Walsall Healthcare NHS Trust

RBK

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

This report describes our judgement of the quality of care provided within this core service by Walsall Healthcare 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 Walsall Healthcare NHS Trust and these are brought together to inform our overall judgement of Walsall Healthcare NHS Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
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

Patients received compassionate care. Staff discussed planned care and treatment with patients and provided information to reinforce understanding. Incidents were reported and investigated thoroughly, outcomes were communicated both to staff and to patients and relatives who were involved. There was a culture of openness in reporting and a 'no-blame' policy to encourage learning.

The demand for community nursing was increasing and this meant low priority visits (such as three monthly checks on patients' skin or reassessments of continence needs) were cancelled and rebooked or alternative approaches taken.

The accurate and timely completion of patient risk assessments was variable which was largely due to community nurses unable to meet patient demand. Staff were aware of their responsibilities to ensure patient safety.

The majority of community staff had good access to training and development opportunities. There was a system to check nurse competencies in procedures such as specialist bandages for leg ulcers. There were good examples of multidisciplinary working to enhance patient care and avoid unnecessary admissions to hospital.

Community services were planned and were mostly responsive to the needs of the people of Walsall and the surrounding area. Community services supported people to receive care either in or close to their home, and at the time that they needed it. There were good initiatives in place to prevent unnecessary hospital admissions.

The leadership was knowledgeable about quality issues and recognised challenges such as the increased demand on community services. Staff said their direct line managers and Professional Lead/Care Group Manager Community were supportive and provided leadership.

We spoke with 43 patients, 28 carers or relatives and 49 staff across a range of roles within the trust and we looked at 20 patient records.

Summary of findings

Background to the service

Walsall Healthcare NHS Trust was first registered with CQC on 1 April 2010. The trust is working towards being an Integrated Care Organisation providing both acute hospital and community services to around 260,000 people in Walsall and the surrounding areas. The trust was ranked 30th out of 326 local authorities for deprivation (with 1st being the most deprived). Walsall is identified as having worse death rates than the national average for under 75s for cancer and cardiovascular disease and smoking related deaths. There is a worse incidence of diabetes and tuberculosis in all ages than the national average. The incidence of deprivation, disease and poor health impact on both acute and community services.

A range of adult community services including nursing and therapy services as well as unplanned care such as rapid response and a clinical interventions team, were provided by the trust. The adult community nursing services were provided by five district nursing teams, 10 community matrons, three Frail Elderly Persons (FEP) case managers and six case managers who supported nursing and residential homes.

Physiotherapy, occupational therapy, podiatry and diabetes care were provided within both Walsall Manor Hospital and the community clinics. The trust provided planned and urgent community nursing visits between 8am and 10pm with an urgent service available overnight. The rapid response and clinical intervention service were available between 8.30am and 10pm. Between 1 March 2015 and 31 August 2015 there were 134,272 face to face patient contacts with all community services which included 91,125 community nursing visits.

For adult community services we inspected a number of locations and all five community nursing teams. The trust provided adult community services to support people to help them manage their long term conditions and to avoid hospital admission. Services we inspected were provided in people's own homes, residential homes and within clinics. These services included:

- Community nursing including out of hours services, community matrons and nursing homes and residential home case managers.
- The rapid response team.
- The clinical intervention team.

Physiotherapy and occupational therapy including the falls management team.

Our inspection team

Our inspection team was led by:

Chair: Professor, Juliet Beale, CQC National Nursing Advisor.

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included a CQC inspector, a community matron, a community nurse and a physiotherapist.

There was one expert by experience who was part of the team, they had experience of using services and caring for a person who used services.

Why we carried out this inspection

We undertook this inspection as part of the comprehensive combined 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 trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 8 to 10 September 2015.

What people who use the provider say

We spoke with 43 patients and their carers during the inspection. Responses were very complimentary about the staff and the care and attention patients received.

Patients told us how kind and caring the staff were and how well they understood their needs and they were pleased with the service provided.

Good practice

- Arrangements for secure and timely administration of medicines for the rapid response team. Medicines were stored in a machine which was accessed by a pre-identified thumb print by nurse prescribers and a camera which identified staff who used it. Medicines were administered with the patient's details and instructions for administration.
- The trust had case load managers and advanced nurse practitioners to providecare, education and support to nursing and residential homes. The project to date had identified those services and patients who most frequently used 999 services and patients who were admitted to hospital. As a result of the scheme, the number of avoidable 999 calls and avoidable hospital admissions had been reduced.

Areas for improvement

Action the provider MUST or SHOULD take to improve

SHOULD take to improve

- Arrangements for patients discharged to their own home requiring specialist equipment such as hospital beds and pressure relieving mattresses should be reviewed to ensure patients have suitable equipment available.
- The completion and review of the patients risk assessment (nutrition, falls and moving and handling) to ensure appropriate and timely actions are in place to reduce the risk of patient harm.
- Community teams have individual monthly performance indicators or 'dashboard' to enable them to monitor and measure their performance .

Walsall Healthcare NHS Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

we rated this domain as requires improvement. The trust measured community nurse visit requirements against actual availability of staff. Demand for community nursing was increasing and this meant low priority visits were increasingly cancelled and rebooked. We found the completion and availability of patient records such as risk assessments was variable which may be one result of community nurses trying to meet patient demand. There was a risk that patients may not receive the visits they needed.

Community services for adults had a good patient safety track record. Staff were aware of their responsibilities to ensure patient safety and their role in reporting incidents to make sure improvements were made when things went wrong. Reported incidents were investigated thoroughly and outcomes were communicated both to staff and to patients and relatives who were involved. There was a culture of openness in reporting and a 'no-blame' policy to encourage learning.

