radiography, conscious sedation, fluoride varnish applications and oral health promotion that facilitated better outcomes for patients. We were told that because of the lack of training
courses for inhalation sedation the trust had developed a course, so they could train staff to become competent in this. They had got the course accredited to ensure it was formally recognised. In addition, they were looking at developing an accredited course for intravenous sedation.

The service provided outreach training to undergraduate dental students from Manchester Dental Hospital at Seymour Grove. This forms part of a student’s clinical training. Students were supervised by qualified clinicians at all times. This scheme provided the dental students with experience of what it was like working in a practice environment.

The service was currently working with Public Health England to carry out epidemiology surveys. The current survey was to assess the dental health of five-year olds in the local area.

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### Community health services

### Community health midwifery services

### Facts and data about this service

The trust provided the following information about community midwifery services at Bridgewater Community Healthcare NHS Foundation Trust:

Community midwifery services are provided in Halton, at Widnes Health Care Resource Centre and from GP surgeries on Runcorn.

Women can self-refer, or can be referred from other services or the GP.

(Source: CHS Routine Provider Information Request (RPIR) - CHS Context tab)

For the twelve months prior to this inspection, the service booked 1,488 women and there were nine home deliveries. Women could choose home or hospital births. The service provided community services only and was the only trust in England to provide this service.

### Is the service safe?

#### Mandatory training

**Mandatory Training completion**

The trust was unable to provide data on mandatory training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust, for all staff groups from April 2017 to March 2018 are in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>2,632</td>
<td>2,883</td>
<td>91.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent Wrap 3</td>
<td>636</td>
<td>719</td>
<td>88.5%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>
The 90% target was met for one of the 23 mandatory training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Trust-wide training included modules that were either face to face or eLearning packages. The trust provided data for submissions in July 2018 as below for midwives.

<table>
<thead>
<tr>
<th>COURSE</th>
<th>NO</th>
<th>YES</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict resolution</td>
<td>5</td>
<td>26</td>
<td>31</td>
<td>83.87%</td>
</tr>
<tr>
<td>E&amp;D</td>
<td>0</td>
<td>36</td>
<td>36</td>
<td>100.00%</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>4</td>
<td>32</td>
<td>36</td>
<td>88.89%</td>
</tr>
<tr>
<td>Health and safety</td>
<td>0</td>
<td>36</td>
<td>36</td>
<td>100.00%</td>
</tr>
<tr>
<td>Infection Control (Clinical)</td>
<td>7</td>
<td>24</td>
<td>31</td>
<td>77.42%</td>
</tr>
<tr>
<td>Infection Control (Non-Clinical)</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>100.00%</td>
</tr>
<tr>
<td>INFORMATION GOV</td>
<td>15</td>
<td>21</td>
<td>36</td>
<td>58.33%</td>
</tr>
<tr>
<td>L2 ADULTS</td>
<td>1</td>
<td>35</td>
<td>36</td>
<td>97.22%</td>
</tr>
<tr>
<td>L2 CHILDRENS</td>
<td>2</td>
<td>34</td>
<td>36</td>
<td>94.44%</td>
</tr>
</tbody>
</table>
In addition, staff completed skills and drills training specific to the midwifery service. Midwives who had joined the trust in the twelve months prior to inspection told us they had received training and induction prior to taking up their caseloads as well as a month of shadowing an experienced trust midwife. Staff told us that time was protected to complete any mandatory training.

### Safeguarding

#### Safeguarding Training completion

The trust was unable to provide data on safeguarding training broken down by department, core service or staff group.

The trust set a target of 90% for completion of mandatory training. Overall mandatory training completion data for the trust as a whole from April 2017 to March 2018 is in the table below.

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Staff trained</th>
<th>Eligible staff</th>
<th>Completion rate</th>
<th>Trust target</th>
<th>Met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>2,719</td>
<td>2,883</td>
<td>94.3%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>2,699</td>
<td>2,883</td>
<td>93.6%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>756</td>
<td>811</td>
<td>93.2%</td>
<td>90.0%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults Level 3</td>
<td>229</td>
<td>336</td>
<td>68.2%</td>
<td>90.0%</td>
<td>No</td>
</tr>
</tbody>
</table>

The 90% target was met for three of the four safeguarding training modules for which staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)

Data provided by the trust is for training completed in July 2018.

<table>
<thead>
<tr>
<th>SAFEGUARDING</th>
<th>COMPLIANT</th>
<th>NO</th>
<th>YES</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>COURSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L2 ADULTS</td>
<td></td>
<td>1</td>
<td>35</td>
<td>36</td>
<td>97.22%</td>
</tr>
<tr>
<td>L2 CHILDRENS</td>
<td></td>
<td>2</td>
<td>34</td>
<td>36</td>
<td>94.44%</td>
</tr>
<tr>
<td>L3 ADULTS</td>
<td></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
</tr>
<tr>
<td>L3 CHILDRENS</td>
<td></td>
<td>0</td>
<td>28</td>
<td>28</td>
<td>100.00%</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>3</td>
<td>98</td>
<td>101</td>
<td>97.03%</td>
</tr>
</tbody>
</table>

### Safeguarding referrals
A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority have their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community midwifery services reported no safeguarding referrals of adults from April 2017 to March 2018.

