

Worcestershire Health and Care NHS Trust

R1A

Community health services for adults

Quality Report

Isaac Maddox House
Shrub Hill Road
Worcester
Worcestershire
WR4 9RW
Tel: 01905 733658
Website: www.worcestershire.nhs.uk

Date of inspection visit: 19th January to 23rd
January 2015
Date of publication: 18/06/2015

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

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

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

Summary of findings

Ratings

Overall rating for Community health services for adults

Good



Are Community health services for adults safe?

Requires Improvement



Are Community health services for adults effective?

Good



Are Community health services for adults caring?

Good



Are Community health services for adults responsive?

Good



Are Community health services for adults well-led?

Good



Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	4
Background to the service	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the provider say	6
Good practice	6
Areas for improvement	6

Detailed findings from this inspection

Findings by our five questions	8
Action we have told the provider to take	22

Summary of findings

Overall summary

We gave an overall rating for the community health services for older adults and the minor injury units of Worcestershire Health and Care NHS trust as good because:

- The trust provides adult community services to support people in staying healthy, to help them manage their long term conditions, to avoid hospital admission and following discharge from hospital to support them at home.
- Services are provided in clinics, outpatient departments and in people's homes.
- The minor injury's unit (MIU) provides a service for a wide range of minor injuries that do not require attendance at the local acute NHS trust.
- The MIU provided treatment or advice to people who presented at this service.
- The services had identified the risks at local level. They had action plans and outcomes in place to manage this.
- The trust management had ensured that learning from serious incidents was shared with front-line staff. This meant that these staff members had the benefit of the results of investigations into incidents.
- Some staff demonstrated a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). When staff assessed the mental capacity of a patient to consent to care and the sharing of information, the assessment was thorough.
- Despite the work pressures staff were compassionate, sensitive and kind to people who use the service.
- Some service managers provided good leadership and were visible and accessible to both people who use the service and staff.

Summary of findings

Background to the service

Background to the service

Worcestershire Health and Care NHS Trust introduced the enhanced care patient pathway in November 2012. The enhanced care teams are responsible for; rapid response crisis intervention, earlier supported hospital discharge, care home admission avoidance and virtual ward case management. Most of the services across Worcestershire were delivered by integrated care teams which provided a 24 hour, 365 days a year service. The teams were located across the trust for example; Wyre Forest in Kidderminster, Worcester, Malvern, Evesham and Pershore. The aim of the services is to provide high quality, short term, rapid-response, emergency services to those individuals who are either acutely unwell or recovering from an acute episode of care and have some potential for rehabilitation and recovery.

Patients were identified by the GP's and admitted to the virtual wards. The virtual wards are overseen by the lead GP for each surgery and the community team. The virtual

wards' aims are to reduce hospital admissions by identifying patients who are at high risk of admission into hospital and treating them more effectively in the community.

We visited the minor injuries units. Patients with a wide range of minor injuries including cuts, grazes, wounds, sprains, strains, minor burns and broken bones could be treated at the Bromsgrove, Evesham, Kidderminster, Malvern or Tenbury locations. These provided treatment or advice to people who presented at this service. This helped to reduce attendance at local accident and emergency departments.

We visited the John Anthony Centre which provides a free and confidential service to people of all ages and backgrounds. The John Anthony Centre provides advice to people on sexual health matters which include testing and treatment for sexually transmitted infections and information on contraceptive methods.

Our inspection team

Our Inspection team was led by:

Chair: Dr Ros Tolcher, Chief Executive Harrogate and District NHS Foundation Trust.

Team Leader: Pauline Carpenter, Head of Hospital Inspection, Care Quality Commission.

The team who inspected this service was a CQC inspector and three specialist advisors with specialist knowledge which included tissue viability, occupational therapy and district nursing.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive community health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services, 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?

Summary of findings

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients.

During the inspection, the inspection team visited:

- People in their home and observed their interaction with staff.
- Spoke with the service managers for each service visited.

- Spoke with 58 other staff members; including doctors, nurses, physiotherapists and occupational therapists.
- Attended a multi-disciplinary team meeting.
- Attended and observed a team meeting.

We also looked at 23 treatment records of patients and reviewed a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider say

We spoke with 21 people who use the service and 12 relatives/carers. We received good feedback from people we spoke with. We spoke with people about the community nursing team and the sexual health team. People and their relatives used the word “Excellent” to describe the care provided. One patient said they were “Very caring”. Another patient said staff were “Excellent and attended to their needs.”

One patient who was having regular support for wound dressing said, “Staff visit regularly” and, “They are always polite and courteous even when I know they are very busy.” One relative said they looked forward to their visits.