There were arrangements in place to ensure equipment was available for community patients, although bariatric equipment was not always readily available. Staff were trained in and understood the process for safeguarding vulnerable adults and knew when to raise a concern.

Foreseeable risks and planned for changes in demand due to seasonal fluctuations including disruptions to the service due to adverse weather, were managed through emergency plans. These included plans to meet the needs of vulnerable patients in severe winter weather, heat waves and during power cuts.

Incident reporting, learning and improvement

- No never events were reported from 1 August 2014 to 31 July 2015. A never event is a wholly preventable serious patient safety incident that should not occur if the preventative measures have been implemented.
- There were 25 serious incidents that required investigation reported from 1 August 2014 to 31 July 2015. The serious incidents related to 21 grade three

pressure ulcers and four grade four pressure ulcers which developed whilst under the care of community staff. The incidence of pressure ulcers was equally spread across the community nursing teams.

- Community staff had an established system for reporting incidents and near misses through an electronic reporting system. Community staff had reported 691 incidents from 1 July 2014 to 31 August 2015. The majority (94%) of the incidents were classified as either low or no harm. Each incident submitted was reviewed and graded by a senior staff member. The subsequent investigation was proportionate to the grading and any harm to the patient involved.
- We reviewed a sample of investigation reports submitted by staff and saw root cause analysis (RCA) had been carried out as part of the investigation process. RCA's identified causes, lessons learned and actions to prevent reoccurrences. One example included ensuring pressure ulcer prevention information 'think skin' was left with patients who were at risk of developing pressure ulcers. Staff nurses explained the information to patients and relatives and this was recorded.
- Staff were confident about how to report incidents and they told us there was an open, 'no blame' culture when reporting incidents. Staff told us they usually received feedback about the incidents they reported and gave us examples about how practice had been improved when incidents had previously been reported. One example of improvement to practice was the use of orange coloured sheets for diabetic patients who required insulin. The orange sheets ensured community nurses were aware the patient needed a priority visit. Team leaders also showed us patients who required essential visits such as insulin injections had identified staff each day for these visits.
- Staff told usincidents and learning from incidents was discussed at team meetings and during staff handovers and staff were encouraged to engage with the process. For example, community staff were reminded all patients who had an air mattress needed to have a fire risk assessment.
- We discussed hospital discharges with community nurses. Managers told us incidents such as unsafe or inappropriate discharges were investigated and lessons had been shared. One band seven nurse told us that they attended joint 'sisters' meetings with hospital ward managers and as a result of sharing concerns improvements had been made, such as with the availability of medicines and equipment.
- Information regarding incidents was reviewed by the business team meeting and quality and safety committee. Serious reportable incidents were also reported at trust board meetings.
- Community teams displayed information at community nursing bases about pressure ulcers, falls and infections that had occurred within the team.
- The trust used a 'dashboard' to show performance of hospitals wards which included patient safety, staffing (sickness and vacancy rates) and compliance with mandatory training. This ensured ward staff were aware of the overall performance of the ward and if improvement was needed. The Professional Lead/Care Group Manager Community' told us there was not currently a dashboard for individual community teams, but this would be considered.
- All adult community staff we talked with told us they were aware of the 'duty of candour'; they told us it was about being honest if things went wrong. A community matron said: "it's about apologising if we get it wrong or make a mistake. "One band six nurse told us: "we are more aware now and staff are more confident to speak up and escalate if they feel that duty of candour has been triggered."

Safeguarding

- Safeguarding adults training was mandatory for all trust staff. Records provided by the trust showed 100% of community staff had received safeguarding adult's level one training. Staff told us the safeguarding adults training was part of their annual mandatory training update and was a 30 minute session. Some staff felt 30 minutes was not long enough and had raised this with line managers. However, there were no plans to increase this session.
- The trust's target for compliance with level one children's safeguarding training was 90%. We saw 97% of community staff had met this target.
- All of the staff we spoke with were aware of their responsibility to report any safeguarding concerns they

had. Staff we spoke with told us about safeguarding referrals they had made and actions taken to protect patients from harm. Staff were aware who the safeguarding lead was and said they could approach them for advice if needed. We saw protocols were up to date and reflected current legislation.

Medicines

- We accompanied community nurses on visits to patient's homes and found medicines were administered safely and appropriately. We also noted community nurses completed a record of each medicine they administered.
- We saw controlled drugs were securely stored.
- Medicines available for the rapid response team were securely stored within a medicines storage unit. We saw access to the machine was by a pre-identified thumb print by nurse prescribers and a camera identified staff who used it. Medicines were labelled with the patient's details and instructions for administration. This machine enabled timely access to required medicines and we saw this to be innovative practice.
- Community nurses in each team told us they were supported to undertake a nurse prescribing course to be nurse prescribers. A community matron told us senior nurses, such as community matrons had attended an advanced course and were able to prescribe from a list of medicines such as pain relief and antibiotics. One community matron told us despite having successfully completed their prescribing course they had been waiting for more than eight weeks for their prescription pad. We were told this delay was due to printing delays from an external source which meant they had to ask the patient's doctor to prescribe required medicines which may delay their treatment.

