Walsall Healthcare NHS Trust

RBK

Community health services for adults

Quality Report

Date of inspection visit: 1 May 2017, 20 – 22 June 2017 and 4 July 2017
Date of publication: 20/12/2017

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RBK		Community health services for adults	

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

Following the last inspection in September 2015, we rated this service good for effective, caring, responsive and well led and requires improvement for safe. This was because;

- Demand for community nursing had increased and low priority patient visits were cancelled and rebooked.
- Completion and availability of patient records such as risk assessments was variable across teams.

However, at this inspection we saw the service had built on their good work within all areas and made significant improvements in the safe domain. This resulted in an outstanding rating for the well led domain and a good rating for safe, effective, caring and responsive domains. The overall rating for this service was good.

Overall rating for this core service: GOOD

Walsall Healthcare NHS Trust provides acute hospital services at Walsall Manor Hospital and community services for adults with long-term conditions throughout Walsall and surrounding areas. We found that community services worked in partnership with the hospital to prevent unnecessary hospital admissions and when required and to promote early discharge from hospital.

We found that community services for adults with long-term disabilities were good. However, we identified that staff had not had either safeguarding training to the required level and may not undertake timely actions to protect people.

We spoke with 22 patients, 10 carers and relatives, and 66 staff across a range of roles within the trust. We held staff focus groups the week before our inspection and 46 community staff attended. We looked at 15 patient records.

Summary of findings

Background to the service

Walsall Borough is made up of a diverse multi-cultural population of more than 270,000 people. In some areas within Walsall, there is a high incidence of long-term conditions, lower than national average life expectancy and high usage of hospital services. In more affluent areas of Walsall Borough, there is a longer life expectancy and a growth in dependency from frail elderly patients. Information provided by the trust identified that there have been approximately 218,926 face-to-face contacts with community adult services between 1 April 2016 and 31 March 2017.

Adult community nursing services are part of the care group within the Division of Medicine and Long Term Conditions. Adults community services include:

• Seven 'Place Based' community nursing teams within four locality areas.

• Named nurses within each community nursing team for palliative care and wound care

• Community wound care clinics

• Community Matrons

• Case managers for private and residential nursing homes

• Specialist falls team

• Osteoporosis specialist service

• Community neuro-rehabilitation

• Intermediate Care

- Rapid Response
- Clinical Intervention team, which provides intravenous and deep vein thrombosis treatment within the community
- Community continence/urology
- Podiatry Services

Within the last two years, there has been a change towards integrated health and social care with the development of the seven integrated locality teams. The community nursing teams are co-located with community NHS staff, social care staff and mental health staff providing a service to GP practices.

These teams work in partnership with acute teams, specialist teams including Rapid Response, Clinical Intervention and Intermediate Care. There is approximately 200 staff comprising of clinical and administrative staff covering an approximate caseload population of 4000 patients.

We last inspected this service in September 2015 when we rated the overall service as good. In September 2015 at that time, we rated the safe domain as required improvement and the effective, caring, responsive and well led domains as good.

For adult community services, we inspected the regulated activities across a number of locations and community nursing teams. Services we inspected were provided in people's own homes and within clinics.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper, Head of Hospital Inspection, Care Quality Commission

Chair: Martin Cooper**,** retired MD, Royal Devon and Exeter NHS

Team Leader: Angie Martin Care Quality Commission

The team included a CQC inspector, community matron and an occupational therapist.

Summary of findings

Why we carried out this inspection

This inspection was carried out as part of the programme of scheduled focussed inspections. The trust is currently in special measures, following an announced comprehensive inspection on 8 to 10 September 2015.We also carried out three unannounced inspection visits after the announced visit on 13, 20 and 24 September 2015.

Following the 2015 inspection, we rated this trust as 'inadequate'. We made judgements about eleven services across the trust as well as making judgements about the five key questions we ask. We rated the key questions for safety, effective and well led as 'inadequate'. We rated the key questions, for caring and responsive as 'requires improvement'.

After the inspection period ended, the Care Quality Commission issued the trust with a warning notice served under Section 29A of the Health and Social Care Act 2008. This outlined the quality of healthcare provided by Walsall healthcare NHS Trust for the following regulated activities required significant improvement:

• Diagnostic and screening procedures

• Maternity and midwifery services

• Surgical procedures

• Treatment of disease, disorder or injury

Due to the special measures status of the trust, we inspected all services at the main acute site, Manor Hospital. We also inspected community services: adult services, children and young people and end of life care.

How we carried out this inspection

We inspected this service in May and June 2017 as part of the focused inspection of the trust, which included community services for adults with long-term conditions.

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

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

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an unannounced visit on 31 May 2017 and then visited announced on the 21 and 22 June 2017.

We contacted key stakeholders to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades.

Before the announced visit, we held focus groups with a range of staff who worked in community services for adults with long-term conditions to share their views.

We visited 12 patients in their own homes and observed direct patient care and treatment. We talked with eight people who used services and their loved ones, and reviewed care or treatment records of 15 people who used services. We spoke with 46 staff about their work and the service provided.

What people who use the provider say

- All patients and relatives we spoke with spoke highly of the staff and the service that their loved ones had received. One person told us, "Angels, that is what I call them". Another patient told us, "I had this problem a

Summary of findings

few years ago and then, as now, they have all been so good". Another said, "They are wonderful people they support me every day". "They give everything they can".

Good practice

- An alert system had been developed to enable the long-term condition teams to be notified immediately when vulnerable adults, i.e. those at risk of hospitalisation, presented in accident and emergency, or any ward area in Walsall Manor Hospital. An automatic e-mail alert was generated and sent to the place based team community nursing mailbox and community matrons.
- The rapid response team had worked hard and had significantly reduced the number of admissions to hospital within 30 days of discharge from the rapid response service.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the service SHOULD take to improve

- The trust should ensure that all staff follow safeguarding policies and procedures.
- The trust should ensure that there are suitable arrangements in place to ensure that all staff receive required safeguarding training.
- The trust should ensure risk assessments are appropriately completed and reviewed.

Walsall Healthcare NHS Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

When we inspected this service in September 2015, we rated this domain as required improvement. We found that the trust had made improvements and recruited sufficient staff to ensure that patient visits were not cancelled and as a result we rated this domain as good.

We have rated this service as good because:

- Staff numbers and skill mix were planned, implemented and reviewed to ensure that people received timely and appropriate care and treatment. Any staff shortages were responded to quickly and adequately. There were effective staff handovers to ensure staff were aware of and managed risks to people who used the service.
- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses and were fully supported to do so. Monitoring and reviewing activity enabled staff to understand risks and gave a clear, accurate and current picture of safety.
- Performance within adult community services showed a good safety record. When something did go wrong, there was appropriate thorough investigation. Lessons were learnt and communicated to support improvement in other areas as well as services that were directly affected.
- Staff had taken appropriate steps to prevent abuse from occurring and had mostly responded appropriately to any safeguarding concerns.
- Staff assessed, monitored and managed risks to people who used the service on a day-to-day basis. This included signs of deteriorating health and any increase in distressing symptoms. A consultant and palliative care clinical nurse specialist were either on duty or on call to discuss patients and their treatment needs 24-hours a day, seven days a week.

However:

- Staff had not all received required safeguarding training; 49% of staff had safeguarding level two training. This meant that there was a risk that staff may not identify and respond appropriately to safeguarding concerns.

Good

Are services safe?

- The use of the new sepsis risk screening assessment was not embedded. Staff did not complete sepsis risk assessments when patients had an infection, which may put them at risk of sepsis.
- Staff told us and we observed that in the absence of the medical lead, there was no doctor cover for the rapid response team and clinical intervention team. However, staff were aware if there were any concerns to send the patient to emergency department which would be usual practice without these services.