Good practice

- Where well-resourced and well managed integrated teams had been implemented, there had been significant improvement in patient outcomes.
- The trust ran a rotational scheme for Band 5 occupational therapists (OT) across the services. This scheme offers OT the opportunity to consolidate skills learnt in training and to experience a range of OT practice prior to specialisation. The objective of the scheme is to offer qualified staff the experience of a variety of work areas to enhance confidence and skills.
- The trust encouraged staff to be involved and participate in research. Two staff occupational therapists had been successful in having their research

into proving the effectiveness of community occupational therapy in the equipment and adaptation setting using the Canadian occupational performance measure printed within the British Journal of Occupational Therapy.

- The stroke team had created a stroke information pack to suit people being diagnosed with stroke. The information pack is made up of three books which covered; being diagnosed and learning about stroke, rehabilitation and life after stroke. We saw that the books were in an easy to read format with pictures as visual aids.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

- The trust must ensure that medicines stored at the John Antony clinic is appropriately recorded and monitored.
- The trust must ensure that all equipment is reviewed to ensure they have been regularly and appropriately maintained.

Summary of findings

- The trust must review all mattresses to ensure they are fit for purpose.
- The trust must ensure that all cleaning materials are suitably stored.
- The trust should review the people's records to ensure that people, their relatives or carers are involved in their care plans.
- The trust should review the people's records to ensure that the recording of consent is correctly identified.
- The trust should ensure that all staff receive clinical supervision
- The trust should ensure that there is consistent feedback from people who use the service.
- The Trust should ensure that medicines stored at the John Anthony clinic are appropriately monitored

Worcestershire Health and Care NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Requires Improvement



Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

We rated safe as requires improvement because:

- The trust management ensured that learning from serious incidents was shared with front-line staff. This meant that these staff members had the benefit of the results of investigations into the incidents.
- Staff had been trained and knew how to make safeguarding alerts
- Staff, where applicable, managed medicines well in the community.
- We found no system in place to monitor medicines stored at the John Antony clinic.
- Some resuscitation equipment at some of the minor injuries unit was not effectively monitored and maintained. This meant that people were placed at risk in the event of a health emergency.
- We found a torn mattress which had been in use since June 2014. This meant there was a risk of cross infection to people who use the minor injuries service.

- At the Princess of Wales hospital we found cleaning materials were not stored as required under health and safety guidance.

Incident reporting, learning and improvement

- In the last year there had been no never events incidents within this service
- Evidence was seen that other serious incidents had been investigated appropriately and any lessons learnt had been shared with the trust's corporate governance structure.
- We saw meeting minutes which identified lessons learnt from incidents for example, staff to ensure that care home staff accompanied them for any procedure to ensure the correct identification of a patient.
- The trust had reported any notifiable incidents appropriately to the Care Quality Commission.

- The quality and safety report for January 2015 showed that the incident of avoidable pressure ulcers had gradually reduced month on month. For example 72% avoidable pressure ulcers were reported in August 2014 against 56% in January 2015.
- Staff knew how to report incidents on the trust's electronic reporting system and senior staff were aware of incidents and they were discussed during staff meetings.
- Actions identified from incident reviews had been effectively followed up for example; all patients having an injection are now advised to lie on an examination couch and not to remain standing when having an injection. This was the action after a patient had fainted after having an injection in the standing position.
- Most staff told us that they received feedback about the outcome of incidents that had happened.

Duty of Candour

- Staff were able to tell us of the new duty of candour regulations. They said the trust was committed to being open and transparent in their approach to safe care.
- Senior staff said they were incorporating the new duty of candour regulations during team meetings.

Safeguarding

- Most staff were able to demonstrate how they would report safeguarding concerns in all areas visited. They said the trust's electronic system which ensured the reported incident was allocated to the specific area.
- Some staff were unsure of how to access the children's safeguarding lead for the trust.
- We reviewed the training records provided by the team leader. The records showed that staff had completed their safeguarding vulnerable adults and children's training this included when staff's refresher training due dates
- Safeguarding "Prevent" training was being rolled out to staff. We saw arrangements had been made for training in February and March 2015.
- All safeguarding concerns were reviewed by the senior management.
- Safeguarding issues were considered and action points noted were required during handover meetings. Specific tracking notes were made in some teams to monitor people most at risk of pressure ulcers and/or risk of falls. Discussion was targeted at ensuring all actions were being taken to mitigate the risks.

- People at the John Antony clinic who showed signs of physical or emotional abuse were referred to the access centre's safeguarding lead. The outreach clinical nurses were also included in the follow up with the access centre.

Medicines management

- People were able to access the acupuncture service for pain relief. The trust had a checklist and consent form which was completed prior to treatment.
- People were given a leaflet which explained that single-use; sterile, disposable needles were used at all times. We found good procedures for the accountability and disposal of needles.
- The intravenous (IV) team was a standalone team who supported district nurses in the community with IV therapy.
- Staff prompted people to access their medicines. Senior staff told us staff did not administer medicines but encouraged and prompted people to access their medicines using a Monitored Dosage System (MDS). The MDS is a multi-dose reusable storage system designed to simplify the administration of medicines.
- National Institute for Health and Care Excellence (NICE) guidance was followed when prescribing medication for individual patients.
- We observed the giving of insulin which was in line with the NICE guidelines.
- We found medicines were managed safely within the minor injuries unit. All units visited had a specific anaphylaxis emergency kit with guidance attached as to dosage for both adults and children.
- Contraceptive pills and antibiotics were stored in a locked cupboard at the John Antony clinic. However, it was found there was no system to monitor these medicines.
- All medical prescription pads were monitored and stored in locked cupboards at the John Antony clinic.