Environment and equipment

- Patients were seen in a wide variety of locations throughout the trust ranging from health centres, residential homes and in their own homes. Equipment such as specialist pressure relieving mattress (in patient's homes) had received the required safety checks. There were no concerns raised about the maintenance of equipment.
- Nursing staff told us they were able to request equipment for patients such as hospital beds, pressure relieving mattresses and commodes. We spoke to three patients who told us they had been discharged from hospital without the required equipment and had been told this would be arranged by the community nurse. One patient said that they did not have a hospital bed and as they were unable to get out of their chair they had developed a pressure ulcer. This incident had been reported electronically and raised with the service manager. We were told an investigation was underway however, no results were available atthe time of the investigation.
- We saw in one community nursing team base that there were two items of out-of-date equipment used for administering medicines. We shared our findings with the Professional Lead/Care Group Manager Community' who told us a full check of the equipment would be undertaken to check safe equipment was available.
- Staff working within the rapid response team told us they had access to equipment for patients such as commodes and walking frames. Staff told us this enabled patients to safely maintain their mobility, reduce the risk of them falling and help avoid the risk of admission to hospital.
- We observed one therapist assessing and assisting a patient to move. We saw despite the patient requiring bariatric (used for overweight patients) equipment and height adjustable moving aids, this equipment was not used. This meant patients may be at risk of falling. The Professional Lead/Care Group Manager Community' told us bariatric equipment could be ordered when needed. Bariatric equipment was not available within the physiotherapy clinic.
- Medical device alerts were displayed on staff notice boards and were replaced at regular intervals to demonstrate up-to-date information was displayed.

Quality of records

- We saw records were paper based and were mostly kept in patient's homes. We reviewed 20 patient records, some in patient's homes and others which had been returned to the community bases when patients had been discharged from the service.
- Records included initial assessments, risk assessments, care plan reviews and a summary of the care provided. We sawthe completion and availability of records such

as risk assessments, was variable. We saw an assessment of the patient's needs had consistently been undertaken with care plans in place to meet identified needs with a summary of the care provided recorded. However, risk assessments such as nutritional, moving and handling and falls were not consistently completed despite this need being identified.

- We looked at 20 records and saw 18 did not contain a up-to-date assessment for the patient's nutrition and hydration needs even though patients were identified as frail.
- Records we looked at did not confirm consent by the patient had been obtained. Staff told us implied consent was obtained but this was not usually recorded.
- Community based staff completed and updated records when they visited the patient and notes were kept within the patient's home or community setting. On return to their base, this information was also recorded in the patient's computerised records.

Cleanliness, infection control and hygiene

- Staff followed the trusts infection control policy. Staff were 'bare below the elbow,' washed their hands, used hand gel when they visited patients and used personal protect equipment (PPE) such as gloves and aprons.
- We saw hand gel was available in clinics and community nurse bases. There were appropriate arrangements in place for cleaning equipment.
- Where patient care was provided to people in their own homes, staff took decontaminating equipment with them, such as alcohol gel and wipes.
- Patients we spoke with told us and we observed staff always washed their hands before and after providing care.
- We saw used equipment and dressings being properly disposed of in sharps bins and clinical waste bags. We saw arrangements for collection of clinical waste followed trust policy.
- Staff told us and we saw each team included an infection control link nurse. The link nurse's role included attending infection control meetings and providing feedback to their team.

Mandatory training

- The trust had a target that at least 90% of staff should have up to date mandatory training.
- We reviewed the trust training records and found compliance with mandatory raining for community staff providing care for adults was mixed and ranged from 79% (Anchor Meadow Community Nurses) to 100%. We found 27 of the 33 community staff teams had achieved the trust target of 90% compliance with mandatory training.

Assessing and responding to patient risk

- We observed a community nursing team handover. We saw concerns were identified and escalated appropriately. Staff demonstrated confidence in being able to escalate their concerns about deteriorating patients. Senior clinical staff provided advice and capacity of the team to respond to the needs of vulnerable patients.
- Community based staff demonstrated awareness of key risks to patients such as urgency of patient visits and arrangements for further support when required, such as the supply of additional equipment.
- Risk assessments such as falls, nutritional and moving and handling risk assessments were inconsistently completed. Only two of the 20 patient records we looked at had all required risk assessments completed. We noted within the falls clinic patient falls risk assessments did not reflect the patients' actual falls risk and did not accurately identify the number of falls they had. Staff told us they only recorded falls they had witnessed and the trust policy we looked confirmed this. This meant appropriate and timely actions may not be in place to minimise the risk of patient falls.
- Tissue viability specialist nurses facilitated training days for community based teams and provided telephone support when required.

Staffing levels and caseload

- The community nursing teams had recently reduced from nine teams to five locality teams across the borough of Walsall. Changes to the teams meant caseloads ranged between 500 and 900 patients in each team rather than 250 and 450 patients when they were smaller teams.

Requires improvement

Are services safe?

- A "demand/ capacity tool" to measure community nurse visit requirements against actual availability of staff was used.
- Community nurses completed this tool weekly to identify required visits for the following week. If demand exceeded community nurse capacity, low priority visits (such as three monthly checks on patient's skin or continence needs) were cancelled or delayed. Community nurses told us priority was given to new visits over pre planned visits.
- Caseloads were regularly reviewed to reassess the frequency and appropriateness of visits to patients with long term conditions.
- Community nursing staff told us the increase in demand for their services with initiatives such as hospital avoidance without a similar increase in staffing put additional pressure on them. Information provided by the trust identified community caseloads are increasing year on year and had more than doubled over the past decade.
- The Professional Lead/Care Group Manager Community' told us they were monitoring whether the increasing number of cancelled or postponed visit had adversely affected patients.
- There were three community matron vacancies and eight band five vacancies although staff had been appointed for all posts and were waiting for start dates.
- Information provided by the trust identified average sickness absence rates for community nurses between February and August 2015 was 5.3% and 2.9% for allied health professionals and was below the trust average sickness rates.
- Community staffing shortages were identified on the trust's risk register.
- The Professional Lead/Care Group Manager Community' told us that they did not use agency staff but did use bank staff. However, as staff must have community experience it was mostly their own staff working additional hours who worked bank shifts. Information provided by the trust identified between January 2015 and August 2015 between 0.7% and 3.4 % community nursing shifts were filled by bank staff. This meant they were always able to provide cover and then non-urgent visits were cancelled or postponed.