Detailed findings

Safety performance

- The community adult's service had a good track record on safety. There were no never events between 28 February 2017 and1 March 2017. Never Events are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- There had been 56 serious incidents within community adults' services. Incidents included grade 3 and 4 pressure ulcers, missed visits for insulin administration and information governance breaches. Staff told us and we saw that a root cause analysis investigation of serious incidents was undertaken. We looked at eight root cause analysis investigations for pressure ulcers, which had developed whilst patients received care from community nurses. We found that the trust robustly investigated pressure ulcer incidents and when required, actions identified to address any shortfalls and lessons were learned and shared.
- The trust completed information for the National Safety Thermometer. This is a way of measuring indicators of good care, the level of harm people suffer while in healthcare organisations, and the improvements an organisation makes to ensure people are 'harm free'. The actual numbers of harm identified at the trust fluctuated. From 1 April 2016 to 31 March 2017, community nursing services identified a monthly average of 32 pressure ulcers, 11 falls with harm, and nine urinary and catheter infections. (An average of one patient harm identified with every 350 community patient contacts).
- Services used safety crosses to identify dates of patient harm such as falls, infection and pressure ulcers. The use of safety crosses had also been cascaded to nursing homes within Walsall Borough. Staff told us that the use of the safety cross provided a helpful visual aid to identify harm and harm free days.

Incident reporting, learning and improvement

- Staff reported incidents via an electronic system. The team manager, a link person within the governance department and other senior managers reviewed all incidents. We spoke to five locality leads, they told us and we observed, that any learning from reported incidents were shared within the team and from outside the team. One example was a missed call to administer insulin. Because of this incident staff told us and we observed, that teams checked which patients nurses had visited and were scheduled to attend later to ensure that all required visits had been allocated.
- Between 1 April 2016 and 31 March 2017, staff working within community adults services reported 312 incidents. There were 285 incidents reported as no harm and low harm incidents, and 27 reported as moderate harm incidents. Incidents included pressure ulcers, medication errors, falls and equipment misuse.
- Staff told us and we observed that they discussed incidents and patient concerns during staff meetings and handovers, and we saw incidents were identified on the staff safety noticeboard. We reviewed team meeting minutes from between January 2017 and June 2017 and found discussion in relation to learning from incidents and complaints. For example, pressure ulcers, which staff identified as 'ungradable', they should report as a serious incident.
- Staff within the spasticity clinic told us about changes they had made following the failure of a fridge, which meant they had to destroy medicines stored in the fridge. They told us that medicines stock was kept to a minimum and medicines were collected during the day. This ensured that should there be another fridge failure; the amount of medicines that they would need to destroy would be minimal.

Duty of Candour

Good

Are services safe?

- Duty of candour is a regulatory duty that is related to openness and transparency and requires providers of health and social care services to notify patients (or relevant persons) of certain notifiable safety incidents and provide reasonable support to the person.
- We spoke with 17 staff and asked them about DoC. All staff were knowledgeable about what it meant and were able to give examples of incidents that would trigger duty of candour, which included pressure ulcers and medicine errors resulting in harm. There had been 109 incidents, which included pressure ulcers, serious patient falls and failures in care assessment and treatment, that had required duty of candour (DoC) investigation within community adult services.
- We spoke to a group of staff at one clinic. One nurse said, "I think we really get duty of candour now. We have always been honest and told patients if mistakes had been made but it's a lot more than that and includes formal processes such as meeting with the person and then writing to them to apologise."
- We saw that root cause analysis investigations included questions asking if the need for duty of candour was required, had it been met and how. The investigation reports also confirmed that the trust had sent a letter to the person, which both apologised and confirmed the findings of the investigation.

Safeguarding

- Staff we spoke with were knowledgeable about their role and responsibilities to safeguard vulnerable adults and children from abuse.
- The trust target for safeguarding training for both vulnerable adults and children (levels 1, 2 and 3) was 90%. Community adults' services were not meeting this target. Information provided by the trust identified the following compliance with safeguarding training:
  - 100% of staff had safeguarding vulnerable adults level 1(1 staff member)
  - 49 % of staff had safeguarding vulnerable adults level 2
  - 77% of staff had completed safeguarding children level 2
  - 100% of required staff had completed safeguarding children level 3
- We observed staff discussed safeguarding concerns during handovers. During one handover, the senior nurse said they had made a safeguarding referral. It was evident that other staff had previous concerns but they did not highlight that they or any other agency had made any previous safeguarding referrals. During a visit, we heard about other safeguarding concerns but the person did not wish to take the matter further. We shared the information with the divisional director for further investigation as it is important that timely actions are undertaken to keep vulnerable patients safe.
- Staff were aware of the safeguarding lead and how to contact them for support and advice.

Medicines

- For adult community services, medication records were kept within patient records in the patients' own homes. Medicine records detailed all the medicines the patient was prescribed and when staff had administered the medicine. Medicine records we looked at were appropriately completed and regularly updated.
- During our inspection, we observed that staff undertook appropriate practice to administer medicines. Staff checked the treatment sheet for the correct medicine and dosage to be administered, and they then gained verbal consent from the patient to administer the medicine. Nurses recorded that they had administered the required medicine.
- We observed several patient visits for patients who required specialist prescribed wound dressings. We saw a community nurse explain to one patient that they would need a patient directive from the doctor (detailed treatment information) to use a particular treatment for soaking infected leg ulcers. The nurse explained this would reduce the risk of potential error should a different staff member visit.
- Staff told us there were at least two senior staff members in each community nursing team, who had undertaken an advanced prescribing course and were able to prescribe medicines such as pain relief and antibiotics. This enabled patients to have medicines prescribed and commence treatment without delay.
- We observed during our previous inspection that the rapid response team were able to access a medicines storage unit, which recognised staff thumb prints and a camera to record the staff member. During this inspection, we found the machine was no longer in use although still sited within the rapid response team base.

Good

Are services safe?

Managers told us that they were reviewing the machines use including availability of different medicines. Staff told us that patients had to take their prescription to a chemist for dispensing.

Environment and equipment

- Community services for adults provided care and treatment in patients' own homes, clinic settings, and within nursing and residential homes. We saw that staff discussed the arrangements to increase safety within the patient's home such as the use of key safes, accessibility and reducing the risk of fire when patients required oxygen.
- We saw that there were appropriate arrangements to reduce fire risk in clinics such as, fire doors with information in relation to use of the lift and fire evacuation. One manager told us and we saw that a fire evacuation chair was available for patients with mobility problems if there was a fire when the lift could not be used.
- The trust did a quarterly 'Essential Steps' audit, which included an environment audit. Information provided by the trust included audits of wound care clinics and one podiatry clinic. All of the wound clinics met the trust's target for at least 90% compliance. The podiatry clinic was held within non-trust premises and was found not to comply with the trust's standards. The trust told us and we saw they had identified an action plan, which the premises owner had now addressed.
- Staff working in the wound clinic at Beechdale wound clinic raised concerns about the use of carpet outside a wound treatment room. Staff explained and we saw that they had to carry bowls of water that may be contaminated from soaking and bathing patients' infected leg ulcers. They explained that there was a risk that these bowls may splash contents onto the carpet, which could not be easily cleaned. They told us that infection control had also raised this as a problem and required that the carpet be replaced with easily cleanable flooring. We saw the infection control audit for the clinic dated 5 December 2016 included the following information: "carpet outside room treatment room which staff carry bowls over to the sluice ideally needs hard floor for decontamination". However, there was no date for the carpet to be replaced.
- Community staff told us that they were able to order and obtain patient equipment promptly.
- We saw equipment in patients' homes such as, specialist mattresses and cushions to prevent pressure ulcers, had a date when it had been supplied and a service date.
- Staff working within the rapid response team told us that they had direct access to a store of patient equipment, which included commodes, walking frames, sticks and trolleys. Staff explained that they would visit patients who may have fallen because of mobility difficulties. The timely provision of this equipment assisted patient mobility and reduced the risk of a further fall, which may result in a hospital admission.
- We observed one therapist assess a patient who had fallen. They assessed the patient using the walking aid. However, as the patient already had other walking aids that they did not use, there was a risk they may also not use this equipment. The therapist also felt there might be a potential trip hazard as all equipment was available in a small room. They arranged with the patient and their daughter to visit again the following day to see if the patient was able to use the equipment safely.