(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)

Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust had safeguarding policies and procedures in place and since the last inspection, there was a safeguarding midwife that could provide guidance and support to staff as well as provide safeguarding supervision. Band six midwives told us the safeguarding midwife was supportive and approachable with a co-ordinated approach to safeguarding. They meet up for safeguarding supervision every three months but felt they could call at any time if they needed help.

The location where the safeguarding lead was based was a trust building where other services were located. This meant midwives could contact health visitors and safeguarding staff easily. Midwifery was part of the children and families’ division within the trust. There was a young person’s midwife who supported women up to the age of 19 years. The young person’s midwife liaised with other professionals particularly family nurse partnership staff. Between July 2017 and June 2018, there were 17 women under the age of 18 years booked; this was 4.6% of women booked for the service.

Alerts were received from the police, community drugs team and social services for women who needed support or were new to the area. Between July 2017 and June 2018, there were 28 child safeguarding referrals.

Records were a combination of paper and electronic. A cause for concern form was completed electronically for woman, if needed such as known mental health condition or safeguarding issue including female genital mutilation or child sexual exploitation. This record was for the ‘unborn.’ Once the baby was born, the cause for concern was added to the child’s records.

Any woman who required extra support, or longer appointment times was highlighted on the electronic appointment system. The trust worked closely with neighbouring acute hospital trusts. Any information that was recorded on paper, either by a midwife or a consultant, was photographed and attached to the electronic record. A copy was printed and added to the woman’s hospital records.
For booking appointments, women were seen on their own initially to check that they felt safe. Appointments that were missed were monitored with midwives contacting women to check non-attendance. There were systems to ensure women who did not attend appointments were followed up for example if they were due to attend scan appointments midwives had the information to ensure they saw the woman.

**Cleanliness, infection control and hygiene**

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

All areas were visibly clean, although these were shared spaces with clinic staff. Staff were observed adhering to ‘arms bare below the elbows’ guidance and washing hands prior to patient contact.

There were wall mounted hand washing solutions at clinical sinks with handwashing instructions. Hand gels and personal protective equipment such as gloves and aprons, were adequately stocked in all areas.

Staff were aware of, and followed, current infection prevention and control guidance. We observed staff using hand washing techniques and personal protective equipment whilst delivering care.

All sharps bins seen were not over filled and used appropriately. We observed that all clinical waste was disposed of in clinics.

Following a home birth, the midwife removed any sharps and medicines from the home; all other clinical waste was disposed of by an external company. Midwives reported, at the team meeting, that there had been a delay in disposal of clinical waste, following a homebirth. The service was checking with the third-party provider of the service.

There were processes for women to receive vaccinations with midwives administering these antenatally if required.

**Environment and equipment**

The service had suitable premises and equipment and generally looked after them well.

There was a process for monitoring available equipment. The asset register included dates when equipment was due, routine maintenance and missing or decommissioned equipment.

All midwives carried their own equipment, such as blood pressure monitors, thermometers, weighing scales and sonicails. Equipment was stored in the hub areas in Widnes and Runcorn where staff could hand in equipment that was due a routine maintenance check or was faulty and exchange for a fully functioning machine.

We visited St Pauls clinic, in Runcorn. The clinic room was shared with sexual health services when not used by midwives. We observed that the sonicaid was labelled as due for service in June 2016. There was also a broken blood pressure machine, labelled midwives. The weighing scales were labelled as due to be checked in August 2018, although these were clinic scales. We noted that the disposable privacy curtains in the room were dated as last changed 8 June 2016. We addressed these concerns with the midwife present and the team leader.
Following the inspection, information from the trust indicated that portable electrical equipment had been tested at both hub offices in June 2018. In addition, equipment based at the Widnes hub was serviced in September 2018.

For women, in Widnes, all midwifery antenatal clinics were based in the same building as the urgent care centre. For Runcorn, antenatal clinics were based in GP surgeries. The consultant-led clinics, for high risk women were at Halton hospital on Wednesdays and Thursdays depending on which hospital the woman had been booked at.

In the event of an emergency, in the urgent care centre, there was a resuscitation trolley, that was checked by their staff, however; this was in a consulting room and not easily accessible for the antenatal clinics.

At Halton hospital, there was a resuscitation trolley, that was checked daily, however; this was in an area where clinical activity had stopped and was not easily accessible to the antenatal clinic. We were told that emergency equipment at GP surgeries consisted of a first aid box and an automated external defibrillator.

Some rooms were fitted with emergency buttons. The electronic system could alert other staff if assistance was required, otherwise the process was to dial 999 for an emergency ambulance. Midwives told us that the familiarisation with emergency equipment, at each location was included in the induction programme.

At each area we visited, there was secure entry, requiring the appropriate staff ID badge access. This included clinical rooms were medicines and samples were stored.

Since the last inspection, two emergency homebirth bags and portable suction had been purchased. These were taken by the midwife on call, overnight, in case it was needed for a homebirth. There was a bag for each of the two teams. These bags were checked daily with a standardised list, however; the contents did not match the list with additional items included.

In the Widnes emergency bag, we found a syringe that had an expiry of September 2017 and scissors with an expiry of 18 March 2018. There was a needle with broken packaging and items (a syringe and cord clamps) were stained. These items were removed, when addressed except the scissors while awaiting the new pair ordered in April 2018.

