

Heart of England NHS Foundation Trust

Community health services for adults

Quality Report

Solihull Hospital
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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
RTF	Solihull Hospital	Balsall Common Clinic	CV7 7RW
RTF	Solihull Hospital	Ward 10, Solihull Hospital Team,	B91 2JL
RTF	Solihull Hospital	Castle Bromwich Clinic,	B36 0EY
RTF	Solihull Hospital	Chelmsley Wood Primary Care Centre,	B36 5BU
RTF	Solihull Hospital	Friars Gate,	B90 4BN

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Summary of findings

Overall summary

We judged that community adult services (CAS) were good.

- Community adult services (CAS) achieved a good standard of safety. This was because there were good methods of reporting, investigating and learning from incidents and near misses that were well understood by staff and embedded in their daily work. There were plans to deal with major incident or events that would disrupt the delivery of care. CAS staff were making appropriate adult safeguarding referrals. There were processes and systems that protected patients from the risk of infection, and the risks associated with equipment used in their care and treatment. There were safe systems of medicines management. Records were accurate, comprehensive and current, and supported the delivery of safe care. Most mandatory training had been completed across CAS against a trust target of 85%. Staffing numbers were reviewed regularly, an active recruitment programme was in progress and arrangements to ensure any staffing shortfalls were managed on an on-going basis to minimise the impact on patients.
- National guidance from government, the National Institute of Health and Care Excellence (NICE) and professional bodies were complied with and that staff showed awareness of relevant guidance in their work. Staff were actively engaged in activities to monitor and improve quality and outcomes. Quality of care was monitored through audits, which informed the development of local guidance and practice. Patients could access all professionals relevant to their care through a hub system of integrated multi-disciplinary teams (MDT). Patients' care was co-ordinated and managed. There were systems to gain people's consent prior to care and treatment. Where patients lacked the capacity to give consent, there were arrangements to ensure that staff acted in accordance with their legal obligations.
- Patients and carers were positive about their experience of care and treatment, and feedback gathered by the organisation showed good levels of satisfaction. The average score for people who responded that they would be likely to recommend community services was 98%. We observed all staff responding to people with kindness and compassion. Patients told us they were treated with dignity and respect, and that they were involved in the planning and delivery of their care to the extent they wished to be.
- The involvement of other organizations and the local community was integral to how services were planned and ensured that services met people's needs. CAS had a model of integrated community hubs to ensure people received joined up working that was responsive to their individual needs. There was provision to ensure that essential services were available out-of-hours, and there were no major issues with waiting lists, with the exception of podiatric surgery, where a few patients exceeded the 18 week wait target due to a lack of available anaesthetists.
- Work was in progress to give community adult services a clear strategic direction and staff felt engaged with the strategy development. There was evidence of innovative practice including podiatric staff working in a MDT in dermatology for patients with epidermolysis bullosa (EB), an inherited genetic condition that makes skin fragile.
- The leadership drove continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care, for example a model of community hubs. There were systems to ensure good governance and monitoring of standards and performance. There was an effective escalation and cascading of information from the board to front-line workers, and vice-versa. We found that there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues and leadership.

Summary of findings

Background to the service

Community adult services (CAS) are offered in Solihull and Birmingham, with some out of area referrals, these are provided by Heart of England NHS Foundation Trust, a combined acute and community services trust. Services are provided in patients' homes or at a variety of health centres and medical centres. CAS includes: district nursing services, podiatry, physiotherapy, dental and a range of other services including: rapid response team (RRT), hospice at home and intermediate care.

- The Rapid Response Team (RRT) offers a range of integrated services to support care closer to home for patients and avoid unnecessary hospital admissions. The fully integrated team of community health and social care staff aims to make contact with a person in need within two hours of the first call for assistance, and can provide equipment to help someone move around their home, arrange emergency short term care support to enable them to remain at home, and regain their confidence and independence.
- District nursing services (DN) in Balsall Common Clinic, Ward 10 at Solihull Hospital, Chelmsley Wood Primary Care Centre, and Friars Gate provide care predominantly to housebound patients, but also in clinics in GP settings. A qualified district nurse (a registered nurse with additional qualifications) leads the district nursing teams.

- Community matrons also operate within the community services for adults. Community matrons are nurses who provide care for adults with complex long-term conditions, such as: diabetes, respiratory disease, or heart disease. Community matrons visit people in their own homes and develop personalised care plans. Community matrons' co-ordinate care with other health and social care professionals. By doing this they can prevent unnecessary admission or attendance at hospital and they work with GP's and the acute hospital to support discharge home.
- Community dental services provide dental treatment for patients who cannot be treated in a general dental setting.
- Community therapies included: physiotherapists; occupational therapists; and podiatrists.

We visited a sample of CAS teams on 18-20 October 2016. We talked with 12 patients and carers. We spoke with over 20 managers, community nurses, therapists, health care assistants and administrative staff. We observed how people were being cared for in clinics and in their own homes and reviewed care or treatment records of people who use services.

Our inspection team

Our inspection team was led by:

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

Inspection Manager: Donna Sammons, Care Quality Commission

The inspection team also consisted of 2 Acute Inspectors, We were also assisted by 2 specialist advisors.

Why we carried out this inspection

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

Summary of findings

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out the announced visit from 18-20 October 2016.

What people who use the provider say

- Patients and carers we spoke with were positive about the care and treatment they received from Community Adult Services (CAS). Words and phrases such as "polite," "professional," "very caring," were used in their feedback. A community nursing patient said, "I could not possibly have had better care."
- Friends and Family Test (FFT) results for August 2016, and patient feedback surveys indicated patients received the information they needed from CAS. A typical comment was, "Everything was explained in great detail, I fully understood the options that were available to me."
- Patients we spoke with told us that clinics ran on time, or that services visited when they were expected. A district nurse patient we visited in their home said, "They phone if they've been delayed."

Areas for improvement

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

Community Services Adults

- There were delays to podiatric surgery due to a shortage of anaesthetists. The situation looked improved for planned surgery in 2017, but there were still one or two patients in May and July 2017 that would be waiting over 18 weeks for surgery.

Heart of England NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safe as good because:

- There were robust methods of reporting, investigating and learning from incidents and near misses that were well understood by staff and embedded in their daily work. There were plans to deal with major incident or events that would disrupt the delivery of care. Staff were aware of the trust's adult safeguarding leads and knew how to contact them.
- We saw that there were processes and systems that protected patients from the risk of infection, and the risks associated with equipment used in their care and treatment. There were safe systems of medicines management. Patients care records were accurate, comprehensive and current, and supported the delivery of safe care.
- Most mandatory training had been completed across Community Adult Services (CAS) against a trust target of 85%. There was good staffing levels and retention with the exception of level 3 health care assistants. However,

vacant posts were being actively recruited to. Staff demonstrated awareness of the key risks to patients, and there were procedures in place to deal with foreseeable risks and changes in demand.

Safety performance

- The CAS had a good level of safety performance over time. CAS participated in the National Safety Thermometer programme; All district nursing services participated in submitting information to the NHS Safety Thermometer. For example, we viewed the results from the August 2016 Safety Thermometer, this recorded that 392 patients, 98%, had received 'harm free care' in the month.
- Further data from the patient safety thermometer showed that in the period August 2015 to July 2016 there were 24 pressure ulcers, two falls with harm and four catheter urinary tract infections reported.

Incident reporting, learning and improvement

- Incidents were reported using an electronic reporting system which also provided reports for managers on

Are services safe?

reporting activity and incidents. All staff we spoke with were aware of the system and told us they were confident in its use. Staff indicated they felt empowered to report any type of safety incident or near miss that might affect patient safety.