Safety of equipment

- Suitable equipment was available. The service had access to specialist mattresses if needed. Staff said they could get additional equipment for bariatric patients when required.
- We observed that the services had additional stock on site. Staff told us they could request additional stock on-line which enabled them to have a quick turnaround.

- We found the resuscitation equipment within the minor injuries unit was not effectively monitored and maintained. For example, items were missing from the trolley and the face masks were out of date. This meant that people were placed at risk in the event of an emergency.
- Resuscitation equipment at Tenbury community hospital was shared with the inpatient wards which meant there was a risk that equipment may not be available in an emergency within the minor injuries unit.
- Staff told us that equipment provision and supply was well-delivered over the weekends with no problems identified. The availability of high grade mattresses were good.
- Blood sugar monitors were calibrated weekly and we saw this was identified in people's records.
- Some checks on medical equipment was seen to be out of date. For example, the podiatrist's nail drills' testing at Pershore hospital was due the beginning of January and had not been actioned and the electrical plug was dated February 2010.
- We found the treatment chair within the podiatry service at Pershore hospital had a check date of March 2014. This was brought to the attention of the manager in charge who said they would arrange a review of their equipment. This meant there was a risk of people being treated with equipment which may be unsafe.
- Within the minor injuries unit at the Princess of Wales hospital we found a torn mattress which had been in use since June 2014. This created an infection control risk to people who use the service.
- The records viewed had care plans in place. However, not all of the records identified that people, relatives or their carers had been involved in the care planning process.
- The trust was looking at introducing a paperless system. There was a scheme in place whereby some staff were trialling working from an electronic tablet. Staff's feedback to the scheme was variable with some staff being enthusiastic whilst others had reservations.
- We looked at the records audit for December 2014 with identified actions. The audit showed that the services had achieved 100% in the recording of discharge planning however only 27% of the records identified people's signatures.
- The sexual health service was supported by the IT system whereby test requests and results could be processed on-line.

Cleanliness, infection control and hygiene

- Staff had access to personal protective equipment which included aprons and gloves.
- We saw the service's environments were generally clean and well maintained.
- The infection control audit seen did not identify any issues or concerns and was discussed at trust level meetings.
- Cleaning materials within the minor injuries unit were not stored appropriately as required under the health and safety guidance. We found the Princess of Wales hospital was not adhering to safety regulations for the control of substances hazardous to health. Chlorine-based cleaning materials were stored in an unlocked cupboard in a room accessible to people who use the service.

Records and management

- The service used an electronic and paper record keeping system. Some paper records were held in people's homes.
- Staff recognised how important it was to keep the information up to date on the system. However, they told us that due to connectivity problems, shortages of staff and the time taken to complete records online they often spent time in the office completing records.
- The records included a brief history of the person including their presenting complaint, their risk of falls and their medical history.
- Paper based risk assessments were completed in therapy services which identified the equipment required for example, walking sticks.

Mandatory training

- All staff including agency staff undertook a local induction programme. The service had a buddy system for all new nurses on preceptorship.
- We saw that staff unfamiliar to the service received a service specific induction.
- 85% of staff working in community care said they had received job relevant training, or leaning and development in the previous year, with 88% receiving training in health and safety (NHS staff survey, 2013)
- Some staff said they received study time to update and upskill their education.

- Staff said they completed additional training in line with their role for example; a degree module in leg ulcer management for community based nurses and leadership training.
- Staff at the John Antony clinic told us they had monthly educational meetings which meant they were able to gain additional knowledge in their specific role.
- The trust reported a 9% vacancy rate with 3.6% sickness for this service, however evidence was seen that bank and agency staff were used when the needs of people required this.
- District nurses said their caseloads averaged between 20 and 30. Individual caseloads were reviewed weekly within the staff team, during multi-disciplinary meetings and at supervision.
- Staffing levels were discussed at daily bed meetings which included the use of agency staff, if required.

Assessing and responding to patient risk

- The trust had good safety protocols in place to ensure staff safety.
- We reviewed the lone working procedures. Staff were able to say how they kept themselves safe by updating their diaries and letting their colleagues know their whereabouts.
- Hand overs were comprehensive and included updates on potential risk factors.
- Staff responded appropriately to tissue viability referrals. They worked jointly with the community nurse to advice and influence good practice.

Staffing levels and caseload

- We reviewed the current and previous staff rotas and these showed us that there were enough staff on duty to meet the needs of the people in this service.