We also found the thermometer temperature was labelled as next due a check 6 August 2017. The portable suction, for the Runcorn team, included a label that indicated the last safety check test was completed 2 August 2016 and the next was due 2 August 2017. We addressed these concerns with the head of midwifery whilst on-site. They were proposing to seal the bags with a tamper-proof tag, once the bags had been reviewed so would reduce the need to check all contents as frequently.

For a planned homebirth, a homebirth box was delivered, at the 36-week visit, to the property prior to the expected date of delivery. Any medical gases were forwarded by the hospital transport service in purpose-built cages.

If a woman chose to have a pool birth, a risk assessment was carried out to check the environment was suitable. The pools needed to be birthing pools and sourced by the woman.
There was a comprehensive policy for midwives to follow regarding pool births and evacuation if needed.

Assessing and responding to patient risk

Risk assessments were carried out for women.

Risk assessments began at the time of booking, to assess the level of risk for the woman during the pregnancy, such as previous history, risk of venous thromboembolism, any allergies, and personalised growth plan as part of the Perinatal Institutes ‘grow’ programme. (This included personalised growth charts to monitor the baby’s growth in utero). The level of risk identified determined any needs for referral to a consultant. The service accepted women for home birth if assessed as low-risk, otherwise delivery was in their local hospital.

Staff used the modified early obstetric warning score system when monitoring women. The system allowed early recognition of physical deterioration by close monitoring of vital signs of women receiving maternity care. They used neonatal early warning scores for monitoring babies if needed.

Data from the trust showed that 86% of midwives had received resuscitation training in the 12 months prior to inspection.

<table>
<thead>
<tr>
<th>RESUS</th>
<th>Staff Group</th>
<th>COMPLIANT</th>
<th>Grand Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Org L7</td>
<td></td>
<td>NO</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>835 Halton Midwifery -</td>
<td>Additional Clinical Services</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Geo Clinical Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>835 Halton Midwifery -</td>
<td>Administrative and Clerical</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Geo Clinical Group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>835 Halton Midwifery -</td>
<td>Nursing and Midwifery Registered</td>
<td>4</td>
<td>25</td>
<td>29</td>
</tr>
<tr>
<td>Geo Clinical Group Total</td>
<td></td>
<td>5</td>
<td>31</td>
<td>36</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>5</td>
<td>31</td>
<td>36</td>
</tr>
</tbody>
</table>

Staffing

Planned v Actual Establishment

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.

There were processes to ensure sufficient numbers of trained midwifery and support staff, to provide safe care and treatment.

Noticeboards displayed the expected and actual numbers of midwifery and nursing staffing levels in clinic areas. Staff were allocated a caseload and held antenatal clinics at their own GP surgery. Some specialists did not hold caseloads, however, if woman requested a named midwife this could be accommodated.
In the hub rooms, details of where staff were located was displayed on whiteboards.

At the time of inspection, there were band six and band seven midwives across the two teams. There were team leaders as well as a co-ordinator and other specialist midwives. The head of midwifery told us there were 28 midwives, of which 21 were band six and two midwifery support workers. There were band seven midwives that included two team leaders, a co-ordinator (role included drug and alcohol), safeguarding, screening, risk and a young person’s midwife.

Midwives worked flexibly either in full-time or part-time roles. Caseloads varied depending on hours employed. At the time of inspection, the midwife, who was employed full-time, with the greatest caseload, was supporting 80 women. The staffing levels and caseloads were in line with national recommendations.

A band six midwife was on call overnight in case of a homebirth or other concerns from a woman. There was one for each team so that in the event of a delivery, the second midwife supported the other in that geographical location. Senior staff told us that due to long term sickness and holidays, the on call had been cancelled three times in the last month; this was added to the risk register. The services dashboard showed that between July 2017 and June 2018, there had been one failed homebirth in January 2018, due to staffing.

There was a senior midwife on-call rota to provide advice and support to the band six on-call midwife if needed. This included all band seven midwives and the head of midwifery.

On Mondays, staff spent an extended period in the hub rooms to review their caseloads for the following week as a team although they could contact each other whenever needed.

Vacancies

Data on vacancies for ‘Halton – Midwifery’ was provided by the trust, however the trust classified the team as ‘community adults’ for some datasets and ‘community children’ for other datasets so the data are not provided here because it is not certain whether this category represents the entire community midwifery core service.

(Source: Universal Routine Provider Information Request (RPIR) – P17 Vacancy)

There were vacancies for two band six midwives, although these were recruited and appointed at the time of inspection.

Turnover

Data on turnover for ‘Halton – Midwifery’ was provided by the trust, however the trust classified the team as ‘community adults’ for some datasets and ‘community children’ for other datasets so the data are not provided here because it is not certain whether this category represents the entire community midwifery core service.

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)
The service retained staff well. Staffing was highlighted on the services’ risk register acknowledging long-term sickness and upcoming retirement of midwives, although there was no formal workflow plan in place.

**Sickness**

Data on sickness for ‘Halton – Midwifery’ was provided by the trust, however the trust classified the team as ‘community adults’ for some datasets and ‘community children’ for other datasets so the data are not provided here because it is not certain whether this category represents the entire community midwifery core service.

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

The head of midwifery told us that two midwives had been on long-term sick leave, although staff told us their caseloads were manageable. Between July 2017 and June 2018, the average sickness levels were 2.69% for midwives and 1.31% for support staff. The overall target was 4%. Sickness levels had been up to 10.14% in May 2018.