Quality of records

- We reviewed 15 patient records. We saw that the trust used 'Single Assessment process' (SAP) to assess and plan patients' care. We found that SAPs were kept in patients' own homes. Patient records within the SAP were carbonated; staff then took the carbonated copy back to the community team base to update central records. We saw that staff appropriately dated and signed patients' records. There was a list with staff members' names and signatures present in the records so it was easy to identify who had completed them.
- We found records included an assessment of patients' needs, some risk assessments such as, pressure ulcer risk and sepsis risk, allergies and the care staff provided during the visit.
- When we visited on 21 and 22 June 2017, we found that a new risk assessment was in place for identification of sepsis. However, we found that staff had not completed the sepsis-screening tool when patients had an infection, which put them at potential risk of staff not identifying sepsis in a timely manner and taking timely action.

Good

Are services safe?

- We did see the sepsis assessment tool in three patients' records but staff had not completed it. One said not applicable although the patient had been prescribed antibiotics and another had extensive infected cellulitis, which could put them at increased risk of sepsis. The patient told us that staff had highlighted the risk and signs of sepsis and told them of actions they needed to take if they were worried.
- The trust completed a three monthly audit of community patient records. Information provided by the trust for community nursing teams between 1 April 2016 and 31 March 2017, showed an average compliance of 88.8%. We saw that average compliance with record keeping was over 90% for the West and South teams, and was below 90% for the North and East teams. The trust target was not identified within the information provided. The trust provided action plans in response to these audits, which included additional training and support for junior staff.
- During our last inspection of the service in September 2015, staff told us about their frustrations with the information technology system. Managers agreed that the electronic systems were not fit for purpose and there was a long-term plan to replace the system. This had not yet been achieved. However, during this inspection, managers told us that there was a plan to improve mobile technology for community staff during the Autumn of 2017. Managers told us that community staff would be able to complete records electronically whilst in patients' homes, and prevent the current duplication of paper records in patients' homes and electronic records at the team base.

Cleanliness, infection control and hygiene

- During visits with community staff to patients' homes, we witnessed good hand hygiene with staff washing their hands pre and post-patient care. Community staff had alcohol gel to disinfect their hands while away from their base and when required, in addition to hand washing.
- We observed the appropriate use of personal protective equipment, such as disposable gloves and aprons when administering care or treatment to patients.
- Staff followed the arms bare below the elbow guidance in all community settings we visited including patients' own homes.
- We saw hand gels were available within community clinics.
- Essential steps audits completed by the trust, included staff hand washing, 'sharps' management, use of personal and protective equipment (PPE) and aseptic technique (steps taken to minimise the risk of infection for procedures such as wound dressings, and catheter and peripheral vascular cannulas management). The trust sent us the essential steps audits undertaken between September 2016 and March 2017. We saw that community staff were 99% compliant with hand hygiene, 99.7% with sharps management, 100% with use of PPE and 99.8% compliant with aseptic technique.
- We observed staff cleaned equipment appropriately when they had used it. For example, we saw that community nurses cleaned equipment used to take patients' blood pressure and temperature. We saw that examination couches in clinics were cleaned between each patient. We saw that staff used liners inside bowls in patients' own homes when washing leg wounds.
- We saw the community nurses carried boxes for the safe and appropriate disposal of needles and syringes. We observed that dressings were appropriately disposed as clinical waste.
- Information provided by the trust identified that 96% of community adult's staff had received infection control training.

Mandatory training

- The trust's target for staff compliance with mandatory training was 90%.
- Information provided by the trust identified that 87% of community adult's staff had received all required mandatory training. This included Conflict resolution 90%, equality and diversity 85%, fire safety 85%, infection control 96%, information governance 93% and patient handling 100%.

Assessing and responding to patient risk

- Staff recognised that an acute hospital might not be the best place for care for many patients who had a chronic illness.
- Community nursing staff highlighted patients who were unwell to the community matron for review and when required they would admit them onto the 'virtual ward'. The virtual ward identified patients who community staff were providing care for but were at risk of a hospital admission.
- Information about patients who were on the virtual ward was available to staff throughout the trust to

ensure, when required, continuity of care. The aim was to manage patients with chronic illness who experienced an acute exacerbation of illness whenever possible within the community.

- Each community nursing team had a senior nurse on duty between 8am and 6pm to triage requests for community nurses. The triage system ensured that staff recorded all messages and teams could identify and respond to urgent visits in a timely manner.
- Patients who were on the virtual ward were regularly seen and reviewed by a community matron during the acute phase of their illness. When their condition had stabilised, the community matron would discharge them from the virtual ward.
- The rapid response team was available form 8.30am to 10pm seven days a week. Community staff and other health professionals were able to refer patients to the rapid response team, when they were unwell, had reduced mobility or had fallen. The team would assess the patient arrange appropriate treatment, care or equipment they required with the aim to keep the person in their own home. If a patient's condition gave cause for concern the team may refer the patient to hospital for further assessment and treatment.
- To reduce the risk of a patient's condition deteriorating the team provided timely intravenous antibiotic therapy and treatment for deep vein thrombosis, which previously may have been undertaken in hospital.
- We observed the rapid response team handover, three community nursing team handovers and one handover between the community nursing team and the community matron. We saw that staff identified and escalated concerns about patients appropriately. Senior staff provided advice such as, a need for referral to another service, treatment options or future visits.
- The service had recently introduced a sepsis-screening tool. One community matron told us that they had attended training for use with the tool and they were cascading this to other staff.

Staffing levels and caseload

- We found that there were sufficient and appropriate staff to meet patients' needs.
- The trust had used a locally developed community nursing workforce tool since 2012. The tool identified the number and category of visits within identified periods for example, routine administration of insulin would require a 15-minute visit, but a complex wound dressing may be identified as 30 minutes for each leg. This tool was in current use within community nursing teams, but managers had an ambition to extend its use to other community teams**.**
- During our last inspection in September 2015, community nursing had a high number of vacancies and as a result, there were a high number of cancelled patient care visits. This was an escalated risk on the divisional risk register. However community nurse vacancies had been addressed and this had been removed from the risk register.
- Senior managers and team leaders told us that they had no community nursing vacancies. They told us they had offered jobs to six student nurses who wanted to work within adult community services when they became qualified nurses. This would mean they were over staffed but meant they were able to provide a fully staffed service.
- Staff told us and we saw that since our last inspection, there had been a significant reduction in cancelled patient visits. Information provided by the trust, showed the number of cancelled patient visits at less than 300 in March 2017, and less than 200 in April 2017, compared to just over 2,000 patient visits cancelled in March 2015. Senior managers said this had improved both staff morale and patient satisfaction.
- Community nurses we spoke with told us they felt the tool was a fair representation of their time and demand for their service. Staff told us that every team was able to see the staffing tool, which enabled them to see if any teams may be short staffed and where cover was required. We spoke to several staff who had either covered for another team or who had benefitted from assistance from another team. All staff we spoke with were positive about these arrangements, which provided equitable and safe community nursing staffing.
- Community matrons told us that their average caseload was around 40 patients. They told us that as community matrons, they actively stepped up and stepped down patients as their needs changed. Community matrons also told us other community matrons assisted them if caseload and patient needs increased.
- Information provided by the trust identified a sickness rate for adult community services of 4.4% between 1 April 2016 and 31 March 2017 (the trust target was 3.4%)

Good

Are services safe?