- In accordance with the Serious Incident Framework 2015, Heart of England NHS Foundation Trust reported 144 serious incidents (SI) in community services which met the reporting criteria of NHS England between August 2015 and July 2016. The most common type of incident reported was pressure ulcers, data submitted showed the number of community acquired pressure ulcers in the period August 2015 to July 2016 included 140 pressure ulcers reported in the period. This was followed by slips, trips and falls, which accounted for four incidents reported. The majority of incidents occurred in patients homes.
- We saw records were kept regarding all safety incidents and near misses reported in CAS. These included details of the incident and how and why it occurred. We saw that actions to mitigate against the risk of recurrence had been formulated and noted that these were appropriate to the incident described.
- A total of reported between . The majority (77%) of these were classified as either low or no harm. The CAS used an incident reporting system widely used in the NHS. We found incidents were consistently reported across teams; and staff used the reporting system appropriately.
- SI's were reviewed monthly at the trust's serious incident (Serious Incident) forum. Root cause analysis was completed as part of the investigation of incidents. Root cause analyses identified learning from incidents and this was shared across teams. We viewed the SI log from the October 2016 forum and saw that there had been a thorough investigation and analysis of SI's by the forum. Learning points had been identified and actions were underway to address the care issues identified.
- Staff understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture

of reporting incidents promptly within community services. However, this was with the exception a few staff at the Rapid Response Team (RRT), who told us they did not receive feedback on RCAs or investigations.

- Incident reporting awareness training was mandatory for all staff. Data the trust provided demonstrated that 100% of staff of all grades were up to date with the training in September 2016.
- Senior managers told us all grade 3 or 4 pressure ulcers were recorded as a SI and would be reviewed by the trust's SI forum meeting. SI's were also reviewed by the clinical commissioning group (CCG).
- A standard agenda was used for staff team meetings and learning from incidents was discussed and shared with staff at those meetings. We saw the notes of team meetings that demonstrated that incidents, their analysis, lessons learned and outcomes were discussed and communicated to staff. Most staff we spoke with told us the discussion and consideration of safety events was frequently part of their routine.
- All patients with pressure ulcers were recorded on the electronic reporting system. Staff told us the system was used to monitor incidence of pressure ulcers across teams.
- Safety alerts were sent to clinical leads by email. The alerts were reviewed by clinical leads for their relevance and shared with staff by email or discussed at team meetings.

Safeguarding

- CAS had a named lead district nurse for adult safeguarding.
- We saw evidence that CAS staff were making appropriate adult safeguarding referrals. Staff we spoke with were aware of the trust adult safeguarding team leads and knew how to contact them. The safeguarding team were described by staff as being helpful and supportive with safeguarding issues.
- The trust had an up to date adult safeguarding policy. Staff we spoke with were able to explain their understanding of the policy and how they used this as part of their practice.
- Staff received training in adult safeguarding as part of their mandatory training. All community staff received

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safeguarding adults level two training. Staff received training updates at a level appropriate to their area of work. For example, district nursing staff and podiatrists received level two training including safeguarding children and young people. We reviewed evidence that medical and dental staff across CAS compliance with mandatory training was 100%. Thereby meeting and exceeding the trust target of 85%. None of the CAS teams' mandatory training fell below the trust's target. This meant there was assurance that staff had up to date safeguarding training and knew how to respond to safeguarding concerns.

- Staff we spoke with were able to describe the categories of abuse and how they would report potential safeguarding issues. Safeguarding issues were reported to the safeguarding team for further investigation. Learning from safeguarding investigations was shared at team meetings and across CAS where appropriate.
- Patients we spoke with told us they felt safe and expressed confidence in the staff that worked with them.
- Information about safeguarding for patients in the community was included in patients home based records, for example, contact details for the trust's safeguarding team. The trust's website included contact details for the safeguarding adults' team as well as advice for people who use services and their families.

Medicines

- Medicines were prescribed, supplied, stored, and administered appropriately.
- Training in the administration of medicines was undertaken by appropriate staff groups. All case holding district nurses were trained in community formulary. Community matrons were trained in prescribing and advanced practice clinical skills.
- We reviewed four medicine administration records and found these were up to date and in order. Medication errors were reported as incidents and were followed up to identify learning.
- Controlled drugs (CD) were handled appropriately, with the involvement of the GP as necessary. The CAS service had procedures to guide staff in CD administration, this included clear guidance. Staff undertook CD risk

assessments to assess the risks to people, including allergy risks and the risk of overdose. Patients' having complex syringe drivers set up would require two nurses to be present.

- The trust had a clear policy and guidance for staff on the management of homecare medicines, this included all staff handling medicines in the home being trained to an appropriate standard.
- CAS had an intravenous (IV) lead nurse who was responsible for providing a wide range of IV therapies in the community. The lead nurse was supervised by the acute hospital's outpatient parenteral antibiotic team (OPAT), who were responsible for the administration of IV antibiotics in the community. This eliminated the need to admit patients whose only reason to stay in hospital was to receive IV antibiotic therapy. All IV patients continued to have their medical condition and therapy closely supervised by a multidisciplinary team (MDT). Staff told us the aims of the service were to reduce patients' lengths of stay in hospital, promote early discharges and improve patient experiences. Receiving IV antibiotics at home, rather than as an inpatient, improved the quality of life for patients and reduced the risk of hospital-acquired infection.

Environment and equipment

- We found there were systems to ensure staff were trained and competent to use the equipment used in their daily work. Mandatory training records dated August showed that all grades of CAS staff had met the trust's 85% target for health and safety training. For example, 100% of planned care nursing staff and 100% of out of hospital nursing, medical, and dental staff were up to date with health and safety training.
- Equipment records were identifiable and traceable with service dates recorded. Syringe drivers were traceable and that their last and next service dates were recorded to ensure that they were maintained in line with manufacturers' recommendations. We noted that these dates for servicing were up to date. Staff told us the medical engineering department held medical device registers and they received notification from them when equipment servicing was due.
- CAS had good levels of compliance with mandatory training, with most modules having 100% compliance. Mandatory training records indicated that 100%, against

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a trust target of 85%, of CAS nursing staff had up to date training in ‘falls awareness’. This was training in preventative measures that could be taken to keep staff and people who use services safe in both clinics and the home environment.

- 100% of CAS nursing staff had up to date training in ‘manual handling.’ This meant staff were trained to minimise the risk to themselves and people who use services when being moved or transferred.
- We saw clinical and domestic waste was separated and waste bins were covered and operated by foot pedal.
- We found that the conditions of the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 were being met. ‘Sharps’ waste was disposed of in appropriate receptacles which were properly labelled.
- Staff told us they had trialled personal alarms for staff when working in the community, but that staff had not considered them “efficient.” Staff said SystemOne indicated any risks to staff when lone working and staff had phones to call in to the office if they were concerned about their welfare.
- We viewed records which demonstrated that patients assessed as high risk of pressure damage, or who had such damage, were provided with appropriate pressure relieving mattresses to meet their needs. These records also showed that hospital style beds were supplied to patients when their care needs and condition warranted this.

Quality of records

- CAS staff had been trained in the NHS SystemOne, a clinical computer system used by healthcare professionals in primary care. This meant NHS staff could have access to information on people’s care and treatment needs without the delays caused by having to request information directly from other primary care providers. It also meant that staff could record actions they had taken to address a person’s needs directly on the system, resulting in people receiving a seamless service.
- Mandatory training records dated August 2016 recorded that 100% of staff working in CAS had completed up-to date mandatory training in ‘information governance’, this was above the trust target of 85%.

- The CAS used a paper light records system. SystemOne was used for allocation of patient visits and appointments. Care plan records were kept in people’s homes. This meant there was a risk that people’s care plan records may not be congruent with their electronic record. Staff told us the trust had trialled mobile working, but there had been problems in some rural areas. However, work was in progress to identify a new mobile working system.