**Nursing – Bank and Agency Qualified nurses**

The trust reported no bank and agency use for qualified nursing staff within community maternity services.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

**Nursing - Bank and Agency Nursing assistants**

The trust reported no bank and agency use for qualified nursing staff within community maternity services.

(Source: Universal Routine Provider Information Request (RPIR) – P20 Nursing Bank Agency)

**Medical locums**

The service was midwifery led and did not employ any medical staff.

**Suspensions and supervisions**

During the reporting period from May 2017 to May 2018, community midwifery services reported that there were no cases where staff have been suspended.

(Source: Universal Routine Provider Information Request (RPIR) – P23 Suspensions or Supervised)

**Quality of records**

Staff kept appropriate records of women’s care and treatment. Records were clear, up-to-date and available to all staff providing care.

Midwifery care records were a combination of electronic and paper records. Midwives completed written notes that remained in the woman’s hand-held notes. A photograph of the document was taken with the midwife’s electronic tablet device and saved as an attachment. The woman’s
The electronic record was updated, when back in the hub room and the attachment was added to the electronic record.

During a consultation with a woman, any information added to the electronic system was printed and added to the woman’s hand-held notes, so that further appointments or hospital admissions were recorded to all records.

We reviewed electronic records for six women and found they were completed and concise with all relevant information included and accessible.

There were occasions when paper referrals or notifications needed to be stored, temporarily. The hub rooms included storage areas that were secure and accessed only by staff.

There was an electronic system for daily communications between staff. As well as emails, the system had a tasks section where information could be shared.

An audit of 13 electronic records was completed for the 2017 to 2018 year. There was 85% overall compliance for the nine standards audited, with five areas over 95%.

**Medicines**

There were medicines stored in fridges that included anti – D (for rhesus negative women), *syntocinon* (used during and immediately after delivery to help the birth and to prevent or treat excessive bleeding) and vaccinations for pertussis (whooping cough). Anti-D was ordered individually as needed, stored in the Widnes fridge and taken to the Halton clinic when attending.

When administering anti-D, two midwives checked the medicine as well as the woman’s identity.

There were no controlled drugs used by the service.

Fridges were accessible only by staff and keys were stored in key safes. We checked the daily monitoring of the fridges. In the sluice room, where blood samples were stored, a fault had been identified with the temperature probe and at the time of inspection, was awaiting a new battery. The temperatures had generally remained within an accepted range.

In the room where medicines were stored, the fridge had been recording high maximum temperatures. Since April 2018 to the time of inspection, the actual temperature had been recorded daily, when clinics were open, as well as the range. The maximum temperature had been recorded between 9 and 14 for this period. Medicines management had been contacted in July. It was documented that it may have been due to opening the fridge door. Infection control had been contacted in August, however; the maximum remained elevated.

Daily checks of the fridge, in Halton, had been completed and were within accepted ranges. This fridge was storing vaccinations of pertussis, although these were at a clinic at the time of inspection.

Portable fridges were used to maintain the cold chain of vaccinations when out of the hub area.

Anaphylaxis kits were carried for immunisation clinic.

Each midwife that gave vaccinations had their own individual patient group direction that accompanied them to clinics. Training was updated annually; details of attendance on courses was discussed in the team meeting at the time of inspection.
Ampoules of syntocinon and syntometrine were included in the emergency bags. These medicines are stored in the fridge but can be stored up to 30 degrees for a period of three months for syntocinon and 25 degrees and two months for syntometrine. There was no date on the ampoules to indicate when they had been removed from the fridge. This was addressed with the head of midwifery who removed the ampoules.

**Safety performance**

**Safety Thermometer**

The service did not use the safety thermometer but did monitor safety performance. Results were displayed in clinics for staff and women to view to show that there had been no falls or pressure ulcers. The service used information to improve the service.

**Incident reporting, learning and improvement**

**Never events**

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. From July 2017 to June 2018 the trust reported no never events within community midwifery services.

*(Source: Strategic Executive Information System (STEIS))*

**Serious Incidents**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community midwifery services, which met the reporting criteria, set by NHS England from July 2017 to June 2018.

*(Source: Strategic Executive Information System (STEIS))*

**Serious Incidents (SIRI) – Trust data**

From April 2017 to April 2018, trust staff within community midwifery services reported no serious incidents.

*(Source: Universal Routine Provider Information Request (RPIR) – P29 Serious Incidents)*

The service managed patient safety incidents well.

Staff reported incidents on the trusts electronic system. In the 12 months prior to inspection, there were 258 incidents reported for the service. Of these six were classified as moderate harm, 146 were classified as low or insignificant harm and 106 were classified as near misses.
Feedback about incidents was provided through the system. Trends from incidents were identified such as communication issues when women were discharged from hospital. This had been included in the midwifery risk register. Women were advised to call their named midwife, on discharge, if no contact by 3pm.

Trend analysis reports were completed quarterly by the risk midwife. These included lessons learned that were cascaded at team meetings.

The lack of feedback from the hospital trust was included in the midwifery risk register and escalated through trust governance meetings.

The service investigated incidents and provided timelines for three in the twelve months prior to inspection. Comments to highlight good practice or areas for improvement were identified. External reviewers were required to reflect and complete any action learning points following incidents. Lessons learned were shared in team meetings and included in quarterly newsletters compiled by the risk midwife. Hard copies of learning were displayed in midwife hubs.

Staff we spoke with understood the term duty of candour. (The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of ‘certain notifiable safety incidents’ and provide reasonable support to that person).