Managing anticipated risks

- Each location had a local risk register which was on display. For example, where recruitment been had identified as an area of concern, the risk register identified the mitigation, the action and areas they were unable to currently address.
- The trust at the Princess of Wales hospital they had identified there was a potential safety risk for staff out of hours. To mitigate the risk the trust had installed a camera and monitor to ensure staff's safety during out of hours working.

Are Community health services for adults effective?

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

We rated effective as good because:

- Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and their assessments of mental capacity were detailed. The trust had developed a rolling training programme to ensure MCA and DoLS were applied correctly.
- Clinical staff made a comprehensive assessment of people who were referred. This included a good assessment of people's physical health needs. The trust used both an electronic system and paper copies for recording and storing information about the care of patients. This meant that this information was available to doctors and nurses as people moved between services.
- Multi-disciplinary teams and inter-agency working were effective in supporting people
- There was inconsistency in the obtaining and recording of consent across the services for both adults and children.

Evidence based care and treatment

- Staff were able to show how they provided care and treatment to both patients and carers in line with the National Institute for Health and Clinical Excellence (NICE) guidelines. For example the records identified the involvement of patients in partnership with their health and social care professionals.
- The health professional for sexual health told us they conformed to the genitourinary medicine Department of Health national strategy guidelines for seeing 95% of patients within 48 hours.
- Staff used the Fraser competency guideline sheet on a regular basis for young adults under the age of 16. The Fraser guidelines outline whether doctors should give contraceptive advice or treatment to children as well as deciding if they are mature enough to understand the implications of their decision without parental consent. A copy of this document was placed in the young person's notes.

- The physiotherapist carried out a falls assessment based on the The Falls Efficacy Scale International. This enabled therapists to promote people's independence, function and safety.
- The care plan wound assessment and treatment chart followed NICE guidelines which included wound type, size and appearance.
- The December 2014 community metrics action plan for Malvern identified that 67% people's records regarding falls in the last 12 months were complete.
- The locality falls team meeting included feedback from the falls implementation group. Examples included that all people over the age of 70 should have a mini mental assessment and people should have their lying and standing blood pressure recorded. The minutes identified that a training guide was being developed.
- The therapists used the Malnutrition Universal Screening Tool (MUST) to raise awareness of a person's risk of malnutrition. This tool was used during the initial assessment of a person entering the service.
- The December 2014 community metrics action plan for Malvern identified that only 22% of people receiving two or more visits had a completed MUST tool. However, the action plan identified that 100% of people had a nutritional care plan in place. The senior management team confirmed they were aware of the poor scores and we saw an action plan to monitor the situation whilst ensuring the safety of people who used the service.
- The records read showed staff adhered to the NICE guidelines, April 2014 for the prevention of pressure ulcers. We saw pressure prevention equipment in place for example mattresses and cushions.
- The occupational therapist told us they used the Canadian Occupational Performance Measure. This is an evidence-based outcome measure designed to capture a patient's self-perception over time.
- The minor injury units had guidance to assist staff in the caring of people. This included for example, a policy for the X-ray of children under three years old.

Approach to monitoring quality and people's outcomes



Are Community health services for adults effective?

- We observed multidisciplinary meetings. There was good professional input from specialists and medical staff were present. Plans for progress and the resolution of issues for people were decided at the meeting. Staff were clear about the next steps for people who use the service.
- We saw assessments of people's needs were comprehensive and included the assessment of pain. We found that the outcome of treatment was being monitored and reviewed at management meetings.
- The trust completed patient satisfaction questionnaires. We found this was not consistent across all areas for example, the minor injury's team.
- We found the trust had utilised a suggestion from the patient satisfaction questionnaire. For example, people suggested they be telephoned after a scan if no further treatment was needed. We found this had been implemented which meant that people did not have to wait for a review appointment.
- With the exception of the Parkinson's disease clinic therapists told us they saw most people within the expected waiting time with the least wait being three weeks and the longest 14 weeks. They told us the waiting time had increased due to winter pressures but they had not exceeded the maximum referral waiting time of 18 weeks. This was confirmed in the records reviewed.
- The waiting list for the Parkinson's disease clinic had exceeded its 18 week referral time. However, all people on the list had been sent a letter with an appointment date within the next four weeks which meant that the team had identified and addressed the excessive wait issues.
- We found that the December 2014 metrics action plan identified areas of concern. For example the score for tissue viability was between 56% and 78% with the lowest referring to no review date on care plans and the highest to completed waterlow score on first assessments.
- People who had accessed the enhanced care team were seen for a period of time which ranged between two and six weeks. Senior staff told us they were aware of the shortfall in collecting outcome data and were looking at ways to capture this.
- Some therapists evaluated people's moods using the Tolerance of Mood State scale. This enabled the specialist teams to outcome measure people in the context of physiotherapy and occupational therapy.
- Some therapists relied on the Measure Yourself Medical Outcome Profile. This enabled the therapist to monitor the person's progress based on the tracking of their symptoms and well-being.
- We reviewed the community occupational therapy results using the Canadian occupational performance measures (COPM) for Redditch and Bromsgrove for December 2014. The results showed that 82% of people had received an initial COPM assessment. The results also showed that 91% of people said that receiving occupational therapy had made a significant change to their well-being.
- We saw the audits for the sexual health service and found that 91% of the records had documented the woman's cycle at the time of unprotected sexual intercourse but only 42% of the records documented that the emergency intrauterine device had been offered to eligible women requesting emergency contraception.