Managing anticipated risks

- There was a lone worker policy in place. Staff were able to tell us about arrangements in place to minimise lone working risks such as visiting new patients in pairs. The out-of-hours team told us they always returned to their base before they went off duty to check that staff were safe and ensured they were always contactable by phone with each other.
- Managers confirmed they had a log of the make, colour and registration of all staff cars.. The potential risk to lone workers was identified on the community's risk register.
- Foreseeable risks and increased pressure for example, seasonal fluctuations including disruptions to the service due to adverse weather, were managed through emergency plans. These included plans to meet the needs of vulnerable patients in severe winter weather, heatwaves and during power cuts.
- Patients with additional support needs had been identified and this enabled staff to identify those who required a visit in an emergency situation, such as oxygen users, diabetic patients and those with electrical equipment.
- Community nurses told us about a fire in a patient's home who required oxygen. Staff told us this had resulted in joint working with the fire service and revised a more robust fire risk assessment for patients who had oxygen at home.

Major incident awareness and training

- Staff were aware of the trust major incident policy and senior staff were aware of their responsibilities in the event of a major incident being declared and the impact this would have on community services

Good

Are services effective?

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

Summary

We rated this domain as good. Care and treatment was evidence based and staff followed current best practice recommendations. The rapid response team, clinical intervention team and work within nursing and residential homes were seen to be excellent examples of good practice for hospital admission avoidance and enabling patient's choice to remain in their preferred place of care.

Staff were competent to carry out their role. There was a system to check nurse competencies in procedures such as specialist bandages for leg ulcers.

There were good examples of multidisciplinary working to enhance patient care and avoid unnecessary admissions to hospital.

The majority of community staff reported positive opportunities for training and development.

We saw examples of good multidisciplinary and multi-agency working with sharing information about patients on the 'virtual ward' and the use of the emergency care passport and patients who were unwell and at high risk of hospital admission.

Evidence based care and treatment

- The trust had a range of policies and national clinical guidelines (The Royal Marsden guidance) available for staff. These were held on the trust's intranet and staff showed us they were readily accessible for staff in the community.
- We observedwhen administering care and treatment the use of pathways and guidance was followed. Staff we spoke with understood how NICE (National Institute for Health and Care Excellence) guidance was applied and supported local guidelines. When we observed staff providing care to patients we saw assessment guidelines were used correctly.
- We saw NICE Guidelines were being adhered to, such as patients requiring care or appropriate equipment to manage pressure ulcers.
- Specific pathways and guidance were used for long term conditions such as chronic obstructive pulmonary disease (COPD) and heart failure, which staff accessed on the trust intranet.
- An audit of wound healing for patients who attended the wound care clinics throughout Walsall between April 2014 and March 2015 was 72.5%. This was the highest healing rate since the wound clinics were staffed by dedicated staff who regularly saw the same patients and assessed their wounds.
- From September 2013 community teams had reviewed data each month for patients who had been admitted to hospital four or more times in the previous 12 months. This had enabled community nurses to review care to ensure appropriate care arrangements were in place. In the first 18 months of completing this work patients deemed high users of acute services had readmissions reduced by over 250 episodes.
- We spoke with senior staff who reviewed patients in nursing and residential homes to ensure their care was appropriately and effectively managed; they told us they had no cause for concern.

Pain relief

- Our observation of staff administering care and treatment and our review of patient records confirmed patients were assessed appropriately for pain symptoms. We observed there was attention to pain during the patient examination and pain relief was offered immediately.
- Patients received effective pain relief and pain management plans were discussed with the patient to ascertain their pain levels and to provide advice.
- Specialist nurse teams referred patients directly to the pain service.
- Community nursing staff liaised with GPs to ensure patients were taking medication as prescribed to control pain symptoms.

- We saw staff ensured patients received medication reviews by their GP in a timely manner.

Nutrition and hydration

- The trust used MUST which is a recognised assessment tool to assess nutritional risk.
- Community and specialist nursing staff told us they referred patients to a dietician where the need for additional support and advice on appropriate treatment was required.
- We saw in nursing and residential homes, senior community staff had provided advice to staff in relation to the management of patients where fluid or dietary intake was compromised.

Technology and telemedicine

- Community nurses told us about their frustrations and limitations of the current IT system. Community nurses did not have access to mobile technology and they needed to complete paper patient records within patient's homes and then electronically when they returned to their base.
- Community managers told usthe current electronic system was not fit for purpose and was time consuming to use. There were long term plans to change the computer system and additional administration staff were available in some teams to support community nurses with the completion of information. However, there was no agreed date for this implementation.
- Community matrons were able to arrangefor patients to utilise 'telemedicine' in their own homes (telemedicine is a system that records and stores patients observations electronically so they are available to health professionals to remotely review and monitor the patient's health).
- One patient we visited had received care from community matrons for several years to manage their long term condition. They had requested not to be sent to hospital and received their care at home. We saw the patient or their carers checked and recorded observations such as temperature, pulse, blood pressure and respiration rate on identified days or if they felt unwell. The observations were then submitted electronically to the community matron for review. If needed the community matron would contact or visit the patient and provide further advice to manage their condition. The use of this equipment ensured the community matron and nurses were able to support the patient's wish to remain at home.

Patient outcomes

- Community matrons and nurses saw their role as crucial in promoting people's health, preventing hospital admissions and ensuring people were able to remain in their own homes for as long as possible.
- Senior community staff worked with nursing and residential homes supporting patients to avoid hospital admission and enabling them to remain in their preferred place of care.
- We saw physiotherapists had recorded patient goals in their records. Staff told us audits of patients achieving their goals was not undertaken.