Cleanliness, infection control and hygiene

- CAS were compliant with the “Code of Practice on the prevention and control of infections and related guidance” issued by the Department of Health in 2010.
- Mandatory training records dated August 2016 recorded that 100% of eligible staff had completed mandatory infection prevention and control training, which included hand hygiene, against the trust target of 85%.
- We saw that premises where patients were treated were visibly clean and hygienic. We saw cleaning schedules that clearly set out how and when premises and equipment should be cleaned. Patients we spoke with did not raise any concerns in regards to the cleanliness of the CAS clinics or health centres.
- We saw that shared equipment, for example scales and blood pressure equipment, were labelled to indicate when they had been cleaned and that they were ready for use.
- We observed that clinic environments and offices we visited had adequate supplies of personal protective equipment (PPE). We observed staff using PPE appropriately in clinics. We also observed staff carrying adequate supplies of PPE, and using PPE when they visited patients at home.
- We saw that all the premises we visited had adequate hand-washing facilities and supplies of hand sanitizer for staff and the public to use.
- A private provider provided cleaning services. The estates manager told us services had introduced a monthly environmental checklist, which was completed by clinicians. The manager told us the results were analysed and any concerns were addressed

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immediately with the private cleaning provider. The manager said the provider did their own audits, but services had also introduced a checklist to ensure standards of cleanliness were being adhered to.

- Staff told us they trust provided them with uniforms annually or if they required a different size of uniform. A staff member told us, “There used to be some staff that didn’t wear uniform, they called it ‘mufty’, but they are phasing that out now.” All the staff we spoke with were wearing clean uniforms and observed the trust’s arms bare below the elbows policy.

Mandatory training

- Staff told us they could access their training records electronically on the trust’s electronic staff record system. Staff could request further training in addition to their mandatory training if it was relevant to their role.
- There were 15 mandatory training modules for CAS including fire safety; infection control; incidents reporting, safer swallowing, and violence and aggression. Overall, the completion rate for CAS was over or met the 85% trust target in 11 of the 15 modules and all modules were completed by at least 81% of staff requiring the training.
- Nursing staff had a training completion rate of 91% overall and achieved 100% in many modules. The only subject which was below the trust target of 85% was waste management where the completion rate was 68%.
- Managers told us staff were supported to attend mandatory training within their working hours.
- Staff we spoke with told us they were supported to complete their mandatory training by their managers and they received reminders when it was due.

Assessing and responding to patient risk

- Community based staff we spoke with were able to demonstrate awareness of the key risks to patients, for example, risks of falls and pressure damage. We viewed four patient records during home visits. As part of our review of patient records, we found that risk assessments were fully completed for each patient. These included skin integrity, nutrition, pain assessments, falls risks, and activities of daily living.

- Patients who were at risk of deteriorating were identified on SystemOne, as well as at district nurse hand-overs to out of hours district nursing services. SystemOne had an instant messaging service for administrators to contact specialist staff if they required advice.
- All patients received a skin assessment. Patients with a Waterlow, this is a tool that gives an estimate of the risk of a patient developing a pressure sore, score of 10 or above remained open to the district nursing service.
- Patients with airflow cushions or mattresses, equipment that alleviates pressure on the skin, were visited by the district nurse monthly or more frequently where required, for skin assessments. Patients who were fed by these are tubes used where patients cannot maintain adequate nutrition with oral intake) also received more frequent visits.
- Patients who were mobile who had static equipment aids and adaptations in the home stayed open to the district nursing team for a minimum of 12 weeks to ensure they were not at risk. If risks were identified the patient would remain open to the team, if no risks were identified and the patient was stable, the patient would be discharged.
- The podiatry service showed us a pain tool they used to assess a patient’s level of pain. Staff told us people were asked if they were experiencing any pain at every appointment and people who reported any pain would receive a pain assessment. We did not view any completed patient pain assessments. However, we viewed the podiatry pain assessment tools and staff explained how these would be used in practice.
- Podiatry patients assessed as ‘high risk’ or who were in the ‘ulcerated’ category had a dedicated telephone line they could contact to ensure they could speak to the team without delay.
- The risk of patients acquiring pressure ulcers was identified as a primary concern for community patients. Pressure ulcers assessed as a severity of grade three or above were referred for investigation as a serious incident and a RCA was undertaken.
- Referrals from G.P’s and hospitals were immediately logged onto SystemOne, which identified patients who

Are services safe?

were at risk of deteriorating. Staff at Ward 10 Solihull Hospital demonstrated how the patients' record system carried alerts for staff to identify patients who were high risk.

Staffing levels and caseload

- As at August 2016, Heart of England NHS Foundation Trust, out of hospital services reported a vacancy rate of 5% for HCA's and a vacancy rate of 2% for nursing staff. Planned care services reported a vacancy rate of 7% for HCA's and a vacancy rate of 5% for nursing staff. Management services report a vacancy rate of 0% for nursing staff.
- As at August 2016 the trust reported a turnover rate of 0% in community health services, dental services, for HCA's. Out of hospital care services reported a turnover rate of 3% for HCA's and a turnover rate of 16% for nursing staff. Planned care services reported a 0% turnover rate for both HCA's and nursing staff.
- From April 2015 to March 2016 the trust reported an average sickness rate of 0% for HCA's in dental community health services. Out of hospital services reported an average sickness rate of 8% for HCA's and 4% for nursing staff. Planned care services had 0% sickness rate for both nursing and HCA's in the same period. Community services management reported 0% average sickness rate between April 2015 and March 2016.
- The trust reported as of August 2016 they were at 100% establishment for junior medical staff in community dental services. Senior and career medical staff reported an establishment rate of -147% indicating that the senior career staff group in community dental services was overstaffed.
- The trust reported a turnover rate of 0% in community health services in August 2016. Both community dental services and out of hospital services reported a 0% turnover rate for junior medical staff and senior and career medical staff.
- Community dental services reported a sickness rate of 0% between 'April 2015 and March 2016 for all medical staff. Out of hospital service reported a 0% sickness rate for both HCA's and nursing staff between 'April 2015 and March 2016.
- We looked at staffing rotas for the month of October 2016. We saw they were constructed to ensure there were appropriate numbers of staff at appropriate grades on duty to carry on the service. We saw rotas had been amended in the light of unforeseen absences to ensure that the service could continue to operate safely.
- All district nursing teams were skill mixed, comprising of one Band 6 and a number of Band 5s, based on the practice population size and geography. Teams also had access to Band 3 Health Care Assistants (HCA). Information on the skill mix and district nurses' caseloads was routinely collected and reviewed by operational managers. Caseloads were managed via SystmOne patient records. The care plan and visit schedule provided details of acuity and the number of home visits that needed to be allocated.
- Locality leads and operational managers assessed the level and acuity of caseloads, and allocated staff resources to meet the needs of all teams. Workload and the complexity of the caseload were discussed and where necessary staff, or patient visits were reallocated to ensure patients' needs would be met.
- When we spoke with staff they all reported that recruitment and retention was good.
- The CAS staffing spreadsheet recorded that CAS nursing services were fully staffed in September 2016, with the exception of the RRT which had a 0.5 whole time equivalent (WTE) vacancy for a Band 3 HCA and the rural district nursing team which had a 0.8 WTE Band 3 HCA vacancy. Managers told us the posts were in the process of being recruited to.