Competent staff

- The trust was rolling out a "raising concerns at work" training for all staff. The team meeting minutes invited staff to attend via the electronic staff record system.
- The minor injuries unit and John Anthony clinic had in service training plans in place. This included pelvic examination, injection therapy and management of common pathologies training.
- All staff had annual syringe driver updates and competency checks with the Macmillan nurses.
- Some physiotherapists within the trust were Members of the Society for Orthopaedic Medicine which is a post graduate qualification. Some physiotherapists also had the Injection Therapy diploma. The clinical lead described it as a "unique role."
- The physiotherapists received clinical supervision and support for their role. They had a close working relationship with the trust's consultants as well as the spinal teams for Birmingham orthopaedic hospital.
- The physiotherapists attended study sessions and clinics with the consultants who observed their skills in reading Magnetic Resonance Imaging (MRI) scans, X-rays and clinical assessments.
- Some staff said they had not received clinical supervision but the trust was rolling out a new initiative in February. Senior staff said they had undertaken facilitation training to implement the new clinical supervision initiative.

Are Community health services for adults effective?

- New staff had a comprehensive location and corporate induction programme prior to working in the community. One person told us that even though they had worked for the trust in another role they spent two weeks with the team on a supernumerary basis and felt the induction met their “initial needs.”
- Checks were in place to ensure that any agency staff had received the required training prior to being booked to work shifts within the community teams.
- Some staff said they had completed the trust’s leadership development course.
- The trust ran a rotational scheme for Band 5 occupational therapists across the services. This scheme offered them the opportunity to consolidate skills learnt in training and to experience a range of practices prior to specialisation. The aim of the rotational scheme is to develop a range of effective clinical skills across the health and community teams whilst developing effective, competent staff.
- Qualified staff across the minor injury units had been trained in IRMER (Ionising Radiation (Medical Exposure) Regulations 2000) in recognition of the use of x-ray within the units.

Multi-disciplinary working and coordination of care pathways

- The trust had reconfigured some areas to form integrated teams which included occupational therapists, physiotherapists and district nurses. The teams did not include social workers but we observed close working relationships with local social services.
- Staff in community teams told us that multi-disciplinary working was good. Staff felt able to consult with colleagues and there was a good rapport with ward staff in bases at community hospitals. Specialist nurses were available to provide consultation when required. Staff said they worked within a supportive team.
- There were daily handovers which reviewed the planned care and treatment programmes for people using the service.
- We attended a multi-disciplinary meeting and observed that each team member’s role was respected in terms of information sharing about people’s care.
- Staff’s caseloads were reviewed which included the time frame for discharge from the service. It was evident that discharge was subject to a package of care being in place.

- The availability of social care response was identified as an area of concern which could impact on the team’s ability to timely discharge people into the community.

Referral, transfer, discharge and transition

- Worcestershire Community Stroke Rehabilitation Service’ (CSRS) clinicians facilitated early discharge and continuing post stroke rehabilitation. The service alongside the community teams delivered individualised programmes of rehabilitation by supporting people who use the service, their family and/or carers to adjust to their new situation.
- All stroke patients were invited to review clinics review clinics which run with an inter-disciplinary approach. All clinicians were scheduled to support the reviews, with a CSRS clinical lead present at each clinic venue. Areas covered included; mobility, speech/language, social and basic needs.
- The rapid response team received referrals from GP’s and other health professionals. Senior managers told us that they responded to emergency referrals within two to four hours, however that data was not currently collected. They told us they were aware of the shortfall in outcome reporting and confirmed this was a work in progress.
- The John Anthony clinic had an appointment service whereby people could be referred either by their GP or via self-referral.
- The discharge pathway between the acute ward and the community services had improved by the facilitation of a meet and greet system. This provided continuity to both the trust and the person receiving the service.
- The trust had a clear discharge pathway called pathway 1 which enables people who are clinically stable to leave hospital and return home. The intervention of social workers and/or therapy assessments would be completed within 72 hours of discharge.
- Within the minor injuries unit we saw evidence of good referral pathways for both adults and children. We saw referrals made to the acute service for additional treatment for example, following an animal bite, referrals back to the GP or paediatrics for follow-up treatment.
- People who had been victims of a sexual assault were referred for medical follow-up and aftercare to the John Anthony service from the sexual assault referral centre.

Availability of information

Are Community health services for adults effective?