Competent staff

- The trust had a target that at least 95% of staff must have had an up-to date-appraisal. Information provided by the trust identified 91% of community nurses had received annual appraisal in the last twelve months. We reviewed the trust report of appraisal rates for each service and location and these varied between 76.8% and 100%.
- All new staff completed a trust induction, complemented by induction and job shadowing locally. The trust provided all staff with training to support and enhance competencies in particular, skill areas relevant to the service.
- Staff told us and we saw training and development was supported throughout the trust. Training needs were identified as part of the appraisal and through one to one meetings. Staff were supported to complete education and skills development.
- The majority of therapy staff said they were appropriately supported to undertake further training and development; we saw evidence external courses were available and staff were encouraged to attend. However, one therapist told us they had not received clinical training from a more senior therapist and there was a lack of clinical support to advance clinical skills.
- There was a system to check nurse competencies in procedures for example, compression bandaging for the

management of leg ulcers and Doppler ultrasound (to check blood flow in patient's legs). There were no formal arrangements for clinical supervision for community nurses. Team managers told us and we saw they used their daily handovers to review patients and their treatment as an informal clinical supervision arrangement.

- Community nurses told us managers would accompany them on visits to check clinical practice and competence but were unsure if a record of the visits and checks was completed . However, we did not see any records of these visits although we requested this from the trust.
- Some therapists told us they had clinical supervision to review and validate their practice however, there was no information to support how many therapists received clinical supervision.
- Tissue viability specialist nurses facilitated training days for community based teams and provided telephone support.

Multi-disciplinary working and coordinated care pathways

- The Community Nursing teams in Walsall were attached to identified GP practices to facilitate multidisciplinary team (MDT) working.
- GPs were kept fully informed of specialist assessments and community teams worked closely with practice nurses and specialist teams were available to provide advice.
- Community nurses and community matrons spoke positively about joint working with specialist nurses such as palliative care, respiratory, heart failure and diabetes.
- One community nursing team was an integrated health and social care team which included social workers, physiotherapists and occupational therapists. There were plans to integrate all teams.
- We saw good MDT working with some community teams and other professionals such as physiotherapists and occupational therapists. We found there were positive arrangements for MDT working when teams had historically worked together or were at the same base but this was not universal with all community nursing teams.
- We saw examples where high risk community nursing patients had a weekly MDT meeting with the patient's doctor, social worker, occupational therapist and community matron.
- There was a 'virtual ward' of community patients who were unwell and were at high risk of admission to hospital. Patients on the 'virtual ward' and their management plans were shared with community matrons, community nurse out of hours service, the rapid response service and the ambulance service. This ensured all professionals were aware of their treatment needs and plan of care and when possible avoided their admission to hospital.
- The advanced nurse practitioner had implemented an 'emergency care passport' for high risk nursing home residents. The 'passport' provided all essential information about the patient and their treatment needs for both the ambulance service and the hospital if they required admission to hospital.
- The Advanced Nurse Practitioner (ANP) told us as part of the trust hospital admission avoidance scheme they had worked closely with West Midlands Ambulance to identify nursing and residential homes which had the highest number of 999 calls in a month. Those homes with the highest number of 999 calls received staff support and training in areas such as pressure ulcer prevention, early and proactive management of urinary infections and reduced fluid intake. The ANP told us one home which had 23 emergency calls in January 2015, had made only two 999 calls in August 2015. The ANP told us following the success of the project support, it would be made available to other nursing homes.
- There were good examples of multidisciplinary working to enhance patient care and avoid unnecessary admissions to hospital.
- Community nursing staff reported there was good communication with the out-of-hours service to ensure continuity of community nursing care.

Good

Are services effective?

Referral, transfer, discharge and transition

- Referrals to community health services came from a variety of services including GPs, practice nurses, district nurses, patients being discharged from hospital wards and complex cases in nursing homes and residential homes.
- Community nurses were able to refer patients urgently for assessment to the rapid response service in order to prevent a hospital admission.
- All referrals followed agreed pathways of care and staff confirmed there were clear criteria for referral of patients which meant inappropriate referrals could be identified.
- We found discharge arrangements between hospital and community settings were not always effective. We visited two patients who informed us they had been told by the hospital community nurses would arrange equipment such as a hospital bed and specialist pressure mattress but this had not been communicated to community nurses. Community nurses agreed they sometimes experienced problems with patient discharges from hospital but this had improved by better liaison with senior ward managers.
- The advanced nurse practitioner told us when a community patient assessed as being 'high risk' was admitted to the hospital, they would discuss the patient's care with the 'in reach matron' in the hospital. They said this meant the patient's care needs and home circumstances were known which facilitated a more timely discharge from hospital.

Access to information

- We reviewed information on the trust intranet staff used to support their work and saw the information was clear and accessible. This also enabled staff to access information about evidence based patient care and treatment through external internet sites.
- Staff received corporate emails with team briefings, newsletters and other updates about particular themes on a regular basis.
- Community staff told us information was shared during handovers and in team meetings.
- In community locations, information displayed in staff areas was up-to-date and relevant. Themes were used to draw attention to particular issues relevant to staff and were colourful and eye-catching. Staff briefings included information about other services within the trust and other organisations nationally.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We saw patients' verbal consent was obtained before care was delivered and this was recorded.
- Staff told us they received training for the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) as part of their annual mandatory update.
  We observed records of investigations into patient harm. We saw it was identified that although the patient had capacity and had refused care, this had resulted in harm. Actions to ensure lessons learned included community staff must not only record patient's wishes but identified risks were also explained to them.
- Staff demonstrated a clear understanding of the Act, of their responsibilities and of DoLS procedures. Mental capacity assessments were undertaken if nursing staff had doubts that a patient lacked capacity to make decisions for themselves.