There were no mortality meetings for the service, however; the risk midwife visited the neighbouring NHS acute trust monthly and attended meetings there.

### Is the service effective?

#### Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. This included guidance from the National Institute for Health and Care Excellence and Royal College of Obstetricians and Gynaecologists.

The service received updates for when there were changes in national guidance. These changes were reviewed and the trusts guidelines checked against the update. Any changes were cascaded at the hub during the Monday meeting.

All midwives were involved in reviewing and updating guidelines. They were delegated to a midwife to research current guidance and to update with a deadline for completion. The trusts electronic system sent alerts for guidelines due for updating. These were discussed at team meetings.

Of the policies and guidelines, we reviewed, all were within their date for review. Policies and guidelines were generally clear and comprehensive, however; two flow charts were not clear to follow and could be interpreted differently. The unplanned homebirth guideline indicated that a midwife should attend all unplanned births. The head of midwifery told us that this would only occur if the midwife was aware of and had been requested to attend.

The new-born jaundice guideline indicated to either monitor or refer to a paediatrician. NICE CG58 guidance includes that a visual inspection of the baby is not sufficient to make a judgement about the seriousness of the jaundice. The midwives did not have access to bilirubinometers (device to
check the seriousness of the jaundice) in the community. This meant babies needed review on paediatric wards. Between July 2017 and March 2018, there were 18 readmissions for jaundice.

Staff could access policies and guidelines on the trusts intranet system and could download them onto their electronic tablet devices. There were no paper versions to ensure that the most up-to-date version was only available for staff to view and refer to.

The service participated in the perinatal institutes growth assessment project (gap and grow) which monitored the growth of babies in utero, with attention to smaller babies.

The woman’s hand-held notes included information about fetal movement in line with saving babies’ lives.

Following the birth of the baby, a post-natal pack was given to the woman. This included information about safe sleeping, feeding, infection prevention and jaundice.

Following any homebirth an audit and reflection were carried out with the midwives to highlight areas of good practice as well as areas for improvement. This was presented at team meetings and shared with all midwives.

**Nutrition and hydration**

The service participated in the baby friendly initiative set up by the United Nations International Children's Emergency Fund (UNICEF) and the World Health Organisation. The initiative recommends exclusive breastfeeding up to six months of age, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond. The service had achieved re accreditation in August 2017.

Between July 2017 and June 2018, the breast-feeding rate was on average 84%, although this dropped to 35% on handover to the health visiting service.

The service referred to the infant feeding support team if needed. (This service was funded by the local authority rather than health.)

**Pain relief**

Following the last inspection, it was suggested that pethidine (a powerful controlled drug) should be considered for homebirths. Staff told us that paracetamol, ibuprofen and entonox were recommended. If stronger analgesia was required then the woman would need to deliver in a hospital environment.

**Patient outcomes**

**Audits – changes to working practices**

The trust participated in no audits in relation to this core service as part of their Clinical Audit Programme.

(Source: Universal Routine Provider Information Request (RPIR) – P35 Audits)

The service monitored the effectiveness of care and treatment and used the findings to improve them, although not all information was included centrally on the dashboard. They compared local results with those of other services to learn from them. The service was an active member of the regional strategic network where best practice was shared.
Midwives completed internal audits to monitor the service. Dash-boards were completed and discussed at team meetings.

The home birth rate was less than 1% with approximately one birth a month. There were also babies born before arrival. Of the nine babies born before arrival between July 2017 and March 2018, a midwife was not called for four of the births.

There was one baby born with a shoulder dystocia that recovered well.

Between July 2017 and June 2018, there were no women who needed to transfer to hospital to deliver rather than a planned home birth, although three women chose to be transferred post-delivery. There was a total of 115 readmissions following discharges following hospital deliveries.

For the same period, there were 16 women treated for Escherichia coli (E. coli) urine infections (one readmission) and two wound infections (readmitted).

The risk midwife submitted data to the Perinatal Institute for their ‘gap and grow’ audit, however; there were technical issues in obtaining accurate results to measure their performance. When a baby was admitted to hospital for intra-partum care, the name of the trust was changed meaning that all antenatal data appeared with the hospital trust. The service had contacted the Institute and were awaiting advice on how to ensure data entries were accurate.

An audit of the pathway for home birth women to check assurance of compliance with NICE CG190: Intrapartum care was completed in June 2018.

The service scored the results as providing limited assurance and similar results to a previous audit. This was thought to be due to the community activity to be mainly antenatal and postnatal care rather than intra-partum. There were plans to redesign the audit to include all aspects of the care pathway.

For the seven standards audited, scores ranged between 97% and 71% with six of them being over 82% compliance. An action plan was in place that included discussion and inclusion of the midwives.

Competent staff
Clinical Supervision

The service made sure staff were competent for their roles.

The service was following guidance from NHS England: advocating for education and quality improvement. This process has replaced the supervisor of midwives’ programme. Two band seven midwives had completed training to be professional midwifery advocates. At the time of inspection, the programme had not been fully implemented due to awaited guidance from the regional network.

Midwives completed annual updates of training in topics such as record keeping, transfusion, screening, safeguarding, mentorship, breast feeding, smoking, homebirths, perinatal mental health and drugs and alcohol.