Managing anticipated risks

- The service managed foreseeable risks and planned changes in demand due to seasonal fluctuations, including disruptions to the service due to adverse weather. Staff told us that SystmOne identified vulnerable patients and calls would be allocated on the basis of care and complexity, this ensured the needs of vulnerable and highly dependent patients were met during the winter and during heatwaves.
- CAS had a winter plan in place. This included community staff having access to 4x4 cars to maintain staff safety and to support access to patients in all community settings; the plan also provided telephone

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access to specialist services, which would provide advice to patients and staff during adverse weather. Planning included using staff that may be snowbound to visit patients in the area where they lived who were within walking distance.

- District nursing teams received 'lessons of the month' information and this was displayed on the office noticeboards. For example, the September 2016 lesson was, 'Do you know how to screen for sepsis.'

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 rated effective as good because:

- National guidance from the government, the National Institute of Health and Care Excellence (NICE) and professional bodies were complied with and Community Adult Services (CAS) staff showed awareness of relevant guidance in their work. Staff were actively engaged in activities to monitor and improve quality and outcomes. For example, district nurses used the SSKIN bundle, this was a five step model to reduce incidents of pressure ulcers and endorsed by NHS England.
- Overall, the quality of care was monitored through audits, which informed the development of local guidance and practice. Patients could access all professionals relevant to their care through a system of integrated multi-disciplinary teams; and that patients' care was co-ordinated and managed. There were systems in place where patients lacked the capacity to give consent, and arrangements to ensure that staff acted in accordance with their legal obligations.
- Staff were supported through supervision and meetings with their manager and most staff had received an annual appraisal. Staff were encouraged and supported by the organisation to gain qualifications relevant to their role, and staff in senior positions held appropriate qualifications. There were robust systems to ensure professional staff remained registered with the relevant professional body. Staff had good access to patient information and policies and procedure on electronic systems.
- relevant codes of practice. Staff used nationally recognised assessment tools to screen patients for certain risks. For example, MSK risk criteria were completed using templates that followed national guidelines. District nursing service the SSKIN bundle, this was a five step model to reduce incidents of pressure ulcers and endorsed by NHS England.
- Staff we spoke with understood how NICE guidance informed local guidelines. We observed staff following appropriate assessment guidelines when delivering care to patients. We saw copies of relevant documents were available at bases for staff to reference, and staff told us they could also access this via the trust's intranet site. For example, Friars Gate district nursing offices had guidance displayed on the noticeboard for staff including, 'A guide to incident reporting – what you should report and why'; and 'Information required for reporting pressure damage.'
- Staff received the minutes of meetings where guidance was discussed; these included changes to practice which might affect their area of work.
- We observed the care for people at risk of falls was broadly compliant with guidance from the National Institute of Health and Care Excellence (Falls: assessment and prevention of falls in older people CG 161).
- Clinical procedures undertaken by community nurses were based on best available evidence within the Royal Marsden Manual of Clinical Procedures. Community Nurses followed NICE guidelines and specific guidelines for Long Term Conditions Management, for example, the Palliative Care Gold Standard Framework. Staff could access guidance and pathways for certain long-term conditions on the trust intranet.
- Staff at the podiatry service told us care for diabetic foot care was aligned to NICE recommendations 1.3.6 and they had introduced risk criteria to ensure their practice reflected best practice guidelines.

Detailed findings

Evidence based care and treatment

- All CAS services worked to Heart of England NHS Foundation Trust policies and procedures, which were developed to reflect relevant guidelines issued by the National Institute of Health and Care Excellence (NICE), government departments and professional bodies. Staff understood their individual roles and responsibilities in the delivery of evidence based care. Staff referred to

Are services effective?

- The community dental service used the world health organisation (WHO) checklist, this is a tool used to reduce the risk of complications during surgery, for patients receiving general anaesthetic or intravenous (IV) sedation.
- The CAS were in the process of producing a range of standard operating procedures (SOP's), these are a step-by-step description of all the processes that take place which all staff are expected to follow; and therefore minimise any risks, errors or misunderstandings that may occur.

Nutrition and hydration

- We saw examples where, on initial assessment, potential risks of malnutrition and possible dehydration were identified and actions were taken to address these concerns.
- We saw patients were assessed for risk of malnutrition using a validated, nationally recognised risk assessment, the 'malnutrition universal screening tool' (MUST) in services where this was appropriate, for example community nursing. The patients' nutrition and hydration assessments we viewed were completed appropriately. We saw that care plans were in place for nutrition and hydration and reviewed regularly.
- Where a need for additional support with nutrition and hydration was identified, for example with diabetic patients, community and specialist nursing staff referred patients to a dietitian, who provided practical advice for patients about healthy food choices and worked with patients to change their eating habits.
- Information leaflets and posters about nutrition and hydration were available to patients in clinics we visited.

Patient outcomes

- Information about the outcomes of people's care and treatment was routinely collected and monitored. For example, all community teams completed a monthly 'essential steps' audit. The audit reviewed staff practice in regards to infection prevention control, sharps practice, and catheterisation. The results of the audits were monitored by the divisional lead and feedback at the 'quality and performance' meeting. Local managers told us they also fed back results of the audits at team meetings.
- CAS completed a monthly audit 'Back to the floor'. As part of the audit three members of staff were reviewed,

this included uniforms, whether dressings and other equipment they carried on visits was in date. Three patients' care plans were also reviewed as part of the audit, as well as tissue viability care and nursing care. The 'Back to the floor' audit target was 95%. We viewed the audit results from February to July 2016 and found that the services 95% target had been achieved in each of these months. The average result in the previous 12 months was 97%.

- CAS completed monthly 'Essence of care' audits. These were based on national guidelines and allowed CAS to benchmark their services against national indicators. We viewed the essence of care audit results for CAS from May 2016 to September 2016. These indicated that CAS services regularly achieved 100% compliance across all benchmarks, including patients' privacy and dignity, communication and tissue viability. The audits also recorded that the service had achieved 97% compliance in nursing care from May 2016 to June 2016 and in September 2016; 100% compliance had been achieved in July and August 2016.
- The CAS has a monthly governance meeting. Patient outcomes performance measures as well as internal audits were a standard agenda item at the meetings. For example, the October 2016 meeting minutes recorded that the divisional managers and team leads had discussed the CAS scorecard activity. This is a patient level data set which delivers robust, comprehensive, nationally consistent and comparable person-based information on patients who are in contact with community services. The minutes recorded that the CAS performance against the services key performance indicators (KPI) were achieving 99% of their targets with the exception of 'You+' health checks for people aged 40 to 74 years, where 67% of the checks had been completed.
- The CAS used a dashboard to monitor patient outcomes. We viewed the dashboard performance report in the October 2016 governance meeting minutes. This reported that the CAS service was achieving trust targets in regards to safety and quality outcomes. For example, from April to September 2016 an average of 96.2% of palliative care patients had a supportive care pathway completed; 99.5% of RRT patients had a discharge summary completed.

Are services effective?

- CAS also had work in progress on an audit of patients seen at home who did not fulfil the criteria of 'housebound.'

Competent staff

- We saw records that showed 100% of staff had attended a corporate induction programme. A corporate induction was completed by staff joining the service. Staff told us new staff also received an induction at locality level.
- From April 2016 to September 2016, 100% of community planned care staff had received an annual appraisal compared to the trust target of 85%.
- Between April 2016 and September 2016 community dental services medical and dental staff had an appraisal rate of 75% while 'other' staff had an appraisal rate of between 87% and 100% respectively. The trust target was 85%.
- Data from September 2016 demonstrated that 89% of community out of hospital staff had received an annual appraisal; this was above the trust target of 85%.
- We saw there was a process to assure the organisation that its registered staff remained registered with relevant professional bodies. Staff and managers were advised when trust records indicated registration was due for renewal and re-registration was verified. A district nursing team lead demonstrated how the system worked and was monitored.
- Staff told us they were supported to gain further qualifications relevant to their role. We saw that senior community nurses held specialist qualifications, and we spoke with a number of staff who had been supported to become non-medical prescribers.
- Patients we spoke with expressed confidence in the skills and competence of those caring for and treating them. A typical comment was, "I think they know what they are doing."
- Staff training and development was supported. We found the service encouraged skills development. Staff of different grades confirmed that training needs were identified as part of appraisal, and staff could request further training that was relevant to their role. Staff were supported to continue their education. For example,

staff at the RRT team told us there was a Band 5 and Band 6 development pathway for nurses to train as community matrons. Staff also told us some staff were being supported to study at University.