Good

Are services caring?

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

Summary

We rated this domain as good. Patient and all carers spoke positively about the care provided.

Patients received compassionate care and we witnessed positive interactions between patients and staff.

Staff discussed planned care and treatment with patients and provided information to reinforce understanding. Staff promoted self-care to encourage patients to maintain their independence.

Staff provided emotional support for patients and their carers and families.

Compassionate care

- During our inspection, we observed patients and relatives being treated with dignity, respect and compassion.
- We did observe one incident of a patient treated without sufficient compassion despite sayingthey were uncomfortable lying down following recent surgery. The therapist did not respond to the patients discomfort and waited for them to lie down without providing assistance to make them comfortable.
- This was an isolated incident. In general, we observed caring, compassionate care being delivered and staff were considerate towards patients, their relatives and other people.
- Community staff had a good understanding with patients and had built up good relationships with patients they knew.
- When delivering care and treatment, staff respected patient confidentiality. Confidentiality was maintained in discussions with patients and their relatives and in written records.
- All patients, carers and relatives we spoke with were very positive about the care and treatment they received. One patient and their family told us: “I don’t know what we would have done without these girls (community nurses).”
- Letters and comment cards received from patients were displayed in community locations we visited and showed consistently positive comments.
- The trust used the Family and Friends Test as a means of receiving patient and family feedback. There was a low response rate for the return of the Friends and Family Test. Information we saw from community teams including the rapid response team, and community stroke team was that 100% of patients who responded said they would recommend the service.
- We received 263 ‘comment cards’ about community services (this included all community services including children’s and end of life care) and all but one commented positively about the services received. Of the comment cards returned, 120 made specific positive comments about the care and treatment they had received. 61 said staff were caring and 32 said they were treated with respect. 27 made general positive comments.

Understanding and involvement of patients and those close to them

- We observed care and treatment being delivered in community locations and staff demonstrated good communication skills during the examination of patients, giving clear explanations and checking understanding.
- We observed staff listened to patients, explained their symptoms and identified patients’ needs.
- Staff answered questions from patients directly and explained what the patient could expect to happen next and likely outcomes. Further visits were arranged where more information was required to support and involve the patient in their care and treatment. Of the 263 comment cards we received 58 made specific mention that staff had communicated their treatment plans.
- We observed community nursing staff involved the patient, family and carers in decision making.. We observed community nurses give advice to patients on

Good

Are services caring?

medication and its use. Therapists set goals with the patient's involvement and planned with the patient so that their needs were addressed to help them achieve their goals.

- We observed home visits by community nursing staff where patients were involved in their own care plans where appropriate and able to do so. Nurses used their relationship with patients and carers to support the patient and determine if information was understood.
- One carer told us although their relative was unable to communicate, staff always spoke directly to them and explained what they were doing.

Emotional support

- All staff we spoke with told us part of their job was to provide emotional support not just to patients but also their carers and families. During home visits staff demonstrated knowledge of people and their unique situations and provided tailored emotional support.
- Patients and relatives were referred to specialist services to provide support where appropriate.

Good

Are services responsive to people's needs?

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

Summary

We rated this domain as good. Community services were planned and were responsive to the needs of the people of Walsall and the surrounding area. Community services supported people to receive care either in their own home or close to their home at the times and in the places they needed it.

There were excellent initiatives in place to prevent unnecessary hospital admissions.

Community services for adults were responsive to the needs of vulnerable people, differing communities, ethnicities and religions.

Referral to treatment times were not delayed and were prioritised for the most urgent care needs.

Patients were given information about how to make complaints and when complaints were raised they were investigated and patients were informed of the outcome.

Planning and delivering services which meet people's needs

- Community services included specialist nurses and therapists to care for, educate and support people to manage their long term medical conditions, for example, diabetes, COPD, stroke, leg ulcers, wound care and continence issues.
- Community nursing teams attended the needs of patients who were assessed as predominantly housebound or their needs were identified as best being met in their own home.
- Patients who were more mobile were able to receive care and treatment at local community clinics.
- Community case managers liaised with residential and nursing homes and provided training to support patient care and when possible avoid the patient's admission to hospital.
- There was a diabetes programme for Walsall patients which patients' doctors could refer them to via an electronic booking system. The diabetes team had developed a 'Diabetes and Me' booklet that was being distributed to community teams for their patients. The booklet included information about diabetes, its management and contact details for diabetes services.
- The trust had a community 'Virtual Ward'. The virtual ward was made up of vulnerable patients identified at 'high risk' of hospital admission or had an earlier than expected discharge from Accident and Emergency. The key aim of the Virtual Ward was to care for acutely ill patients within the community to prevent avoidable hospital admissions and deliver care within a patient's own home environment.
- The community neuro-rehabilitation team had developed a self-management programme for patients who were living with Parkinson's disease. The programme consisted of seven three hour patient group sessions. The aim of the programme was to promote better self-management of Parkinson's disease and ensure effective and appropriate use of rehabilitation services tailored to the needs of the individual.

Equality and diversity

- Staff confirmed translation services were available for people whose first language was not English and were able to provide examples where the interpreter service had been used.
- Staff also stated they had a multi-cultural workforce who spoke several languages and could also provide translation when needed. This is not considered best practice.
- Staff said they asked what the patient's cultural needs were as part of their initial and ongoing assessment. This was confirmed by patients we spoke with.
- There were no equality and diversity training figures available for community adult teams.
- Leaflets for services stated the information was available in other formats and languages other than English. However, the only information we saw was in English.