- Senior managers told us that due to the success of the rapid response team and high numbers of patients referred, they were increasing the team size with three whole time equivalent staff.
- The trust had recruited in-reach matrons so that there would be one community in-reach matron attached to each place-based team. We saw that the trust had already recruited an in-reach matron to the South team in April 2017 with recruitment in place for the remaining three teams. A senior manager told us that initial outcomes for south team had been encouraging.
- The adult community services care group had one full time doctor. The doctor mainly provided medical support for the rapid response and clinical intervention teams, but also provided advice for patients with complex care requirements across the place based teams. In the absence of the medical lead, there was no doctor cover for the rapid response team and clinical intervention team. However, staff were aware that if there were any concerns to send the patient to accident and emergency, which would be usual practice without these services. Therapists worked on a rotational basis across acute and community services. Some therapists told us that there were allied health professional (AHP) vacancies. We saw that AHPs were part of the women and children's care group. Information provided by the trust identified that there were 21.5 whole time AHP vacancies throughout the trust.

Managing anticipated risks

- Each community team we visited had a daily handover. During the handover, staff confirmed the visits undertaken and the visits they were scheduled to undertake. This ensured that all visits had been appropriately allocated to staff.
- Staff also highlighted patients who were unwell or whose condition had deteriorated and would need additional visits or a medical assessment by the GP.
- Staff described that during winter months in adverse weather conditions, there was a plan in place to prioritise patient visits.

Good

Are services effective?

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

Summary

We have rated this domain as good because:

- Evidence based care and treatment were used to support the delivery of high quality care. The trust had a range of policies and procedures in place for adult community services, which met best practice and the National Institute of Health and Care Excellence (NICE) policies and procedures.
- Staff working across community adult's services were competent and knowledgeable. There were appropriate systems in place to support junior staff and develop all staff competence.
- There was effective and excellent multidisciplinary working to ensure that patients received innovative, efficient and joined up care that reflected their needs and choices.
- There were robust systems in place to monitor and improve quality and patient outcomes.
- Consent to care and treatment was obtained in line with legislation and guidance including the Mental Capacity Act 2005. Staff fully supported patients to make decisions and where appropriate, they assessed and recorded their mental capacity.

However;

- We saw that six out of seven patient records belonging to patients who had pain, had no pain assessment in place.
- The frequency of reviewing nutritional screening tools was inconsistent when patients were identified at risk of insufficient nutrition.

Detailed findings

Evidence based care and treatment

- This service had an external West Midlands Quality Review in April 2016. The review included community teams and patients in their own homes, the frailty team and some acute hospital services. The outcome of the review included a "well done", for defined service pathways.
- We saw that the trust had a range of policies and procedures in place for adult community services, which met best practice and the National Institute for Health and Care Excellence (NICE) policies and procedures.
- We saw that the osteoporosis services used the fracture risk assessment screening tool (FRAX) and National Osteoporosis Society guidelines, which met NICE guidelines.
- The community stroke team followed NICE guidance to provide patients with five-day rehabilitation therapy.
- Catheter passports are identified as best practice (national evidence based guidelines for preventing healthcare acquired infection in NHS Hospitals in England, NICE 2012) (Healthcare associated infections: prevention and control in primary and community care, NICE 2011).
- The trust audited community nursing caseloads, to check the ongoing use of catheter passports following completion of commissioning for quality and innovation (CQUIN) during 2015/16.
- We saw that staff followed NICE guidelines for patients who were at risk of pressure ulcers or who had a current pressure ulcer.

Pain relief

- We saw that the trust had a pain assessment tool in place. However, we reviewed seven patient records and six had no pain assessment in place, despite the patient identifying pain.
- We found that although community nurses discussed pain, there was no formal pain assessment available in four of the five records we reviewed, when pain was an identified patient need.
- We observed one patient visit during which the patient appeared to be in pain. We asked the community nurse if they used a pain assessment, they said they had one in their car. We observed that when they formally assessed the patient, they said they would discuss a need for additional pain relief with the doctor.
- We saw and staff told us, some community nurses and matrons were able to prescribe medicines such as pain relief. We saw that other community nurses would liaise with the patient's doctor if pain relief was required.

Good

Are services effective?

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST), which is a recognised assessment tool to assess nutritional risk.
- Our last inspection of the service in September 2015, found that staff had not consistently completed MUST risk assessments.
- During this inspection we found that staff had not completed nutritional risk assessments at the required frequency in relation to risk. For example, a patient identified as high risk should have the assessment reviewed at least every month and low risk every three months. When we visited unannounced on 31 May 2017, we found that three of the five patients whose records we looked at, did not have their nutritional risk reviewed at the required frequency. When we visited on 21 and 22 June 2017, we found that the completion of risk assessments had improved and individualised nutritional care plans were in place.
- We did however; see staff ask patients about their appetite, fluid intake, and actions to increase diet or fluid intake. We observed one community matron discussed nutritional supplements and other preferred supplements with one patient and their carer.
- Staff told us that community staff provided support and advice to the staff at nursing and residential homes, in relation to the management of patients where fluid or dietary intake was compromised.

Technology and telemedicine

- Community matrons told us and showed us that when their patients were admitted to hospital, they received an alert to make them aware of the patient's admission. The alert also highlighted they were a community matron patient to enable staff to discuss the patient and their needs with the matron. Community matrons told us that this communication supported early patient discharge. Staff told us that the alert system was to be made available for all patients on community nurses caseloads.
- During our last inspection of the service, we observed community matrons were able to arrange for patients to use 'telemedicine' in their homes (telemedicine is a system that records and stores patients' observations electronically so health professionals are able to review and monitor the patient's health). However, community matrons told us that commissioners had decided to remove funding for telemedicine and there were plans for alternative technology, but there was no time frame for this proposed implementation.

Patient outcomes

- The service had reviewed all patients who had been seen by the falls clinic between 2015 and 2017, and had a subsequent fall within 12 months, which had resulted in a hospital admission. The review identified that 21 of the 980 patients seen, had a subsequent fall that required them to be admitted to hospital within 12 months of being seen within the clinic.
- The rapid response team carried out quarterly audits to identify patients who had avoided an admission to hospital following discharge from the service. An initial audit in October 2015 showed 47% of patients were admitted 30 days after discharge from this service. This audit identified poor step down to community teams and patients had been discharged too soon from the service. We saw information that showed improvements had been made following a period of stabilisation. There were now 13% to 14% of patients admitted to hospital within 30 days of discharge from the rapid response team between September 2016 and March 2017.
- The CQUIN outcome in 2015/16 identified 95% of patients in acute and community settings had a catheter passport in place. An audit in October 2016, identified 80% of adult community nursing patients with a catheter had a catheter passport in place. One staff member told us that if they found a patient with a catheter without a catheter passport or without the passport being updated, they completed an incident form to ensure all staff were aware of its importance.
- The trust had a CQUIN, which required the identification of 150 patients who had a long term wound that had failed to heal within four weeks. The CQUIN identified best practice that all wounds should have a full assessment. Failure to complete a full wound assessment can contribute to ineffective treatment, which delays wound healing. Wounds that fail to heal can have significant consequences for patients' quality of life and financial implications for the trust. We saw that three of the four patients whose records we looked at with a long term wound had a wound assessment and treatment plan.

Good

Are services effective?