- Staff told us individual supervision took place every four to six weeks, and there was regular supervision in team meetings. However, staff at the district nursing team in Balsall Common told us clinical supervision was ad hoc and on an as required basis. Staff said they would receive clinical supervision upon request.
- District nursing teams had developed competency assessment tools for each nursing band. District nursing staff had developed a competency framework for HCAs to ensure they were competent to complete patient checks.
- Band 3 HCA's worked independently in the community with support from district nurses. A manager told us all HCA's were trained in doing pressure area checks, trained in the use of equipment, and trained in assessing people's Waterlow scores for pressure area care.

Multi-disciplinary working and coordinated care pathways

- District nursing staff had regular multidisciplinary team (MDT) meetings with GPs. Staff told us GPs would arrange the meetings and request a district nurse attend. Staff said this was usually in response to the need for strategic planning for a patient with complex needs.
- We found that RRT staff were co-located with district nurses, community mental health nurses, community matrons which facilitated a joint approach to providing holistic care that met the needs of patients and their families and carers. We observed interactions between these staff groups which enabled them to respond quickly to the needs of patients, especially when these were changing.
- District nurses and the RRT had daily handovers to ensure both teams were aware of each other's caseloads.
- Specialist nursing staff provided support for community clinics and professional advice for district nursing colleagues to support multi-disciplinary working and

Are services effective?

the use of best practice for patients. For example, the tissue viability team or the falls risk team. Nursing staff told us they felt well supported by other professional staff that provided multi-disciplinary support.

- Specialist clinical leads worked effectively in multi-disciplinary teams. For example, the clinical lead for the specialist podiatry service maintained links with other specialists including physiotherapists and occupational therapists.
- District nursing, multi-disciplinary team meetings could be convened to address the needs of patients with complex care needs.
- Community adult services had a community mental health nurse who worked as an integral part of the team. The nurse worked with a clinical psychologist weekly and joint worked with patients in the community; this included the psychologist visiting patients in their own homes.
- Community matrons had a weekly MDT meeting with staff from Solihull hospital to discuss patients ready to be discharged into the community.
- The estates manager told us they had, “strong links,” with the community clinical leads and regularly liaised with them about room bookings and matters relating to community service buildings.

Referral, transfer, discharge and transition

- Referrals for in hours community nursing in the ‘Rural Central’ district nursing team were made directly to the team, 9.00am to 5pm Monday to Friday. Staff told us most referrals were from GPs.
- Staff would telephone the patient to arrange an appointment visits. A qualified district nurse was allocated for all first visits.
- The hub at Ward 10 Solihull Hospital provided a single telephone number for referrals to community services. This had the aim of making it easier for people to know where to call to get the correct help. Services responded quickly and waiting times were low.
- Referrals in hours at Balsall Common Clinic, Castle Bromwich Clinic, Chelmsley Wood Primary Care Centre, and Friars Gate Clinic went directly to the team, who triaged and either arranged a visit, or referred on to the most appropriate service.
- The RRT facilitated hospital discharges and provided same day care or therapy support to patients who had

been discharged. Access to the service was via referral from the hospital. . Urgent referrals for immediate response were allocated through a MDT process to determine the level of action required and the appropriate management of risk.

- The community nursing service had an urgent two hour response time for patients on the caseload, for example, patients receiving palliative care or with blocked catheters. CAS told us that if an urgent task was received, the team taking the referral would contact the patient to establish the nature and urgency of the call and to provide interim advice. Non-urgent calls would be offered an appointment for a visit for a specific day based on treatment required. Calls to the night nurse would be seen between 7am and 9am by community nurses, this time was ring fenced for urgent calls.
- CAS had referral pathways and procedures in place. Referrals to community services were from a variety of services including GP’s, practice nurses, district nurses, patients being discharged from hospital, complex cases in nursing and residential care homes, and others including the police. Staff told us there were clear criteria for referral of patients which meant that inappropriate referrals could be identified.
- The CAS hub facilitated hospital discharges and reduced long-term care. Nurses in the hub could arrange domiciliary services to prevent avoidable admissions to hospital; and could ensure access to community nurses 24 hours a day. Staff from the team told us they worked closely with the discharge nursing teams at the trust’s acute hospitals.
- Patients were discharged from the community nursing caseload if they were admitted to hospital. Community nurses liaised with the hospital ward to support patients’ admission. If a patient was due to be discharged to their home, the acute hospital would refer to the hub.
- The community based musculoskeletal physiotherapy (MSK) service offered individual assessments, advice and a range of treatments including acupuncture to adults. The service provided appointments to patients in a range of locations, including community clinics, GP surgeries and patients’ homes.
- We viewed the MSK referral pathway. This outlined the patients’ journey through the MSK service. We observed

Are services effective?

patients attending a MSK clinic. The service accepted self-referral; however, most patients using MSK services were referred by a health care professional. We saw patients receiving full physical examinations. During the observation we saw MSK staff explaining treatments to patients in accessible language, as well as agreeing future care and treatment plans with patients.

- Staff at the community dental service told us most referrals were from local general dental practices. The service also accepted referrals from Macmillan nurses for palliative care patients.
- Community mental health nursing services took referrals from GPs, RRT, and district nurses. The mental health nurses provided a pathway into specialist mental health services.
- The podiatric service clinically triaged all patients. Staff told us 90% of podiatric referrals were by fax from GP's. Staff said all referrals were triaged within 24 hours, with the exception of an ulcerated open wound, which would be triaged the same day. Podiatry had "embargoed" appointments every day to enable them to see patients requiring an urgent appointment. Patients received a letter informing them of the date and time of their first appointment, successive appointments would be booked at the time of their appointment for patients assessed as 'high' risk. However, 'moderate' risk patients would be informed when their next appointment was due and would make their appointment by contacting the trust's central booking office.
- Patients and carers we spoke with told us that they did not experience difficulty getting care and treatment when they needed it. One patient told us, "They come as quickly as they can." Another said, "It's not like the hospital, you are in and out fairly quickly."
- Staff told us the CAS service had run a trial on offering extended hours in some clinics to enable people with work or other commitments to attend when it was convenient for them. However, this had not been implemented due to a lack of demand, and patients saying they did not want to attend clinics out of hours.
- Patients we spoke with told us that clinics ran on time and services visited when they expected. A patient said, "I'm seen promptly, it's straight in and straight out;" Another patient said, "They let you know if they are delayed with another patient."

- Staff we spoke with told us that visits were rarely cancelled as they were able to pass on any uncompleted work to the out-of-hours teams. Patients did not tell us that missed or late calls were a frequent occurrence.
- CAS told us they did not routinely collect data on the number of patients in the community that were discharged and readmitted to hospital within seven days.