Good

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- The trust had designated dementia champions who provided advice and support to community staff.
- Staff explained two members of staff attended visits with some patients, depending on the assessment of their need for example, patients living with a learning disability or dementia.
- We found there were good working relationships with the community matron and the 'in reach' matron in the hospital.
- Community patients who were identified as vulnerable and may be elderly or living with dementiabenefited from shared information about their needs. Community stafftold us they also facilitated timely and appropriate discharge arrangements.
- The emergency admission alert was an electronic alert system which identified when a vulnerable community patient was admitted to hospital. It provided key intelligence regarding the patient's needs, home environment and care package in place and facilitated when possible their early but safe discharge.

Access to the right care at the right time

- There was a single telephone access point to contact community nursing services between 8am and 5pm. After 5pm requests for community nursing could be made via the Walsall Manor Hospital switchboard.
- Community nurses would call patients back and when needed would visit them at home. This helped patients get the right care at the right time and where possible avoid admission to hospital.
- Information provided by the trust identified between 1 March 2015 and 31 September there were 849 referrals to the rapid response team for urgent review (to be visited within two hours). 95 of 849 patients seen by the rapid response team were admitted to hospital and 88.4% of patients who were seen by the rapid response team avoided a hospital admission.
- The clinical intervention team provided intravenous treatment for deep vein thrombosis, pulmonary embolism and intravenous antibiotics within local community clinics. The involvement of the clinical intervention team enabled patients to receive care whilst being at home and avoid a hospital admission.
- When we visited patients at home, three patients were unsure how to contact community nursing services. In addition, there were no contact details for community nurses in three out of 20 of the patient records we looked at.
- Information provided by the trust showed 100% of urgent referrals to community nursing were within both the 24 and 48 hour target. Community nurses told us they would see any urgent referral for example, end of life care, on the same day.
- Information provided by the trust showed the average shortfall between 28 March 2015 and 6 September 2015 of community nursing availability was 398.2 hours and 348 visits were cancelled during the same time frame.
- Information provided by the trust identified only low priority visits werecancelled and alternative arrangements were made, such as telephoning the patient and discussing their health or visits were rearranged for the following week depending on priority of need.
- The trust target for urgent visits by community nurses was either 24 or 48 hours (dependent on identified need), which the service had achieved for 100% of patients. Routine referrals (over 48 hours) were not audited. However, information supplied by the trust confirmed this information would be available and reported on in future as key performance indicators (KPI's).
- The trust had a two hour target response time for referrals to the rapid response team. There had been an ongoing drive to improve response times. We saw the response time from 57% of referrals in March has increased to 91% in August 2015.
- Information provided by the trust identified therapy services met their maximum waiting list time frames of referral to treatment within three to four months (dependent on the service). For locality occupational

Good

Are services responsive to people's needs?

therapy and physiotherapy there was a four week wait, community musculoskeletal physiotherapy had an eight week wait and community adult domiciliary visits hada two week wait.

- New referrals into the Community Neurological Rehabilitation Team were seen in the multidisciplinary Goal Attainment Scaling clinic (including Occupational Therapy, Physiotherapy and Clinical Psychology).
- Waiting time for this clinic was two weeks. More urgent referrals for 'high risk' hospital discharges were seen within one week. Patients were then offered follow up with therapist's dependant on the outcome of their multidisciplinary assessment.
- The percentage of patents who did not attend community appointments or were not in when community staff visited between January 2015 and August 2015 was between 3.7% and 4.1%.
- The falls prevention team provided a service for patients who had 3 falls in the last 12 months or a fall resulting in injury/hospital attendance. The team consisted of both physiotherapists and occupational therapists and identify how patients' falls risk may be decreased. There was a six week wait to be seen by these services.

Learning from complaints and concerns

- Information provided by the trust identified there were five complaints about community services between 1 April 2015 and 31 August 2015. We saw complaints were appropriately responded to and actions in response to the complaint were shared with the complainant such as additional training in specialist techniques such as Doppler checks for patients with leg ulcers.
- The Professional Lead/Care Group Manager Community' told us they previously had a high number of complaints which had included missed visits and poor communication between staff. They told us the reduction in the number of community nursing teams had improved communication, visits were not missed and as a result of this, complaints were few.
- Staff we spoke with were aware of the complaints procedure and told us they tried to resolve complaints locally as they arose and we saw a robust complaints policy in place.
- We saw evidence both complaints and compliments were shared at team meetings.

Good

Are services well-led?

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

Summary

We rated this domain as good. Staff in community services for adults were positive about the trust's vision and strategy. Community staff saw their role in the trusts strategy as providing patient care closer to home, maintaining patients in their own homes for as long as possible and when possible, avoiding hospital admission.

Safety incidents were promptly reported and rigorously investigated and when needed lessons were learned and shared. Risks were appropriately identified and actions were in place to address current and future risk.

Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role.

The leadership was knowledgeable about quality issues and recognised challenges such as the increased demand on community services. Staff said their direct line managers and Professional Lead/Care Group Manager Community' were supportive and provided leadership.

Service vision and strategy

- Community staff were clear of the vision and strategy for their services. They told us the trust had a vision with "Care closer to home" and hospital admission avoidance and supporting patients to remain in their own home or chosen place of care for as long as possible.
- The development of case load managers to support care homes to manage patients more effectively and avoid when possible admission to hospital supported the trust vision.