- The trust previously had two whole time equivalent community in reach matron posts to review patients admitted to Walsall Manor Hospital from community matron caseloads.
- Information provided by the trust had shown that when there was in-reach community matron working with ward staff and doctors. The information showed that there was a reduction in length of stay for these patients and actual numbers of patients in hospital reduced from between 30 and 35 to between 10 and 15 at any one time.
- The trust had developed enhanced case management with staff working in private nursing homes. The trust had been successfully achieved additional funding through West Midlands Health Academic Science Network and learning through excellence. Staff told us and we saw, that pressure ulcer incidence within private nursing homes had decreased and increased numbers of people were able to die within their care home where they had staff who knew them, rather than in an acute hospital.
- Information provided by the trust identified that there was an established insulin pump service in Walsall for adult patients with more than 110 people receiving insulin pump therapy.
- The last inspection report included the April 2015 report for leg ulcer healing rates for all four wound care clinics. The findings were positive and found that wounds healed more quickly within the clinics. The trust did not complete a wound healing audit for the year 2016/17 due to changes in teams and staff working within the clinics. A new audit will be undertaken in April 2018 and will include healing rates for all community services alongside patient satisfaction.

Competent staff

- We observed clinical practice, attended staff multidisciplinary team (MDT) meetings, and saw that staff working across community adults services were competent and knowledgeable.
- Staff told us they were able to access courses to develop their practice such as prescribing courses, which they identified as part of their appraisal. Staff also told us that they received updates from specialist nurses, community matrons and link nurses within the team.
- Senior managers told us that the trust seconded two community senior nurses each year to undertake the community specialist practitioner course.
- Staff told us and we saw that each team had a senior nurse for both wound management and palliative care. The trust identified that whilst all community nurses had skills and competencies to deliver high quality wound care, a senior nurse taking overall responsibility for wound care provided consistency of management. In addition, they provided education and support for junior staff in the team, advice in the completion of root cause analysis investigations and clinical audit.
- Staff told us that all new staff received a trust induction followed by shadowing of other community staff.
- Staff told us and we observed that their competencies in procedures such as compression bandaging and Doppler assessment were checked and signed off.
- Managers told us that there was no formal staff supervision. Some staff told us they could accompany a band 6 nurse if they required additional support with a particular procedure. Staff also told us that they used the team handover as clinical supervision.
- Allied health professionals (AHPs) told us they had regular staff supervision.
- The trust's target for staff appraisal was 90%. Appraisal achievement ranged between 79% and 100% within adult community services.
- Additional competencies were achieved with nursing home case management team and comprised of a senior advanced nurse practitioner and senior clinical sisters, to support enhanced case management in nursing homes. Their role was to identify and undertake comprehensive frailty assessment of residents who were high risk of hospital admission, develop a personalised written management plan, optimise medication and provide care co-ordination for identified caseload. They provided nursing home staff with education and training in-order to enhance the quality and consistency of care provided for patients.
- The trust provided information that showed 98% of staff working within community adult services had received training in dementia awareness.

Multi-disciplinary working and coordinated care pathways

- We saw some excellent multidisciplinary team (MDT) working during our inspection, which facilitated high quality patient care.
- The trust had aligned place based community nursing teams to GP practices across Walsall Borough. Staff told

us that this facilitated excellent working relationships with general practices as it gave GPs named community nurse contacts and enhanced professional relationships.

- We saw that place based community teams had named social workers and mental health professionals for each team who worked together to achieve better care and treatment for community patients.
- Walsall Healthcare NHS trust physiotherapists and occupational therapists worked within the rapid response team but not community nursing teams. Staff told us and we observed that occupational therapists from Walsall Metropolitan Borough Council worked closely with community nursing teams.
- We saw that the rapid response team had a daily MDT meeting during which staff discussed all patients on the caseload and their visit needs. For example, nurses communicated that they had taken blood tests from a patient for the team doctor to review. The doctor arranged to go out to see the patient, as there was some concern about their blood results. The doctor said that they felt the patient may require a hospital admission, but they would contact the occupational therapist if the patient remained at home, to enable them to assess the patient's mobility.
- The diabetes team were available Monday to Friday and provided on-going support and education to patients within the service. The diabetes team consisted of diabetes specialist nurses, an Asian support worker, podiatry and clerical support. The specialist diabetes team provided advice, education and support within the community for patients who needed complex care to control their diabetes.
- Information provided by the trust showed there was a dedicated multidisciplinary foot team that included a tissue viability nurse, vascular surgeon, orthopaedic consultant in line with NICE guidance 119.
- Staff told us about the good links they had with consultants working within the acute hospital. For example, the Frailty services told us that they had the benefit of being able to access support from a consultant geriatrician, and the community neurological rehabilitation team said they had direct support from a designated consultant in neuro-rehabilitation.
- The osteoporosis nurse specialist managed the falls team and as a result, we saw there was excellent multidisciplinary working between the falls team and osteoporosis service. The falls team and osteoporosis service told us they also supported acute outpatient clinics and worked in partnership with the consultant rheumatologists.
- We saw that the podiatry service had extended scope podiatrists, who undertook some nail surgery in community clinics, and had strong links and referral pathways into acute consultant podiatrists, vascular surgeons and the diabetes service.
- We spoke with the community diabetes nurse specialist who confirmed that diabetes specialist nurses had aligned Diabetologists who were available to offer advice for complex patient care at home.
- The community neurology rehabilitation team (CNRT) included a rehabilitation consultant, physiotherapists, clinical nurse specialists, occupational therapists, speech and language therapists and clinical psychologists. The service provided both rehabilitation and long term neurological condition management, and worked with social care and regional specialist services to support effective patient management.
- Occupational therapists and physiotherapists within the intermediate care team set joint goals with the patient, which included goal attainment scaling (GAS) and therapist outcome measures.

Referral, transfer, discharge and transition

- Doctors and other health professionals in the acute hospital and other community services made referrals to community nurses through the community team base.
- Community nurses and community matrons told us that patients who were unwell would be 'stepped up' to the community matrons and when they were stable they were either discharged or 'stepped down' to community nurses.
- Community staff told us that there was regular review of the caseload to look at appropriate referrals, transfers or discharges to meet the needs of the patients and balance the demand for the service. Staff and general practices could make referrals to the rapid response team in order to try to prevent a hospital admission.
- Referral to the teams were made direct to each place-based team between 8.30am and 6pm, or to the Manor Hospital switchboard outside these hours.

Good

Are services effective?

- We saw that there was a directory for health professionals that identified all community services with contact numbers for both urgent and non-urgent patient referrals.

Access to information

- Information was available on the trust intranet for staff to refer to when they were at their team base, but this was not available when they were in patients' homes. However, staff told us and we observed, that a band 6 triage nurse was available during working hours whom staff could contact for advice.
- Staff received corporate emails that included information from the trust's Chief Executive Officer about their work within the trust and other updates about particular themes such as training to support them with easy access to information.
- We observed that staff shared information during handovers, team meetings and within the multidisciplinary meetings.
- We saw that the trust used a catheter passport that included all information about the patient's catheter such as, date of insertion and when the catheter should be removed. The passport should be taken with the patient with them if they were admitted to hospital, to ensure the patient received appropriate catheter care.
- Information provided by the trust showed that they had developed a 'passport' for nursing and residential home residents that provided other services with information about the person, key contacts, their needs and medication. This enabled health professionals to be aware of their needs, as frequently these patients may be confused, agitated or unaware of their needs such as medicine requirements.
- We saw during the rapid response team meeting that staff were able to access information such as, test results and the number of and reasons for a patient's admission to Walsall manor Hospital. This meant that patients received timely and appropriate treatment and care.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We observed community staff gaining informed consent appropriately prior to carrying out any procedures during home visits.
- Staff were knowledgeable about processes to follow if a patient's ability to give informed consent to care and treatment was in doubt. Staff demonstrated a good understanding of consent in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- We saw that the records audit included a section that assessed the completion of records when patients may not have capacity to consent to care or treatment.
- Information provided by the trust showed that 34% of staff had received training in relation to the Mental Capacity Act 2005 and 38% of staff had training in the Deprivation of Liberty safeguards.