All midwives attended skills and drills training that was bespoke for community services. It was based at a neighbouring acute NHS hospital trust. There were plans to use a mock home environment to be as realistic as possible. This training covered obstetric emergencies such as
post-partum haemorrhage (excessive bleeding following child-birth), shoulder dystocia and newborn life support as well as perineal suturing.

There were scenarios where simulations could be carried out to practise skills including emergency evacuation from a birthing pool. Data from the trust indicated that all band six and seven midwives had attended a course in the 12 months prior to inspection.

Since the last inspection, all band six midwives attended the neighbouring NHS acute hospital trust for an in-service update of 22.5 hours per year (a block of two or three days). The midwives chose the area that they felt they needed to attend. This could be the delivery suite, induction area, midwifery-led unit or fetal assessment unit. This meant they could enhance their personal development and have a greater understanding to pass on to women in their caseload or at clinics.

Band seven midwives told us that they had spent one day, at the hospital trust in an area relevant to their role.

Between June 2017 and June 2018, 11 midwives had each delivered one baby and two midwives had delivered two babies. There were three of the midwives who had a delivery during the in-service update and one midwife who had two deliveries at that time. Three midwives had joined the trust, within the last 12 months, two of which had delivered more than 10 babies, in acute hospitals, prior to starting.

Three midwives had attended a baby born before arrival (BBA) of the midwife and two midwives had attended two BBA’s. There were two midwives that had no deliveries or BBA’s in this time period.

If any additional training took place, such as hypnobirthing, midwives were encouraged to cascade this newly acquired knowledge at team meetings.

The service participated in the perinatal institutes growth assessment project (gap and grow) which monitored the growth of babies in utero, with attention to smaller babies. Data from the trust indicated that all midwives had completed the training in 2017 except for two midwives who were booked onto a course. The service was awaiting the eLearning, from the Perinatal Institute, to update the annual training.

At the time of inspection, there were eight midwives who had received training in new-born and infant physical examination.

**Appraisal rates**

Managers appraised staff’s work performance and provided support. At the time of inspection, all staff had been appraised, had a date booked for their annual appraisal or had joined the organisation within the last 12 months.

**Multidisciplinary working and coordinated care pathways**

Staff worked together as a team to benefit women. Consultants, midwives and other professionals supported each other to provide good care.
Midwives shared information with GP’s, if unaware of the pregnancy, although the form did not request any health or social information from the GP.

The service worked well with neighbouring acute NHS hospital trusts. Perinatal mental health support was available via the hospital. An example of shared care was provided where a woman with a known mental health condition was supported with an individualised package of care through two pregnancies.

Specialist midwives liaised with social workers, safeguarding leads, the police and family nurse partnership colleagues when necessary.

The service was also liaising with continence nurses, in the trust, for advice and support.

Records reviewed showed that information was shared with GPs, and health visitors as part of the transition of care process.

**Health promotion**

Health advice was offered during appointments. Midwives discussed areas such as healthy eating, supplementing diet with vitamins, alcohol in pregnancy and smoking. Smoking cessation support was available if required. Testing for carbon monoxide levels were included in the process.

Information leaflets were available and posters displayed in clinics.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion.**

The trust was unable to provide data on mental capacity act training broken down by department, core service or staff group.

Staff understood their roles and responsibilities under the Mental Capacity Act 2005. They knew how to support women experiencing mental ill health and those who lacked the capacity to make decisions about their care.

The Mental Capacity Act was included in safeguarding training.

If women lacked capacity to make their own decisions staff made decisions about care and treatment in the best interests of women and involved their representatives and other healthcare professionals appropriately.

We observed staff obtaining verbal consent from women prior to providing care and treatment.

Staff we spoke with understood their responsibilities in consent from younger women with regards to Gillick and Fraser competence. (Gillick competence is a term originating in England and is used in medical law to decide whether a child (under 16 years of age) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. The ‘Fraser guidelines’ specifically relate only to contraception and sexual health.

There was a trust interpreter and translation service to assist with consent for women whose first language was not English.

**Deprivation of Liberty Safeguards**

The trust reported that no Deprivation of Liberty Safeguard (DoLS) applications were made to the Local Authority.
Is the service caring?

Compassionate care

Staff cared for women with compassion. Feedback from women confirmed that staff treated them well and with kindness.

Women described care as excellent from staff. This included both midwifery and medical staff.

All staff introduced themselves and communicated well to ensure women fully understood.

Women were encouraged to ask questions and were given time to ensure they understood what was being said to them.

Staff involved women and those close to them in decisions about their care and treatment.

We observed staff interacting positively with women and those close to them. Staff spoke to women sensitively and appropriately depending on individual need.

We observed, that women could attend for extra appointments, if a concern was raised to provide extra assurance in-between routine appointments.

From the last inspection, the layout of the clinic, at Halton hospital had been reviewed. A concern was raised that women could be overheard during consultations as bays were separated only by a privacy curtain. We observed that a room was now allocated for consultations between the consultant and the woman.

The women attended the bays for routine checks with midwives. When there were two consultants, one was located, in a bay, although it was away from the main area and therefore conversations remained private. There was no call bell system, in the bay, although staff told us that they would use the alert button on the electronic system if assistance was required.

The trusts quality report for 2017 to 2018 included results following the NHS Friends and Family test results. The trusts “talk to us” form was used to request feedback from women and those close to them.

The Friends and Family test results showed that 100% of women would recommend the antenatal service. This was based on 168 responses. For post-natal services the results showed that 99.2% would recommend the service. This was based on 375 responses.