Access to information

- Staff at the RRT service and district nurses demonstrated how they could access all the information needed to deliver effective care and treatment in a timely and accessible way. For example, we viewed patient's paper based notes in their homes and saw these included care plans and risk assessments. District nursing staff also demonstrated the use of SystmOne to gain access to case notes and patients test results.
- Staff told us that having access to the SystmOne record systems, had improved patient access and reduced the amount of paperwork district nurses had to complete. Referrals from G.P's and hospitals were immediately logged onto SystmOne. Staff said work was in progress to introduce auto-allocation which would bring e-rostering and SystmOne together and enable teams to allocate work on the basis of staff banding, to ensure a suitably qualified member of staff attended each patient, whilst also allocating staff on the basis of postcodes, to make the system more efficient for patients and cost effective for the trust.
- The RRT service demonstrated how the SystmOne record system carried alerts for staff to identify patients who were at risk of deteriorating. GP's could refer patients directly to the RRT service if they thought a patient would benefit from extra support.
- District nursing staff told us they had trialled mobile working, but there had been issues with the system used. Staff said there was work in progress to introduce a new mobile working system, which would increase their ability to deliver effective care and treatment by improving access to patient records whilst working in the community.
- Staff told us the trust intranet was a useful source of information and allowed them access to tools. For example, a local team lead told us, "The intranet is fabulous, we can access Health Roster online."

Are services effective?

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Overall, staff we spoke with were aware of their responsibilities in relation to the Mental Capacity Act 2005 and could describe how they applied it in their daily work.
- We did not see figures for the percentage of staff that had completed training in mental capacity. Staff told us this was covered in their level 2 safeguarding training. 100% of nursing and therapy staff had completed the level 2 training.
- We found there were procedures in place for patients who lacked capacity to have access to an Independent Mental Capacity Advocate (IMCA) when serious

decisions about their health and welfare needed to be made in their best interests. We did not see evidence of the referral rates or patterns of CAS overall performance in regards to IMCA referrals.

- We found patient consent forms had been signed by the patient or their relative and representative. Consent was also recorded on SystemOne. We also observed staff gaining verbal consent before providing care in clinics.
- We attended four home visits with DN's and observed staff asking patients for their consent prior to providing care or treatment.
- Staff told us the local authority would inform them if a patient had a power of attorney in place, and a copy of the document would be placed in the patients file.

Are services caring?

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

Summary

We rated caring as good because:

- Community Adult Services (CAS) showed good standards of caring. This was because patients and carers we spoke with were positive about their experience of care and treatment, and feedback gathered by the organisation showed high levels of satisfaction. We viewed Friends and Family Test (FFT) results August 2016; the average score for people who responded that they would be likely to recommend community services was 97%.
- We observed staff responding to people with kindness and compassion. Patients told us they were treated with dignity and respect, and that they were involved in the planning and delivery of their care to the extent they wished to be. Staff were aware of the emotional aspects of caring for patients.

Detailed findings

Compassionate care

- Patients and carers we spoke with were positive about the care and treatment they received from CAS. Words and phrases such as “polite,” “professional,” “very caring,” were used in their feedback. A community nursing patient said, “I could not possibly have had better care.
- We accompanied staff on four home visits and observed that staff were respectful of patients’ homes, and that matters of dignity were given due consideration.
- We observed a podiatrist providing a follow up appointment with a patient. We saw the podiatrist displaying rapport with the patient and responding to the patient with kindness and compassion.
- Community services scored between 96% and 99% in the Friends and Family Test (FFT) between August 2015 and July 2016 against an England average of 95%.

Understanding and involvement of patients and those close to them

- Comments from patients responding to the patient satisfaction surveys and the FFT indicated they received the information they needed. A typical comment was, “Everything was explained in great detail, I fully understood the options that were available to me.”
- We attended four home visits and saw staff demonstrating good communication skills during the examination of patients. Staff gave clear explanations and checked patients understanding.
- We saw district nurses taking time to clarify patients understanding of their care and treatment; carers we spoke with told us they were reassured by the nurses’ knowledge and advice.
- In our discussions with staff, patients and carers we found that there was an appropriate rehabilitation focus and that patients were encouraged to be partners in the planning of their care and enabled to participate in care activities.

Emotional support

- We observed staff providing emotional support to patients and to relatives. Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed.
- During home visits we observed staff responding to people in a kind and compassionate manner. All the patients and carers we spoke with were positive about the emotional support the community staff provided.
- A specialist community mental health nurse provided mental health interventions and support for patients with physical health issues.
- A patient comment was recorded in the August 2016 CAS patient experience report as, “I felt such relief when I spoke to the members of staff, I felt they helped me with my personal issues, it felt like I was in a counselling session.”

Are services responsive to people's needs?

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

Summary

We rated responsive as good because:

- Community adult services (CAS) had a model of integrated hub community teams to ensure people received joined up working that was responsive to patients' individual needs. There was a focus of providing services close to where people lived and at times that were convenient to them. There was provision to ensure that essential services were available out-of-hours, and there were no major issues with waiting lists, with the exception of podiatric surgery where the service were not meeting their 18 week target for a few patients.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met needs and promoted equality. This included people who are in vulnerable circumstances or who had complex needs and patients for whom English was not their first language. Feedback from patients was actively sought and acted on. Complaints were investigated and responded to; staff were made aware of the issues raised by complaints.

Detailed findings

Planning and delivering services which meet people's needs

- CAS had a 'community hub' model of integrated health care teams to ensure people received joined up working. The aim of the service model was to improve patient outcomes and experience through bringing existing community health services into a more combined way of working. The aim of the model was to reduce the number of different health professionals patients needed to interact with, reduce duplication of work, and ease patients' transition from hospital to home.
- Staff told us they worked with local service commissioners, including local authorities, GP's, and other providers to co-ordinate and integrate care pathways. The service had arrangements in place to facilitate patients who required support from mental health services or local authority social services.
- The rapid response team (RRT) was part of the community hub and provided 24 hour care to prevent patients living in their own homes and under the care of their GPs, from being admitted into hospital if they became unwell and were safe to remain at home.
- The hub had two community matrons who worked with the district nurses on preventing hospital admissions by taking referrals from GPs. The community matrons also worked with staff on the wards at Solihull hospital in ensuring the prompt discharge of patients who could be cared for in the community.
- The hub also integrated the hospice at home service. This gave additional support to patients nearing the end of their life to help them either stay at home or leave hospital if they had already been admitted. The team worked closely with GPs, district and community nurses, Macmillan nurses, community matrons and the Marie Curie Hospice to deliver care for patients in their preferred place.
- The supported integrated discharge (SID) team had a pathway to 48 nursing home beds across three sites. The trust provided extra nursing to the nursing homes, which provided an environment where specialist carers could focus on patients' assessment, rehabilitation and re-ablement.
- Ward 10 staff at Solihull Hospital could arrange packages of domiciliary care for patients who were returning home.
- Senior managers told us the trust worked very closely with both the Clinical Commissioning Groups (CCG) and held regular meetings with the local authority to review population data, disease prevalence and service modelling to reflect local needs. Examples of this were for the podiatry service where more specialist care was provided by the trust and other routine services were provided by a private provider.
- Out of hours district nursing services were available to those patients who had been referred to the service by a health professional. Existing patients who were attended to by a district nurse could call the service Monday to Friday between 16.30pm to 9pm, and all weekend and Bank Holidays.

Are services responsive to people's needs?

- The community dental service worked across four sites, as well as two mobile dental units to provide dental care for patients requiring specialist dental care. The dental service also provided home visits to patients who were housebound.
- The estates manager told us there were proposals for Hurst Lane clinic to close and to move to a new purpose built clinic in Smithswood Lane, which was local to Hurst Lane. The manager told us the trust were in the process of finalizing planning for the proposal prior to submitting it to the local authority for planning permission.
- We saw there were displays and leaflets covering condition-specific topics, general health advice and signposting to local health and social care services.
- SystmOne had a recall system for patients with dementia, this meant patients with dementia would be automatically rebooked for their next appointment.
- The community mental health nurse worked with patients with dementia and mental health issues.
- The community dental service provided specialist dental care for patients with challenging behaviour, medically compromised patients, patients with anxiety or cognitive impairment, and patients with learning disabilities. The service provided a monthly clinic for patients with special needs who required general anaesthetic.
- There was a wide range of printed information available to patients in the clinics we visited. For example, clinics had copies of the trust's 'news' newspaper in patient waiting areas. We also saw information on healthcare options, explaining to patients the health care options that were available in the area before they visited the hospital's emergency department This included explanations of NHS 111 services and pharmacy services, as well as which services to contact about specific symptoms including patients own GPs.