Good

Are services caring?

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

Summary

We have rated this domain as good because:

- Feedback from people who used the service and those close to them was continually positive about the way that staff treated people.
- People who used the service were treated with dignity and respect and their privacy was maintained.
- Relationships between patients, people they were close to and staff were strong, caring and supportive.
- Patients were active partners in their care.
- We saw that patients' emotional and social needs were highly valued by staff and were embedded within their care and treatment.

Detailed findings

Compassionate care

- We saw that community staff built up trusting relationships with patients and people they were close to by working in an open and supportive way.
- All patients and relatives we spoke with spoke highly of the staff and the service that their loved ones had received. One person told us, "Angels [the community nurses] that is what I call them".
- Another patient told us, "I had this problem a few years ago and then, as now, they have all been so good". One relative told us, "X [the community matron] has been coming in for a while; they are very good and supportive". We saw that staff spoke to patients and their relatives in a caring and compassionate way.
- Comments that we received from patients included, "They visit every day and I am very grateful for what they do for me". "They are wonderful people they support me every day". "They give everything they can".
- We observed that staff were respectful to patients, spoke to them in a courteous manner and asked their permission to examine them. We saw that staff ensured that patients' dignity was maintained and ensured they were treated with respect.
- We visited one patient who had daily home visits from community nurses for personal care. We observed that the nurse was extremely compassionate ensured the patient's dignity was maintained by ensuring they were covered up and asked if they could shut the curtains (the patients said no need). We observed that the nurse was friendly and chatted with the patient making sure they were comfortable and did not rush any aspect of the care provided.
- We observed, during one home visit, the community nurses went beyond what would have been expected. They went to dispose of dressings and found several rubbish bags waiting to be disposed of. The nurse asked the patient if they would like them taken to the bin as they had mobility difficulties. The patient explained they had been unable to bring the dustbin back and they would appreciate it and said the nurse was, "very, very kind".
- The Friends and Family test results for overall community services (May 2017) showed that 96% of people who returned the survey would recommend the service (against a national response of 94% for community services.
- We saw friends and family data results shared within the west 1 team meeting (16 June 2017). There had been 37 patients who returned the survey with an overall score of 94.9% likely to recommend the service. The community matrons had six surveys returned and 100% of patients would recommend the service.
- Information provided by the trust showed us that podiatry staff had undertaken a patient focussed quality improvement audit during December 2016. The audit interviewed 16 patients following biomechanics assessments (assessing their mobility and gait) and treatment appointments. The aim of the audit was to review patient perceptions of the service and identify areas of good practice and areas for development. All 16 patients said they would recommend the service to friends and family.
- A survey undertaken by the nursing home case management team identified an overall score of 9.7 out of 10 for "staff were caring and professional".

Understanding and involvement of patients and those close to them

- We saw that staff informed patients about their care; this included an explanation of why they had taken wound swabs, when the results would be available and the next stage of treatment.

Good

Are services caring?

- We observed that patients and their carers' views were sought on the success of previous treatment within the spasticity clinic.
- We observed that the stroke team listened to a patient who told them they were struggling with five-day therapy. In response and with consultation, the therapist reduced the number of sessions to three each week.
- We observed that community nurses and community matrons involved both the patient and carer in their care assessment discussing sleep, pain and breathlessness.
- We observed that one community nurse fully involved the patient's relative during personal care at the patient's request, helping to move and hold the person. We saw that this also gave the patient additional reassurance.

Emotional support

- We observed that staff gave patients and their loved ones good emotional support.
- We observed that one patient became upset during their treatment and were worried about skin condition of their other leg. We saw that the community nurse gave reassurance that they were checking both legs to ensure that they could identify any problems and they could commence early treatment if required. The nurse also gave advice on how to promote healing of the patient's leg wounds, which included elevating their legs and dietary advice.
- We observed that one family became distressed thinking that they may have their care removed. The community nurse reduced the patient's anxiety and explained that this was not the case, as they needed community nurses to provide their care and treatment.

Good

Are services responsive to people's needs?

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

Summary

We have rated this service as good for responsive because:

- The service worked creatively with commissioners to plan new ways of meeting people's needs and tailored to respond to the needs of the local population.
- Access to care, support and advice was managed and timely to take into account patient's needs, including those with urgent needs.
- The trust provided an equitable community adult service irrespective of the patient's diagnosis, socio-economic group, ethnicity or sex. The service monitored access to its services by all groups, to ensure the service remained accessible to all.
- There were innovative approaches to providing care within patients' own homes and whenever possible, avoiding admission to hospital.
- Admission, discharge and transitional care between community and acute settings were models of best practice in integrated and person-centred care.
- Concerns about the service were taken seriously and appropriately responded to.

Detailed findings

Planning and delivering services which meet people's needs

- District nursing received around 9,250 new referrals each year and 190,000 face-to-face contacts. The place community nursing teams operated 24-hours a day, seven days a week to provide both scheduled and non-scheduled care within patients' own homes and a community setting.
- Community matrons had advanced skills in long-term conditions and knew whose patients had complex long-term needs, were frail, and were at risk of hospital admission. Community matrons including transitional case managers, saw around 500 new referrals each year and had 15,000 face-to-face patient contacts. They worked seven days a week between the hours of 8am and 6pm.
- Senior managers told us about service changes to meet local demand. This included changes and enhanced banding for posts within the continence and respiratory services, to provide additional support for patients who had recurrent urinary tract and respiratory problems.
- Information provided by the trust showed that they had commenced a new initiative whereby they identified all community nurse and community matron patients. This enabled the trust to generate an alert when a community nurse patient was admitted to hospital. We saw that this system was already in place for community matron patients.
- Information provided by the trust identified that the rapid response team had been expanded following an increase in average referrals from 150 each month to over 200.
- The community wound clinics saw approximately 700 contacts (patients may attend more than once during the week). Two of the four clinics had reduced from five days to three days for 12 months. However, the trust had recruited two additional staff and all wound clinics were open five days per week. There was also an additional clinic in the west locality. The clinics provided care for patients with a range of wound types including venous leg ulceration requiring compression therapy.
- Walsall Healthcare NHS Trust retained the specialist falls service following their successful bid for this service in 2015.

Equality and diversity

- The trust provided an equitable community adult service irrespective of the patient's diagnosis, socio-economic group, ethnicity or sex. The service monitored access to its services by all groups to ensure the service remained accessible to all.
- We saw that the diabetes service had an Asian support worker who was able to communicate, contact and understand the needs of Asian patients.
- Staff received equality and diversity training as part of their mandatory training. Information provided by the trust showed that 85% of staff working within community adult services had received this training.

Good

Are services responsive to people's needs?

- We saw that translation services were available for patients and that they were able to access information leaflets in a number of languages from the trust's website.
- Disabled toilets, wheelchair access and disabled car parking were available across all community clinics we visited.