- The trust had produced literature to people accessing the service, for example a contraceptive leaflet was available in Polish this meant they had a good understanding of the service being provided. This could be requested, when required, in a different language or format.
- The John Antony clinic widely advertised the specific clinics available which included free condoms and information and advice on all contraceptive methods.
- The trust had access to interpreting and translation services from which they could arrange both face to face and instant telephone interpreting, document translation and British sign language services.
- The stroke team told us they had adapted the information pack to suit people being diagnosed with stroke. They created three books which covered being diagnosed and learning about stroke, rehabilitation and life after stroke. We saw that the books were in an easy to read format with pictures as visual aids.
- The records read had consent to information sharing documentation as well as forms which required a tick to confirm verbal consent.
- The records had a “decision against treatment” form alongside a capacity assessment form. We looked at 23 records and found that fourteen of the records did not have the required signature or tick. This meant that staff could not ensure that people, families and/or carers had given their consent to the sharing of information and/or consent to treatment.
- Some staff demonstrated awareness of the Mental Capacity Act (MCA). Staff said the team leaders for mental health had taken the teams through the MCA and the process of assessing capacity.
- We observed that if there was a need to share information it was conducted via the telephone, facsimile, e-mail or post. There was a risk of sending information to the wrong person. Senior staff told us they were aware of the risks and all messages were checked and verified to ensure the information was correct.

Consent

Are Community health services for adults caring?

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

We rated caring as good because:

- Staff were kind and respectful to people and recognised their individual needs.
- Staff actively involved people in developing and reviewing their care plan although this was not always identified in the records read.
- People had access to an advocate if they needed one.
- Staff also made sure that families and carers were involved when this was appropriate.
- The privacy and dignity of patients at Tenbury hospital was compromised by there being only curtains surrounding the patient areas.
- Confidentiality across the minor's injury unit was compromised due to the openness of the reception areas.

Dignity, respect and compassionate care

- The reception areas within the minor injury's units lacked confidentiality. People's details could be overheard when requesting details.
- During our visits in the community, we observed staff treating people with dignity and respect. They introduced themselves and sought consent for treatment.
- Staff explained to people what was happening and checked their understanding.
- We noted that staff treated patients with kindness and respect.
- Staff explained to us how they delivered care to the different people who use the service. This demonstrated that they had a good understanding of these different needs.

Patient understanding and involvement

- The admission prevention team showed us examples of successful admissions avoidance interventions and their acceptance to the virtual ward. One person said they felt the link between them and their doctor made them "feel safe" and another said that they could "discuss things when they felt depressed."
- We saw the result of a people's experience questionnaire which showed that 79% of people said

they were able to discuss what was important to them in managing their health care needs. 92% of people said they had not experienced any delays in the care they received.

- Additional comments said that staff were "very helpful and considerate" and "extremely friendly and professional."
- The records showed that staff had received their Mental Health Act training in December 2014 and there were clear procedures in place regarding the use and implementation of this Act.
- The records showed advocacy support, when required, during care programme approach meetings.
- Due to the cognitive ability of some people it was difficult to involve them with their care planning. However, we found evidence of some people's involvement with their care planning.

Emotional support

- During our visit to people's homes we observed staff providing emotional support to a person who was distressed. They spoke calmly and with respect whilst protecting the person's dignity.
- We witnessed staff handling an emergency situation within the minor injury unit in a professional manner whilst providing support to other patients who had witnessed the situation.
- The sexual health service ran the 'Care after Termination' project which provides emotional support to young people less than 19 years of age.

Promotion of self-care

- Staff told us they promoted patient independence. A patient discharged from hospital was supported and encouraged to recommence giving their own insulin which they had stopped doing whilst in hospital.
- We observed a community nurse visit to a patient's home. The patient was empowered to make choices, such as the preferred place of care, they were informed regarding pressure areas and encouraged to self-manage pressure areas. There was a good rapport, and the patient participated fully in the discussion and was encouraged to express concerns.

Are Community health services for adults caring?

- Staff provided information leaflets to patients including one on preventing pressure ulcers.

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

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

We rated responsive as good because:

- The services were able to provide a range of different treatments and care. People could access a range of therapeutic interventions.
- The services were aware of the diverse needs of the people who use the service and provided a range of support as required.
- Information for people after treatment was inconsistent. Some information was in an easy to read format and used pictorial aids. We observed that information for people who accessed the minor injury's unit was not available in alternative languages or easy read format. There was no child-friendly information available on those services visited.
- We found that the environment at Tenbury and Malvern hospital was not child friendly due to the sharing and re-designating of areas.
- Staff knew how to support people who wanted to make a complaint