Equality and diversity

- Staff we spoke with were aware of the need to obtain interpreting services when required and could describe the process for doing so. This meant that patients whose command of English was insufficient to ensure they could communicate their needs, symptoms and experience were supported.
- Equality and diversity training was mandatory for all staff. Overall 84% of in CAS had completed training against a trust target of 85%
- Staff told us all of the trust's printed information was available upon request in any language from the trust's accessible communications team.
- Premises contained adequate waiting facilities with comfortable chairs and patients had access to drinks and other refreshments.

Meeting the needs of people in vulnerable circumstances

- Services were provided by nurses, social workers and other professionals who worked with patients both in the home and in primary care settings such as clinics and GP surgeries. Staff told us a range of leaflets had been produced in easy read format and were available from the trust's accessible communications team.
- Podiatry provided sessions exclusively for people with learning disabilities to provide them with a quiet calm environment and minimize any anxiety they may be experiencing.

Access to the right care at the right time

- The CAS informed us that patients did not routinely wait to be treated by the community nursing service. The service responded when the patient needed to be seen. Community nursing services were available 24/7, this meant patients could access care at any time, and they, or other health and social care professional could contact the community nursing service at any time if required.
- District nurses could take rapid response calls 24 hours a day. The night nurse would provide "make safe" calls at night and the RRT would prioritise the patients at 9am, when the RRT resumed. Staff told us they had trialled RRT out of hours, but most referrals to the team

Are services responsive to people's needs?

were from GPs and came in during GP hours. The response time for the RTT was within two hours. Staff told us they were achieving 100% of the response time target.

- District nurse home visits would normally take place between 9am and 5pm Monday to Friday. Staff told us patient needs would determine what time they were visited, for example if a patient needed an injection at a certain time. Patients who needed a visit outside of DN hours, were visited by the DN out-of-hours team.
- The out of hours team worked from 5pm to 11pm. The night nurse covered calls overnight. The out of hours team had administrative support until 9pm. A nurse in charge was available on the phone to support staff out of hours for the period they were on duty. However, staff said the night nurses would have to deal with any calls to the service out of hours, not just out of hours calls, once the administrator went off duty.
- Between 11pm and 9am the night nurse would attend on a 'make safe' call. The RRT would prioritise calls attended by the night nurse when the service resumed in the morning.
- CAS informed us that community nursing services had an urgent 2 hour response time for patients who were in receipt of palliative care or who had a blocked catheter. If an urgent task was received the team would contact the patient to establish the nature and urgency of the call and to provide interim advice. For non-urgent calls these would be booked visits for a specific day based on the treatment required. For new referrals, if a timescale was not indicated on the referral, then the patient would be contacted to establish when a visit was required.
- The continence service provided assessment for patients with bladder or bowel problems, as well as a home delivery service which provided continence products direct to patients homes. The service was achieving 99% of their targets for first face to face visits.
- The RRT provided immediate support to enable people with a sudden illness, medical condition or change in circumstance who were at risk of hospital admission, to remain at home. Typically the team's involvement lasted for a maximum of 72 hours.
- Podiatry told us there were waiting lists for patients assessed as 'moderate need.' The average waiting time on SystemOne for these patients was 10 weeks. However, the waiting list for nail surgery was four weeks.
- Podiatric surgery staff told us there were delays to podiatric surgery due to a shortage of anaesthetists. However, work was in progress to produce a business case to provide further anaesthetist sessions. The podiatric surgery dashboard indicated that in October 2016, 65 patients were due surgery and two of these had breached the trust 18 week target. One patient had waited 19 weeks and another patient had waited 27 weeks. In 2017 the situation had improved, but there were still one or two patients in May and July 2017 that would have waited over 18 weeks for surgery.
- Staff told us some patients had already had to wait for treatment and then had a further wait for their surgery, the time they had waited for their treatment was not added to their surgery waiting time. Hence, some patients may have had longer waits than the podiatric surgery dashboard indicated.
- The MSK team worked across six sites including a nursing home and had a waiting time of two to four weeks. Staff told us the service had trialled providing clinics in the evenings, but there had been low uptake of evening appointments and the clinics had been withdrawn.
- The community dental service sent a standard letter for patients' first appointment. Patients that did not attend (DNA) appointments were sent a letter explaining the impact non-attendance had on the service. Patients would be offered a further appointment with a letter explaining if the second appointment was missed the onus was on the patient to make an appointment.
- District nursing teams had access to a visual display unit (VDU) in all offices. The VDU displayed staff schedules on a daily basis. This enabled managers and supervisors to quickly identify staff with capacity in their schedules and meant urgent calls could be allocated quickly. Managers told us the system was still in development, but was useful. The system also allowed managers and supervisors to see staff schedules in other area offices, this meant staff from other offices could be utilised in the event of an area's schedules becoming full.
- Staff we spoke with told us visits were rarely cancelled as they were able to pass on any uncompleted work to the evening or out-of-hours team. Patients did not tell us missed or late calls were a frequent occurrence.

Are services responsive to people's needs?

- Patients we spoke with told us that clinics ran on time, or that services visited when they expected. A DN patient we visited in their home said, "They phone if they've been delayed."

Learning from complaints and concerns

- Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was not included in patients home based care records. However, patients had access to information on accessing an independent complaints advocacy service in all the records we viewed.
- We saw PALS information was available in most of the clinics we visited, including the community dental service.
- Between August 2015 and September 2016 there were 14 complaints about community health services. The trust took an average of 33 days for the first response and 40 days to closure, this was not in accordance with their complaints policy. One complaint took 137 days to investigate and close. The trust was aware of the shortfall and had undertaken focussed work to reduce the backlog.
- As at August 2016 there were four complaints open. The complaints had been received in February, April, May and July 2016. This meant the complaints could not be resolved and closed within the timescales set out in the trust's complaints policy.
- Community nursing services had received four complaints in the period August 2015 to September 2016; this was the highest rate of complaints to individual services. Followed by community liaison nurses who had received three complaints in the period.
- Communication and information problems accounted for the highest number of complaints, (4), followed by complaints relating to staff attitude and behaviour, (3), and two complaints relating to nursing care.
- Staff told us the trust's approach to dealing with complaints had changed in the previous 12 months. The trust "were keen" for staff to meet face to face with formal complainants, and complainants would be asked if the meeting could be recorded. Staff told us they thought this was for training purposes and would always gain consent prior to recording a meeting. However, staff said they were not fully clear about the purpose of recording a meeting.
- We found that where a complaint had been upheld patients had been offered an apology and this was recorded. The spreadsheet also recorded that the CAS were open and transparent in dealing with complaints and patients had the outcomes of complaints investigations explained to them.
- Staff told us learning from complaints was disseminated in team meetings.

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

Summary

We rated well led as good because:

- Work was in progress on a clear articulation of the strategic direction for Community Adult Services (CAS) and staff felt engaged with the strategy.
- We found evidence of innovative practice and research including community podiatry working in a multidisciplinary team (MDT) in dermatology for patients with epidermolysis bullosa (EB) an inherited genetic condition that makes skin fragile.
- The community adults' leadership drove continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.
- There were systems to ensure good governance and monitoring of standards and performance. There was an effective escalation and cascading of information from the board to front-line workers, and vice-versa.
- We found that there was a positive culture, with staff and managers feeling proud of their work and achievements and speaking well of their colleagues and the organisation. Front-line staff felt supported by their managers to deliver high quality care, and empowered to implement and participate in quality improvement projects.
- Managers, including those at executive level, were described as being visible, open and accessible.