Meeting the needs of people in vulnerable circumstances

- The specialist falls team received referrals for adults primarily over 65 years of age, who had a fall resulting in injury or a history of falls. The service undertook a multidisciplinary assessment, which included mobility, gait and medication. The service also provided low to moderate level balance exercise classes, to assist this cohort of patients to improve their balance.
- The osteoporosis service was a community based nurse-led service, which assessed people who may be at risk of osteoporosis or increased fractures. People were predominantly seen post fracture. The service provided assessment, specialist scans to diagnose and when required, provided treatment.
- Patients living in nursing homes are both vulnerable and dependent. The trust had a team working across Walsall Borough, which provided support and advice to the independent care home sector. A member of the team undertake a fragility assessment and weekly visits to review patients. From January 2017, the team secured a two year fixed term funded contract for a quality lead nurse, to support with embedding the model to improve the quality of care in private nursing homes. In addition, funding was in place for a 12-month contract for education to reduce avoidable harms in residential care. The Regional Patient Safety Collaboration had funded both posts.
- The stroke service ran four groups each week for patients with swallowing difficulties. The groups provided lifelong access, providing support and information for patients to manage their swallowing difficulties.
- We observed at Beechdale wound clinic, there was one large treatment room that was used for two patients at the same time. Staff told us that they would only accommodate same sex patients at the same time and would ask patients if this arrangement was acceptable.

Access to the right care at the right time

- The community nursing service was available 24-hours a day, seven days a week. The integrated place based teams operated seven days a week between the hours of 8am and 6pm, an evening service was available between 5pm and 10pm, and a night nurse and driver were available for unscheduled care between the hours of 9.30pm and 8am.
- Information provided by the trust showed that community nursing did not have a waiting list.
- Community nursing worked within a 24 to 48-hour response target for urgent referrals and this was audited. Information provided by the trust showed that the target of 100% response rates both for urgent and non-urgent referrals were met.
- The rapid response team worked seven days a week between the hours of 8.30am and 10pm. Information provided by the trust showed that the team had consistently prevented hospital admission for up to 95% of patients referred to the service over the last 12 months.
- The rapid response team worked to a two-hour response target, however; referrals into the team had significantly increased, which had reduced compliance with two-hour response. Work was ongoing with commissioners to implement a clinical triage, to assess urgency and identify a requirement for either a two or a four-hour visit by the team based on initial referral information. We saw that information provided by the trust showed that in April 2016, 90% of patients (144 patients) were seen within two hours and in March 2017, 64% of patients (207 patients) were seen in two hours.
- The clinical intervention team was available seven days a week between the hours of 8.30am and 10pm. The team consisted of registered nurses who responded within 24-hours to set up clear pathways for patients with a suspected deep vein thrombosis (DVT), confirmed DVT, pulmonary embolism, cellulitis or patients requiring intravenous antibiotics. Patients attended community clinics or if housebound staff would visit them at home. Information provided by the trust showed that the clinical intervention team met the target that they saw patients within 24 hours of referral.
- An alert system had been developed to enable the long-term condition teams to be notified immediately when vulnerable adults, i.e. those at risk of hospitalisation, presented in accident and emergency, or any ward area

in Walsall Manor Hospital. The trust's technology system generated an automatic e-mail alert, which was sent to the place based team community nursing mailbox and community matrons.

- The podiatry service was available five days a week between 8.30 am and 5pm within six community locations. The service had also introduced evening clinics on Tuesdays and Thursdays at one community location and also provided a domiciliary service. The service had undertaken a patient focussed quality improvement audit during December 2016. The audit included interviewing 16 patients following their biomechanics assessment and treatment appointments. The audit identified overall positive feedback regarding staff attitude and care. However, locations and appointment times were identified as requiring improvement. Staff working within the podiatry service told us and showed us that following the audit, all new patient appointments included a map to show where the podiatry clinic was and had improved signage to the clinic outside the building.
- Information provided by the trust identified that podiatry services met contracted waiting times for referrals as were the clinical intervention team.
- Information provided by the trust showed that there were often patients waiting for rehabilitation beds within the intermediate care services. Staff told us that there were changes in place to improve patient assessment and discharge models although there was no information available for us to view.
- Community wound clinics infrequently had waiting lists. Information provided by the trust showed that if a preferred clinic was full, the patient would continue with their care by their current provider e.g. community nursing or practice nurse until a suitable appointment was identified.
- Information provided by the trust showed that all new referrals to the community neurological rehabilitation team were clinically triaged dependent on urgency. All new referrals were seen within eight weeks by the multidisciplinary meeting or following review by a neurology consultant.
- The specialist falls and osteoporosis services assessed patients within four weeks of referral and the service prioritised urgent referrals. Waiting time for triage of physiotherapy appointments exceeded the trust's key performance indicator. We saw that the trust was taking appropriate actions to address this, which included a review of staff availability.
- Community professionals referred to named mental health link nurse who assessed the patient and when required referred onto the mental health services.

Learning from complaints and concerns

- Staff told us that if a patient or relative raised any concerns they would try to resolve concerns locally and make their manager aware. The complaints policy was up to date and accessible to all staff via the intranet.
- The manager told us that they logged any complaints received centrally. A senior manager then investigated and provided feedback. Learning was highlighted during team meetings. We saw meeting minutes to support this.
- There had been 12 complaints made about adult community services between 1 April 2016 and 31 March 2017. We saw that complaints included frequency and availability of visits by community nurses. Staff told us that following complaints received about messages not being appropriately responded to, the trust had introduced a senior triage nurse. We saw minutes from the team leader meetings that confirmed what staff told us. This had ensured staff contacted patients and, or carers within a couple of hours of leaving the messages. Staff also told us and we observed staff handovers, which confirmed that following missed insulin visits, staff confirmed patients they had visited during the morning and those they were due to undertake later that day to ensure no required visits were missed.

Outstanding ☆

Are services well-led?

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

Summary

We have rated this service as outstanding for well led because:

- Leaders were approachable and supportive. They inspired and motivated staff to deliver a high quality, effective and innovative adult community service.
- The strategy to deliver a joined up service between acute, community and other services to reduce hospital admissions had been a challenge but was being achieved through the passion and determination of the leaders and staff.
- There was integrated and coordinated patient care between the acute and community services.
- The leadership drove continuous improvement. There was a clear proactive approach to seeking out and embedding new and sustainable models of care.
- Governance and performance management arrangements were actively reviewed to identify, understand and monitor risk and meet best practice. Performance issues were escalated to relevant committees through clear structures and processes. There were clear evidence of actions to resolve any concerns.
- Comprehensive and successful leadership and leadership development strategies were in place to ensure the delivery and development of the desired culture.
- There were high levels of staff satisfaction. Staff were proud to work for the service and spoke positively about the culture. Staff at all levels were actively encouraged to raise concerns.
- The service provided a systematic approach to working with others in the health and social care economy to improve patient care outcomes.
- There was a strong collaboration, team-working and support across adult community service and into the acute hospital with a common focus on improving the quality and sustainability of care and people's experiences.
- The vision and strategy of the service were achieved and embedded.
- Safe innovation was celebrated. There was a clear proactive approach to seeking out new, more sustainable and innovate models of care, whilst maintaining high quality care and transformation programmes.

Detailed findings

Leadership of this service

- The adult community leadership had identified a clear direction for the service to deliver high quality and innovative adult community services to avoid hospital admissions for their patients and reduce hospital length of stay.
- We found that managers were approachable, supportive, and inspired and motivated staff to deliver high quality and effective patient care and to develop innovative practice.
- The leadership were highly respected by staff.
- The leadership provided a service that staff wanted to work for and were proud to work within.
- The community adult's service was part of the medicine and long-term conditions division. The division management structure included a divisional director, a director of operations, a divisional director of nursing (acute) and a divisional director of nursing (community).
- The care group of community adults had a clinical GP lead, a care group manager and a business support manager who supported the divisional director of community services.
- Each community service had a clinical team leader who reported to the care group management team. Each clinical team leader had direct management responsibility for one or more community teams such as, community nursing teams, the falls service, the rapid response team and nursing and residential home case managers, and the clinical intervention team and podiatry.
- Therapy services, which included community therapists, were within the women's and children division.
- Staff told us that managers, including the divisional director of nursing, were extremely supportive and

approachable. Several staff also told us that the Chief Executive had visited teams and had undertaken patient visits with community nurses and felt he was approachable.