Planning and delivering services which meet people's needs

- The trust had a hospital admission prevention service whose aim was to avoid unnecessary adult hospital admission and support people who may otherwise have been taken into hospital unnecessarily. Examples included the monitoring of people's condition and/or prescribed medicines.
- The district nurses used a standard scoring system to plan staff's length of visit. For example, 15 minutes equated to one unit of time when planning a visit. Most felt the system was unsuitable as it did not take into account the team working across the enhanced team as there was additional patient contact required as their needs fluctuated.
- The Integrated Clinical Assessment and Treatment Service (ICATS) assessed complex musculoskeletal problems. The ICATS are based in the South of the trust and they enable people to be assessed and treated closer to home. This reduces referral rates to secondary care for example, Birmingham Orthopaedic Hospital where spinal services are based.
- The waiting list for people to be seen by the ICATS was between six and eight weeks. People whose scans

showed potential malignancy or other serious concerns were referred back to the ICATS clinician, with a copy of the result send back to ICATS. Referrals into the service were triaged and transferred to the relevant department. Staff told us that they responded to each call within two and six hours. However, we found that the trust did not monitor the outcomes to ensure a prompt response.

- We found occasions whereby the evening service were handed over visits which the district nursing service had not managed to attend due to emergencies throughout the day. For example, we saw 15 visits handed over with four being handed back in the morning. Senior staff told us they were aware of the problem, but confirmed that all cases were reviewed to ensure that treatment could be safely deferred to the morning.
- The service was flexible according to the needs of the patient and was based on a rapid response process from the time when the problem is identified. Normally the service is provided for 24-72 hours and included overnight cover.
- We found that the environment at Tenbury and Malvern hospital was not child friendly due to the sharing and re-designating of areas. Malvern community hospital had a children's play area
- In the waiting room at Malvern hospital we saw good health promotion information available. For example, we saw information on the Department of Health's initiative "Sugar Swap" for children.
- The John Anthony clinic had a variety of services available which met people's needs for example; a walk-in service was available each day as well as a contraceptive service with a dedicated implant clinic.
- The sexual assault referral centre provided a counselling service to people who use the service.

Equality and diversity

- The training records identified that staff had completed their training in equality and diversity, and when asked they were able to demonstrate their understanding.
- Staff said that specialist advice could be contacted if support was required when working with people with learning disabilities.

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

- All of the services we visited were accessible to people using mobility aids by use of ramps and/or lifts. Disabled parking was available at the hospital and surgery sites we visited.

Meeting the needs of people in vulnerable services

- Dementia services liaised closely with social workers, patients' families and allocated care co-coordinators from their home area.
- Vulnerable people were identified on the trust's electronic system which enabled staff to be aware of their needs.
- Patients' diverse needs such as religion and ethnicity were recorded and we saw these were being met for example through religious specific diets and access to religious services.
- Staff told us that if people with dementia, with a known learning disability were diagnosed, they would work alongside the community psychiatric nurse to provide the support suitable to the needs of the person.
- There were systems in place for identifying the community's needs and trends in attendance within the minor injury's unit. For example, these included the higher incidence of domestic violence in one area therefore local staff had received additional training.
- We were informed the services did not have a braille service for visually impaired people.
- We saw the trust had installed a hearing loop service in the reception area of the John Anthony clinic.

Access to the right care at the right time

- The trust used single point of access arrangements to screen referrals into the service. Staff triaged the calls to prioritise urgent referrals such as falls, palliative care, prevention of admission and facilitating discharge.
- Most staff in community teams said access to standard pressure relieving cushions and mattresses was not a

problem and when required, they could access bariatric equipment. The tissue viability nurse specialist said they could get equipment promptly on the same day if needed.

- Waiting time for physiotherapy, speech and language therapy and occupational therapy was within the 18 weeks target, and ranged from an average of 25 days for physiotherapy to 56 days for speech and language therapy.
- There were many community teams whose key focus was to either prevent hospital admission or promote early supported discharge. These services such as rapid response teams or access units were established to promote patient's independence care at home and reduce inpatient admissions.
- Malvern community hospital had information aimed at the teenage population regarding contraception. This meant that the information was readily accessible to young adults.
- Staff at the John Antony clinic said they had worked closely with local commissioners for the last two years to provide local sexual health clinics although this service was not available at the Wyre Forest locality. Staff told us discussions are currently taking place between the acute trust, commissioners and other stakeholders to provide an integrated sexual health clinic at Wyre Forest.

Complaints handling (for this service) and learning from feedback

- Information was displayed for patients to report any 'concerns, complaints and compliments.
- An information pack given to people on their first contact included a patient Advisory Liaison Service (PALS) leaflet on how to complain.
- There were systems for complaints and concerns to be investigated and complainants to be given a response.
- Staff told us they supported people, their relatives and/or carers to make complaints as required.

Are Community health services for adults well-led?