Detailed findings

Leadership of this service

- The chief executive was well known to staff in community services. Staff felt there was clear leadership at executive level. Staff told us the chief executive was approachable. Some staff told us they had attended staff briefings with the chief executive. Staff said the meetings had taken place across trust sites, and the chief executive was committed to community services being fully integrated with acute services.

- Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was effective and staff said their direct line managers were supportive. Staff told us the senior management team for community services provided visible leadership to staff.
- Staff in community nursing teams felt their line managers were supportive and accessible. However, some staff told us there had been a lot of changes in senior management in the previous 12 months. A staff member said, "It's hard to keep up with at times."
- Most Band 5 and Band 6 staff we spoke with told us they felt comfortable in their role and well supported in their development.

Service vision and strategy

- The trust had developed a vision and a set of values where quality and safety were the top priority.
- Staff were aware of and able to articulate the trust's values. Staff we spoke with were also aware of work in progress on the CAS strategic plans and the direction of the CAS integration agenda.
- We viewed the work in progress on the CAS elderly care and community services plan 2016-2020. This was a realistic strategy for achieving the trust's priorities and delivering good quality care. The strategy identified the priorities of quality, safety and caring. We noted it contained a concise, but clear vision for integrated care in each locality, as well as an overview of the essential elements of the integration and a description of the operational arrangements to enable the vision to be realised.
- There were systems to monitor and review the CAS plan's strategic progress via monthly departmental and divisional governance meetings. This demonstrated that there was consensus on CAS organisation priorities and an appreciation of how these needed to be implemented at each level of the organisation.

Are services well-led?

- CAS managers we spoke with told us they were in the process of producing a statement of purpose (SOP) for each CAS service to support the work on the CAS strategy. Staff we spoke with told us they felt engaged with service developments.
- Therapy services including MSK had their own strategy which was aligned to the trust strategy. This included ensuring there was a robust system of both clinical and corporate governance.
- Podiatry service staff told us work was in progress on a local vision and strategy for therapies.

Governance, risk management and quality measurement

- Staff told us the trust's division had changed in April 2016. CHS had been placed in Division 4, Medicines. However, therapy staff were in the Therapies division. Senior managers told us there were regular cross divisional meetings and senior managers regularly communicated to ensure the CAS were providing a seamless service.
- We found there was a system of governance meetings which enabled the escalation of information upwards and the cascading of information from the management team to front-line staff. We spoke with a wide range of staff that were familiar with the service's governance structures and felt confident regarding its effectiveness. For example, podiatry staff told us the podiatry team meeting and the podiatric surgery team meeting fed into the departmental business meeting and the directorate meeting, which fed into the trust's board meeting. Staff also told us podiatry was represented on the trust's joint negotiating committee.
- We reviewed the minutes of various governance meetings and found they contained information on incidents, complaints and other critical incidents, the outcome of audit activity and progress against action plans and the review of risk registers.
- Staff told us Division 4 had introduced a monthly directorate delivery meeting commencing in October 2016. We viewed the minutes from the first delivery meeting dated 26 October 2016. The meeting reviewed key areas of concern including pressure ulcers and incidents; the meeting also reviewed key areas of progress, including a planned audit of the rate of incidents and a 'deep dive' review of incidents and recommendations resulting from incidents. The

meeting had also reviewed the CAS 'issue log.' This was a tool the service used to reduce risk and to try and resolve identified risks promptly, and to avoid risks being added to the risk register and staying on there.

- CAS had a risk register in place, there were systems for formally signing off action plans or removing risks from the register which ensured that matters were managed appropriately to their conclusion. The risk register was regularly reviewed and updated. The service's risk register was monitored by the clinical commissioning group (CCG). We viewed the risk register and noted that CAS did not have any risks on the register.
- At a local level there were daily meetings where all relevant safety information was shared with the teams. These were supplemented by weekly and monthly team meetings. We reviewed the formal notes kept of these. Staff told us they found team meetings were a means of keeping up-to-date with local and organisational matters. Staff were positive about team meeting and valued them as a source of valuable feedback and the opportunity to discuss and escalate issues.
- Staff we spoke with were aware of the duty of candour (DoC) and said the electronic incident reporting record prompted staff if an incident required DoC procedures.

Culture within this service

- Staff told us community services had felt like a "bolt on" since community services had been integrated with the trust in 2011. However, staff said the culture had changed under the direction of the chief executive who, "Recognised that community services should be engaged in the same way as acute services."
- Staff generally reported a positive culture in CAS. A manager told us, "Community services tend to just get on with it."
- Generally staff spoke positively of the organisation, their teams and their work. Staff reported that morale was high across CAS.
- Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. Staff told us they were able to put forward ideas and discuss them as a team.
- All the staff we spoke with were positive about community services and felt positive about their role and contribution in this.

Are services well-led?

- Staff said the trust was good to work for, with an open and patient focused culture. Staff said they were consulted and felt involved in decision making processes.

Public engagement

- There were systems for gathering patient feedback and we saw the results of surveys, for example FFT surveys.
- The CAS FFT average performance was generally better than the England average between September 2015 and August 2016. However, some parts of CAS did not return data consistently over the twelve month period, or response rates were very low. For example, community inpatient services did not return data or the numbers returned were too low to be scored in 6 of the 12 months.
- CAS produced a monthly patient satisfaction report which was discussed at departmental business meetings and directorate meetings. We saw that feedback from people who use services; was regularly reviewed at governance meetings and used to inform improvements and learning.
- Staff at the MSK service told us how they had introduced rapid assessment clinics in response to feedback from a patient satisfaction questionnaire.
- We viewed CAS patient satisfaction reports from March to September for 2016. We found that CAS regularly achieved 100% for patient satisfaction and regularly achieved between 90% and 100% for patients recommending the service.
- Community locations had information on how patients or visitors to clinics and health centres could become involved with the trust as volunteer.

Staff engagement

- We saw that teams held regular team meetings and we reviewed the minutes of these. This meant there were opportunities for staff to meet formally to discuss issues pertinent to the operation and development of their service.

- Staff received a daily community team bulletin, this updated staff daily on what was happening across the trust.
- Staff across community services received a monthly newsletter that contained articles and informed staff of events across the trust.
- Staff at the RRT team told us they were offered support and debriefing sessions if they had worked with a difficult or stressful situation. This demonstrated the service were aware of the need to promote staff wellbeing.

Innovation, improvement and sustainability

- Podiatric staff worked in a MDT team in dermatology for patients with epidermolysis bullosa (EB), an inherited genetic condition that makes skin fragile. Podiatry provided specialist footwear and podiatry input to reduce friction on patient's skin.
- District nursing teams had access to a visual display unit (VDU) in all offices that displayed staff schedules on a daily basis. This enabled managers and supervisors to quickly identify staff with capacity in their schedules and meant urgent calls could be allocated quickly.
- CAS had created a 'hub' of primary care provision across the county seven days a week. The model cut across organizational boundaries and included fully coordinated discharge and the SystemOne shared IT system that supported better care in a number of health settings as well as patients' homes.
- District nursing services had worked with district nursing staff from other trusts on a joint formulary for dressings to promote safe and economic prescribing of dressings.
- Some patients we spoke with reported notable improvements in the service they were receiving. For example, a MSK patient commented, "They have definitely improved from when I last visited in 2009. I waited 10 minutes in the waiting room and both the manager and physiotherapist introduced themselves."