Emotional support

Staff provided emotional support to women to minimise their distress.

We observed staff providing reassurance and comfort to women. Staff provided support as required.

In the 36-week antenatal visit assessment form, there was a section for mental well-being to be discussed as well as routine checks at each antenatal appointment.

The service had been given a cuddle cot, from a local bereavement charity. This meant parents of stillborn babies could be at home with their baby, for as long as needed until the funeral date.
Perinatal mental health support could be requested via the neighbouring acute trusts if needed. In addition, ‘Parents in Mind’, (part of the National Childbirth Trust) provided peer support, for women and those close to them.

**Understanding and involvement of patients and those close to them**

Staff involved women and those close to them in decisions about their care and treatment. We observed staff interacting positively with women and those close to them. Staff spoke to families sensitively and appropriately, dependent on individual need. Staff respected women’s choices and delivered their care with an individualised person – centred approach. Women’s care records were individualised to consider their personal wishes.

Family members were encouraged to attend with women.

**Is the service responsive?**

**Planning and delivering services which meet people’s needs**

The service planned and provided services in a way that met the needs of local women.

Women could self-refer, or be referred from other services such as the GP.

In the Runcorn area, women could attend their local GP clinic (six GP’s in total) for their antenatal care, if assessed as low risk. In Widnes, all clinics were held in the urgent care centre building for low risk women. Additional appointments were made for the local hospital if assessed as high risk. There was good public transport provision in the area and changes in the road network had reduced travelling times across the two areas.

Women had a choice of hospital or homebirth. Both neighbouring hospitals included a midwifery-led unit as well as delivery suites. There was no standalone unit in the area.

If a woman requires a hospital clinic appointment, these were made at the hospital they were booked for the delivery. Women assessed as high risk provided additional antenatal appointments for women at the hospital where booked.

Midwives were responsible for their own clinics and caseloads, within the GP surgeries for continuity. There was a buddy system to cover for any leave or any absence. Each woman had a named midwife and was provided with contact numbers for midwives.

A home antenatal assessment was completed at 36 weeks as part of the care pathway. This included a range of topics such as signs of labour, feeding, safe sleeping and home environment.

**Meeting the needs of people in vulnerable circumstances**

The service took account of women’s individual needs.

There were good systems to meet the needs of women whose circumstances made them vulnerable.

Women identified as vulnerable were assigned to specialist midwives, such as drug and alcohol (to support the named midwife) or young person’s midwife for extra support. There were other specialist midwives in the unit including risk, screening and safeguarding.
Equipment could be sourced for individual need such as larger blood pressure cuffs for women with a larger body mass index.

Parentcraft sessions were available at a variety of locations throughout the area and were scheduled during the day and in the evenings to allow office-hour workers to attend. Women and those close to them could choose which session and location to attend.

The trust provided baby boxes that were available for women. As the first trust in the region to implement this, they had been in place since April 2017. The boxes were made from cardboard and included a mattress, as well as a thermometer, nappies, a vest, baby lotion and a pair of bootees. They provided a safe and portable sleeping space for the first months of a baby’s life.

We were told that all areas were accessible for women with reduced mobility and included portable hearing loops for women with a hearing impairment.

There was a trust-wide interpreter service that could be accessed either face to face or by phone for women whose first language was not English. We observed that appointment times could be extended to ensure full understanding. The trusts website included a feature for accessibility that included text magnification and translation into multiple languages.

Women were directed to a smart phone application ‘Common Approaches to Children’s Health’ (CATCH App) for information. This provided advice and support for women from the antenatal period up to children aged five years old.

Midwives could access trust leaflets on their electronic tablet devices and forward them to women by email.

We were told that leaflets, for screening, were available in languages other than English. For women, who understood English, normal results could be given over the phone or text, whereas as others needed to wait and were posted at 16 weeks gestation. Results that needed further investigation were given out by the hospital trust.

Easy read formats of leaflets could be sourced for women with learning disabilities, although we were told that packages of care were arranged on an individual basis depending on the need. An example of a woman with a mild learning disability was shared whereby the woman understood the advice given but had difficulties retaining information. This meant further intervention to help with retention of information.

**Access to the right care at the right time**

Women could access the service when they needed it. There were early bird clinics where women could speak to a midwife, ahead of their booking to support women earlier in their pregnancy.

The midwifery dashboard showed that between July 2017 and June 2018, on average 85% of women had bookings prior to 12 weeks and six days gestation which met the trust target. For the months where the target had not been achieved, the service reviewed each woman and found this was because the woman had booked with a different trust prior to this booking.

A home antenatal visit took place at 36 weeks pregnant in preparation for the birth.

Additional clinics, including drop-ins, were available in the evenings and introduced for Sundays mainly for post-natal women and babies. This meant there was a choice of either a home visit, or a clinic when a specific time slot was allocated.
Learning from complaints and concerns

Complaints
From April 2017 to March 2018 the trust reported one complaint which referred to community midwifery.

(Source: Universal Routine Provider Information Request (RPIR) – P52 Complaints)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff.

Women were encouraged to provide feedback about the service. They could contact midwives for any advice and support.

Compliments
From April 2017 to March 2018 the trust received 655 compliments. Of these seven referred to community midwifery services at Halton, which accounted for 1% of all compliments received by the trust as a whole. A breakdown by location is below:

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwifery</td>
<td>2</td>
</tr>
<tr>
<td>Midwifery Postnatal</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P53 Compliments)

There were thank you cards displayed in all clinic and hub areas visited.
Is the service well-led?