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

We rated well-led as good because:

- The feedback from patients was good however there were challenges in collecting it from all services.
- Staff said they received regular appraisals and supervision
- Staff knew the vision and values of the organisation
- Good governance processes identified where the services needed to improve
- Staff morale was improving and teams worked well together.
- The leadership in some areas required improvement due to the lack of robust auditing.
- The auditing of performance over the minor injury units was not robust which included monitoring and recording of care plans and cleaning regimes

Service vision, values and strategy

- Staff were aware of the trust's visions and values which were on display within the services.
- The trust's vision and values were discussed at team meetings. Staff told us they did a brainstorming session of the meaning of the trust's vision which included posters. They told us this was very effective.
- Staff at the John Antony clinic said they had few opportunities to get involved in service design and business planning.

Governance, risk management and quality measurement

- Senior clinicians had access to governance systems that enabled them to monitor the quality of care provided. This included the provider's electronic incident reporting system, corporate and ward based audits and electronic staff training record.
- Monthly community quality and performance meetings took place which cascaded into divisional meetings. The minutes showed us that these were comprehensive and any actions arising had been addressed.

- The auditing of performance and care provision was deemed not robust across the minor injury's units. Examples included the monitoring and recording of complaints, auditing of care records and cleaning regimes.
- The feedback from people was not consistent across the services. Senior management told us they were aware of the lack of feedback and were looking at ways of increasing people's involvement.
- Staff confirmed that they received e-mails from the trust giving updates on corporate developments. Some staff said the chief executive's weekly communities identified current issues which they needed to be aware of.
- Staff said they received annual appraisals and regular supervision.
- The community services created, reviewed and amended the annual business plan. Areas identified included what the service was doing well and what could improve.

Leadership of this service

- Staff told us that local management was very supportive. They felt listened to and that managers would act on their behalf and look after their best interests.
- Some staff said the trust was very visible and proactive. They said the trust provided a lot of information via e-mail.
- Some staff said there had been many changes which they felt were detrimental to the community nursing service provided.
- Staff said they attended regular team meetings. The minutes identified the learning from serious incidents which resulted in new procedures for staff when entering a person's home.
- Worcestershire Integrated Neuro-Rehabilitation Service's met quarterly. Areas discussed included continuing healthcare concerns, outcome measures and caseloads.
- Whilst there were challenges to recruitment and retention of staff for the services evidence was seen that the provider was taking action to pro-actively recruit and retain staff.

Are Community health services for adults well-led?

- Staff were very enthusiastic and felt valued and listened to. They said they “loved their role.”

Culture within this service

- Staff shared their views about the service openly and constructively. They were caring and passionate about the service and the care they provided to people who use the service.
- Staff said they worked well as a team and supported each another.

Public and staff engagement

- There were examples of some people being closely involved in service development. These included patient survey feedback and learning from complaints. For example, we saw 13 patient feedbacks forms from the John Antony clinic which were all positive about the service.
- We saw positive feedback from people in some areas. Senior management told us they were aware of the shortfall in obtaining feedback and were looking at ways to capture this.
- There was information about the services on the trust's website.

- Information was sent to staff regularly by e-mail and newsletter. Staff were encouraged to look at the staff intranet.

Innovation, improvement and sustainability

- Staff told us they participated in the “Stop the Pressure” which is a national campaign encouraged to reduce pressure ulcers and to make life better for people who use the service.
- A framework for improvement had been laid out. Key performance indicators were discussed at the service's clinical governance meeting. For example, safeguarding, incidents and complaints
- Periodic service reviews had taken place to monitor the quality of the service with actions identified as relevant.
- Two staff occupational therapists had been successful in having their research into proving the effectiveness of community occupational therapy in the equipment and adaptation setting using the Canadian occupational performance measure printed within the British Journal of Occupational Therapy.
- The trust had developed and supported the sexual health services for example, Redditch early medical termination unit.

Compliance actions

Action we have told the provider to take

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action they are going to take to meet these regulations.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 16 HSCA 2008 (Regulated Activities) Regulations 2010 Safety, availability and suitability of equipment</p> <p>At the Princess of Wales hospital items were missing from the resuscitation trolley should be replaced and monitored</p> <p>At the Princess of Wales the torn mattress which had been in use since June 2014 should be replaced and all equipment must be properly maintained and be suitable for its purpose.</p> <p>At the Tenbury community hospital, there must be separate resuscitation equipment in the minor injuries units and in the inpatient wards as there was a risk of equipment not being available in an emergency. All resuscitation equipment must be monitored to ensure it is in date</p> <p>At the Evesham and Malvern community hospitals procedures need to be put in place to ensure resuscitation equipment was properly maintained.</p> <p>At Pershore hospital the treatment chair within the podiatry services equipment needs to be checked and maintained in a timely manner.</p> <p>This is a breach of Regulation 16 (1) (a) (2)</p>

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control</p> <p>At the Princess of Wales the torn mattress which had been in use since June 2014 should be replaced as there it was not suitable for its purpose and a risk of patients being exposed to a health care associated infection.</p>

Compliance actions

At the Princess of Wales Hospital cleaning materials should be stored as required under health and safety guidance.

This is a breach of Regulation 12 (1) (a) (b) (c) (2) (a) (c) (ii)