Governance, risk management and quality measurement

- The safety thermometer was completed monthly. However, information included all community services and was not available for individual teams to identify where improvements were needed or had been made.
- Governance arrangements were in place to ensure incidents, complaints and concerns were appropriately managed. Staff were able to tell us about lessons which had been learned and actions in response to identified incidents such as the fire risk assessment for patients in receipt of oxygen.
- There were monthly business team meetings with clinical team leaders representing all service areas. This meeting reviewed not only the management of the business unit but increased areas of risk such as staffing capacity. Any issues which could not be resolved by the business team were escalated to the Care Group Quality meeting and then onto the Divisional Quality Board if they remained unresolved. The Care Group Manager/ Professional Lead chaired the monthly business meeting, had a senior representative attending the Care Group Quality meeting and was also a member of the Divisional Quality Board to ensure risks were clearly understood and identified.
- There were four identified risks on the community risk register. There were no red (highest risk), three amber risk (moderate risk) and one green risk (low risk). The amber risks were: insufficient capacity of community nursing to meet increased patient demand and increased demand for loan medical equipment which may mean inappropriate patient management and lone working in the community.
- We saw there were strategies in place to reduce the risks. One example included the review of equipment for patients who were no longer community nursing patients or needs had changed. The Professional Lead/ Care Group Manager Community' said the 'repatriation of equipment more than paid for the staff members time.' Staffing capacity was reviewed and an agreement to use bank staff was in place and also the rearrangement of non-urgent visits.
- However, the number of cancelled or postponed weekly visits meant this was usual practice and further exploration of potential risk of patient harm was required.
- There were regular meetings for community services long term conditions (minutes of meeting provided

showed these meeting had been held in April, July and August 2015). We saw a serious case had been discussed and actions taken to reduce the risk to other patients with the implementation of a fire risk assessment for patients who required oxygen. This meeting had discussed increased demand for community services without sufficient capacity and actions needed to minimise risk. The outcome of these meetings were shared with community staff at monthly team briefings.

- There were monthly community matron meetings which discussed key performance indicators (KPIs), hospital admission avoidance strategies and outcomes and service improvements.
- There were monthly team leader meetings to discuss and review current and future provision of services and improvements. Minutes of these minutes showed initiatives such as 'named nurse' and revised actions required to reduce needle stick injuries for staff who administer insulin.
- Community team leaders told us following a notification of a serious incident such as a pressure ulcer, a route cause analysis investigation (RCA) was undertaken. The RCA was then discussed with other senior nurses and staff within the trust. One team manager told us they had recently presented a RCA and following its scrutiny a decision was made that it was unavoidable.

Leadership of this service

- The Professional Lead/Care Group Manager Community' 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 and provided leadership.
- All community staff told us the Professional Lead/Care Group Manager Community' was supportive and approachable. However, community nurses told us they were not aware of and had no contact with more senior nurses within the trust.
- There was no overall approach to checking patient's care plans were reviewed and updated. Staff told us this was everyone's responsibility however, we saw this was an area in need of further work.
- We also found team leaders did not routinely visit with their teams as part of a review of staff practice and to assure themselves the care delivered was of a high quality.
- There had been changes to the leadership and management of therapy staff. Therapists were managed by a different division to community nursing which led to some confusion about provision of the service. The manager of therapy services was unable to tell us the total number of therapy staff they managed or the therapy budget.
- One therapy (Neurology rehabilitation) team had been without a team leader since January 2015 and staff felt they needed additional support.
- Staff in other community teams such as the out-of-hours team, the rapid response team and the clinical interventions team told us their line managers and head of community nurses were supportive and accessible.
- Community staff told us the Chief Executive had visited several community services and had visited patients in their own home with community nurses. Community staff told us they felt the Chief Executive was approachable and understood and appreciated the value of community services.
- Health care assistant staff felt comfortable in their role and well supported in their development.

Culture within this service

- Community staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. There was good team working. They were able to put forward ideas and discuss them as a team.
- Staff said the trust was good to work for and there was a patient focused culture which supported patients to receive the care and treatment where they preferred.
- Staff were mostly enthusiastic and felt the value of community services working alongside the acute hospital to improve patient care and this was recognised by the Chief Executive. One staff member told us following an upsetting incident both the Chief Executive and Professional Lead/Care Group Manager Community' had contacted them to check on their welfare which they had appreciated.

Good

Are services well-led?

- Community staff did raise concerns developments such as hospital admission avoidance and increased management of patients receiving end of life care in the community had put additional strain on community staffing.

Public engagement

- Community services had recently commenced engagement with the public through the NHS Friends and Family test. However, numbers which had been returned were small.
- Some services used comment cards to capture feedback from patients. The notice board in community locations displayed thank you cards demonstrating patients and relatives had taken the time to write and thank staff.
- The neurological rehabilitation service had quarterly drop in sessions for patients at Short Heath clinic and provided an opportunity for patients to discuss developments in neurological rehabilitation with therapists.

Staff engagement

- The trust used a combination of email, intranet messages and newsletters to engage with community staff. We saw information on the trust web site informing staff about the CQC inspection.
- Staff said team managers ensured they were aware of trust developments.
- Staff told us the Chief Executive had visited community services to discuss their views about the service provided.

Innovation, improvement and sustainability

- The trust had case load managers and advanced nurse practitioners to provide education and support to nursing and residential homes. The project to date had identified those services and patients who most frequently used 999 services and patients who were admitted to hospital.The number of avoidable 999 calls and avoidable hospital admissions had been reduced.
- 'Emergency care passports' provided easy reference and accompanied the patient to hospital when required and provided all essential information about the patient and their needs.
- The rapid response service advanced practitioners (nurses and therapists) visited within a two hour response time with an aim when possible, to avoid hospital admission. Information provided by the trust demonstrated the effectiveness of this service to prevent hospital admission.
- The emergency admission alerts was an electronic alert system which identified when vulnerable community patients were admitted to hospital. It provided key intelligence regarding the patient's home environment and care package and links between community matrons and hospital staff to facilitate early discharge when possible.