Leadership

The service had managers at all levels with the right skills and abilities to run the service.

There were clearly defined and visible leadership roles across the midwifery service.

The head of midwifery was supported by team leaders and specialist midwives that were all very visible, accessible and approachable to other midwives.

Midwives, of all grades, told us they were well supported by their managers.

The senior management team, for the trust, had visited the midwifery hubs. They could contact them through the trust intranet and received information through a blog or by email.

Vision and strategy

There was no written vision and strategy in place for the midwifery services. We were told that staff followed trust values and worked within the Neonatal Strategic Networks for the region.

Band six midwives explained trust values as safety, caring, effective communication, innovation.

There was a non-executive director for the children and families’ division who also represented midwifery services.

Culture

The head of midwifery promoted a positive culture that supported and valued staff with an open-door ethos.

Staff reported a very supportive culture. Many of the midwives had worked for the service for many years. The midwives who had been recruited within the 12 months prior to inspection felt supported and could approach peers or managers if needed.

The two main teams were now more integrated and midwives worked flexibly to cover all areas.

Midwives reported they received positive feedback from student midwives.

There was an open and transparent culture that encouraged reporting of incidents to learn from them and improve quality for people in the local community.

There was a positive attitude and culture where staff valued each other. Staff reported good team working and a sense of pride providing continuity of care in the antenatal and postnatal periods.

All staff were passionate about the service they provided.

Governance

A clinical governance process was in place within the trust that allowed risks to be escalated to divisional and trust board level.

Midwifery services were part of the children and families’ division within the trust.
A risk midwife had responsibilities for monitoring governance arrangements including facilitating or reporting incident investigations as well as maintaining the risk register for the service and coordinating the audit programme.

The service collected data to monitor and improve performance. Maternity dashboards captured compliance with several indicators.

We were told the service did not have an individual governance forum but contributed to trust committees when necessary.

Team leader meetings were held monthly, chaired by the head of midwifery. Band seven midwives also represented the head of midwifery at senior meetings.

The head of midwifery shared information following trust meetings to the midwifery staff in staff meetings. There were six weekly team meetings, although time was allocated on Monday mornings for information to be shared. The services electronic system included a task communication area where information could be posted.

**Management of risk, issues and performance**

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

There was a maternity risk register that identified risks across the service. This was reviewed by the risk midwife.

The risk midwife attended one of the neighbouring acute NHS hospital trusts monthly. Requests for feedback following incidents was requested as well as supporting the trust as an external reviewer.

The risk midwife participated in monthly, trust-wide meetings for the quality and safety sub group for the localities for the west areas covered by the trust. These were attended by managers for each service where safety was discussed including trust-wide high risks identified such as, incidents, medicines management, information governance and infection prevention and control.

An exception report was presented to the meeting that provided an overview of the service. An action log was maintained with tasks allocated to staff for follow-up. This was reviewed at each meeting.

There was a trust-wide major incident plan and staff were in regular contact with managers regarding locations and any need to change plans due to unforeseen circumstances. There was also a summary document displayed in the hub offices.

**Information management**

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems.

Midwives recorded information in electronic tablets and accessed the trusts system with key cards. In the event of electronic failure, we were told that midwives would complete activities on paper until systems were restored.
Following the last inspection, the digi pens have now been discontinued and are no longer used by the service. Staff told us that they were concerned that information could be lost or data not received in a timely manner.

**Engagement**

The service engaged well with women, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively.

Midwives were employed both on a full-time and part-time basis.

Staff attended the hub offices each Monday for an extended period to discuss the week ahead and communicate any other information. Team meetings were held every six weeks and staff protected the time to attend if possible. We observed a team meeting: this was well attended by band six and seven midwives and one of the midwifery support workers and the administration staff for the service.

Actions from the last meetings were discussed followed by a structured agenda of items including dashboard results, sharing of lessons learned from incidents, training needs, away days, vaccinations, safeguarding, good news stories, social events and any other business. There was active participation from the staff present.

Trust-wide feedback was shared on the trust intranet system, including the newsletter. Posters for star of the month were displayed in the hub offices. There were also current contact details displayed for staff on a whiteboard.

Midwives were encouraged to maintain contact with peers and managers. Staff had phones and buddy contacts. They were required to sign in and out at the hub office to let others know where and when they were. There were panic buttons in some clinical areas, although the electronic system included a way to alert other staff in the building if needed. There were no lone worker specific devices at the time of inspection, although lone working had been identified and reviewed on the midwifery risk register.

A ‘caring for you’ group included midwives with meetings held quarterly to support well-being of staff at the trust.

Women were encouraged to join the maternity voices forums at the neighbouring trust hospitals to provide feedback and offer suggestions for the service. A social media site was also available.

**Learning, continuous improvement and innovation**

**Accreditations**

NHS Trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The service had received accreditation for the baby friendly initiative set up by the United Nations International Children’s Emergency Fund (UNICEF) and the World Health Organisation.
The service was committed to improving services by learning from when things go well and when they go wrong, promoting training.

As a unique community service, midwives provided continuity of care, as part of Better Births, in the antenatal and postnatal periods. Home births were offered although women were encouraged to make an informed choice where to deliver based on their preference and level of risk.