- We found that within community nursing, the addition of wound care and palliative care senior nurses provided excellent support and development opportunities for other staff to provide high quality and safe care.
- We found that leadership had enhanced patient pathways between acute and community care, to ensure that the trust provided integrated and coordinated patient care. For example, the role of the in-reach matron, the chronic disease management to avoid unnecessary hospital admission, the rapid response team and the clinical intervention team.
- The senior nurse practitioner, who was the lead for the private nursing home case management service, had achieved a Florence Nightingale Older Persons Fellowship and MSC in Quality and Leadership.

Service vision and strategy

- There was a five-year strategy in place for the community adults with long-term conditions service. This strategy identified five key aims, which included providing care for patients at home whenever possible, use resources well to ensure a sustainable service, provide safe high quality care across services, work closely with partners in surrounding areas and value colleagues so they recommend the trust as a place to work. We found that staff fully understood these aims and strived to work by them daily.
- The service had a systematic approach to working with others in the health and social care economy, to improve patient care outcomes.
- All staff we spoke with were proud that they were able to deliver the 'care closer to home' vision and were clear of how the service was able to prevent avoidable hospital admissions.
- Staff we spoke with told us they were aware of their role with the future of the service and were kept well informed of changes that would affect them.
- Community services had undertaken analysis of the reasons for emergency admissions into acute care across place based teams. Monthly analysis since January 2017 identified that diseases of urinary tract and respiratory were the most common reasons for why known community patients were admitted to hospital. This analysis had informed a need to change and develop the service. Changes made ensured that there were sufficient and suitably skilled nurses available in each team to provide appropriate patient care and management and when possible prevent a hospital admission.
- We saw that the service provided a systematic approach to working with others in the health and social care economy, to improve care outcomes. For example, the rapid response team had a mental health nurse employed by another trust to assist staff to manage patients who had a mental illness; trust staff worked along staff within the private sector to improve care to people living in residential homes.

Governance, risk management and quality measurement

- Information provided by the trust showed that governance and performance management arrangements were actively reviewed to identify, understand and monitor risk and to meet best practice. Performance issues were escalated to relevant committees through clear structures and processes. There was clear evidence of actions to resolve any concerns.
- Minutes we looked at showed that there were monthly community nursing senior nurses' advisory group (SNAG) meetings and adult community care group meetings. We saw that these meetings included performance, risks, and quality issues, and evidenced that information was escalated either up to the board or down to community staff.
- We saw that the SNAG meeting included senior managers from the care group and team managers. This meeting discussed incidents, complaints and performance of each team. Team managers we spoke with told us and we saw, that they shared information with their teams on information boards, during handovers and team meetings.
- Locality leads we spoke with told us that it had been invaluable to have a governance link representative aligned with the community teams. They checked that investigations were in place, and that actions were identified to ensure timely and appropriate response to incidents. The governance link identified all incidents that the team had reported or they had attributed to the team. Incidents such as pressure ulcers, may have been reported from outside the team or been attributed to

the team because the patient lived in that particular area. However, the patient may not have been known to the service, but this review enabled a wider review to check if either Walsall Healthcare trust or another service undertook all required actions. This ensured that appropriate actions could be undertaken to prevent possible reoccurrence.

- At the time of our last inspection, the care group used a dashboard to identify performance for the entire care group, however; no team dashboards were available. Information we saw during this inspection showed that managers had an overview dashboard of the entire service and a dashboard for each service. We saw that the dashboards were displayed at each team base we visited.
- Dashboards provided positive motivation to highlight where they were doing well, but also inspired them to improve practice in areas they were not performing so well. Information in the dashboard included numbers of patients seen, numbers of patients admitted to hospital, number of incidents reported and the number of patient harms. Managers told us that these dashboards provided essential information to monitor the service, identify themes of clinical incidents, and ensure that there were robust action plans in place, to ensure that they learnt. We saw that they shared this information.
- The current Care Group risk register had 15 risks, which range from a score of three to 12. The top five risks were as follows:
  - Lone working in the community
  - Inadequate working environment (rapid response team)
  - Inadequate medical cover for the rapid response team when the team doctor was not available (which included weekends and evenings).
  - In the absence of the medical lead, there was no cover for the Clinical Intervention team.
  - The waiting time for physiotherapy triage exceeded the trusts key performance indicator.

We saw that trust had taken appropriate actions to address or manage the risk, there were action plans in place, a responsible person was named to monitor the risk and review dates were regularly reviewed.

Culture within this service

- There were high levels of staff satisfaction. Staff were positive that teams were fully staffed and they felt this increased their morale.
- Staff told us they enjoyed working for the service and spoke positively about the culture within the service and that the number of students wishing to work within adult community services had increased.
- Staff told us that they felt respected, valued, supported and that their achievements were recognised.
- Staff demonstrated a 'can do' approach' to developing an innovative service and identifying improved patient outcomes.
- There was a waiting list of staff wanting to come to work within community nursing.
- New and junior staff told us they felt extremely supported by their team and managers.
- Staff at all levels were actively encouraged to raise concerns.
- The service had Freedom to Speak up guardians who visited the teams to discuss their role and the support they were able to offer.
- The trust had a lone working policy in place. Staff were aware of a need to visit in twos for all new visits, and rapid response visits were undertaken in twos. Staff also told us that they could ring their base with a code word that alerted other staff when they required urgent assistance. We saw that staff carried panic alarms.
- Managers told us that new technology would be in use in the Autumn 2017. The technology included a monitoring device that could track staff and could be activated if they felt concerned about their safety.

Public engagement

- The podiatry service had undertaken a survey to solicit patients' views about the service to identify areas of good practice and areas for development.
- The case management service for nursing homes had undertaken a survey of views in February 2017, about the service from 10 nursing homes. Respondents identified that their expectations of the case management service was met. We saw that when improvements had been identified, these had been met.
- We saw that the intermediate care service had a "graffiti board" to share all (inpatient) patient feedback about the service provided including complaints and other key messages.

Staff engagement

Outstanding ☆

Are services well-led?

- Staff received regular emails and newsletters from the Chief Executive and the organisation to provide updates on trust-wide issues.
- The Chief Executive held weekly staff meetings outside a coffee shop within Walsall Manor Hospital. Staff were aware and were encouraged by their line managers to meet with him if required. In addition, a 'pod cast' had been set up which staff could access on a laptop.
- We saw that the teams had regular meetings and daily handovers. Managers told us that they used the meetings and handovers to ensure that staff were kept up to date on new initiatives, incidents and any complaints, and implement improvements.

Innovation, improvement and sustainability

- We saw that staff were encouraged to develop practice and demonstrate benefits to patients from the service, which included avoidance of hospital admissions. We saw many areas of innovative practice to support this such as:
- The trust had developed an alert system to notify community-nursing teams when a patient on their caseload had been admitted to hospital.
- The rapid response service responded to patients who were unwell, had deteriorated, were struggling to walk move or had fallen. The service provided care and treatment to avoid unnecessary hospital admissions. Information provided by the trust identified that 13% to 14% of patients seen and discharged by the rapid response team were admitted to hospital between September 2016 and March 2017.
- The nursing home case management team supported enhanced case management in nursing homes. Staff developed a personalised management plan for residents who were at high risk of hospital admission to optimise medication and provided care co-ordination.
- The private nursing home case management service had continued to develop and had secured additional funding through West Midlands Health Academic Science Network, to continue the development of the service. New initiatives included: learning from excellence and appreciative inquiry reduction in pressure ulcer incidence and implementation of quality boards in care homes.