The Royal Wolverhampton NHS Trust

RL4

Community health services for adults

Quality Report

New Cross Hospital, Wolverhampton Rd,
Wolverhampton WV10 0QP
Tel: 01902 307999
Website: www.royalwolverhamptonhospitals.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/unit/ team)
RL4X2	The Royal Wolverhampton NHS Trust Community Services		
RL4X1	West Park Rehabilitation Hospital	<Placeholder text>	<Placeholder text>

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good

Overall we judged community health services for adults were good.

Incidents were reported across teams, learning was identified and shared at regular meetings. The incident reporting and safeguarding policies were understood by staff and regularly used. Sufficient equipment was available and was used safely. The service had infection prevention and control policies and staff were seen to observe good practice. The service had a lone working policy in place and staff were aware of and used procedures to reduce risks when working alone. The service regularly undertook a range of audits to improve performance and support safety.

Community services had carried out a number of recent patient satisfaction surveys, with results showing a positive overall satisfaction rating of 90%. Several examples of new and emerging innovative practice were observed.

Staff and managers understood their roles and responsibilities in the delivery of evidence-based care.

A recognised assessment tool was used to identify deteriorating patients and nutrition and hydration assessments were completed. Staff appeared very competent in their contact with and treatment of patients. Multi-disciplinary working within the trust and joint arrangements with external organisations worked well. Community nursing teams worked closely with GP practices, nursing homes and with social services.

Patients and their relatives were treated with dignity, respect and compassion. Staff respected confidentiality in discussions with patients and their relatives and in their management of written records and other communications. Staff demonstrated good communication skills and were aware of the emotional aspects of care. Advice about self- care was provided when appropriate and we found some outstanding practice in this respect. Patients we spoke with were very positive about the care and treatment they received and about the members of staff with whom they had had contact.

Action to be undertaken following the investigation of a complaint was identified, the action proposed was discussed with the patient and the completion of actions was monitored. Staff could describe how services had changed as a result of action taken.

The service responded to identified risks and maintained a risk register. The service managed foreseeable risks and planned for changes in demand due to seasonal fluctuations and severe weather. The service had contingency plans in place to respond to major incidents.

Staffing levels were sufficient in most areas. In some community locations staffing levels including cover arrangements required review to ensure adequate staffing arrangements for community nursing teams so that patients were not placed at risk.

Patients could access community health services promptly when they needed to and services were provided with ease of access for patients in mind.

Completion of mandatory training stood at over 95% overall for community services for adults staff.

Staff felt there was clear leadership at executive level and the executive team were approachable. Regular open meetings were held for staff to meet with trust executives and these were well attended. Local leadership was effective and staff said their direct line managers were supportive and encouraging. Managers and staff told us they felt there was a clear vision for the community services and a strategy of improvement and development of service delivery.

Before our inspection we held two listening events to allow members of the public to tell us about their experiences of using this service. During our inspection we spoke to 24 patients, eight patients' relatives, 76 nurses, 12 healthcare assistants, three student nurses, 24 therapists, two doctors, two pharmacists and three ancillary staff. We also looked at 28 sets of patient records.

Summary of findings

Background to the service

Community services for adults provided care and treatment for patients' in their own homes and in residential care throughout Wolverhampton and part of South Staffordshire. Apart from the primary location at West Park Rehabilitation Hospital we visited two other locations from where community services for adults were managed: Bilston Health Centre and Primrose Lane Health Centre. Services they provided were anticoagulation and phlebotomy, diabetes treatment, district nursing, infection prevention, neurological rehabilitation, primary and intermediate care, continence nursing, foot health services, healthy lifestyles, a hospital at home team and a homes in-reach team. Services were provided from six locations across the city.

Our inspection team

Our inspection team was led by:

Chair: Karen Proctor, Director of Nursing Guy's and St Thomas' Hospital NHS Foundation Trust

Team Leader: Tim Cooper, Head of hospital Inspection, Care Quality Commission

The team included CQC inspectors and a variety of specialists: who were a Medical Director, an Executive Director of Nursing & Quality, a Designated Nurse for Child Safeguarding, a Consultant Physician in Diabetes & Endocrinology, a Consultant in Clinical Oncology, a Outpatients Doctor, a Consultant in Palliative Medicine, a Consultant Orthopaedic Surgeon, a Consultant, formerly Emergency medicine, a Consultant Obstetrician & Gynaecologist, a Consultant in Intensive Care & Associate Medical Director, a Paediatrician and a FY2 (Junior Doctor), a Clinical Nurse Specialist Older People, a Staff Nurse - End of Life Care & Oncology, a Renal Specialist Nurse, a Principal Radiographer Head of Imaging and Equipment Services, a Surgery Nurse Midwifery, a Senior Staff Nurse Senior management / Nurse - Paediatrics and child health and a student nurse.

The specialists advisors who worked with our community teams had experience: Community Children's Nurse, a Senior Health Advisor for Looked after Children, a Registered Nurse - Nursing and clinical care both acute and primary care, leadership/management & governance systems, a Service Manager District nursing and two Nurses Palliative Care.

There were three experts by experience who were 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 our commitment to review all acute and integrated trusts by March 2016. This service was scheduled sooner because it had incorporated services from the now dissolved Mid Staffordshire Trust and we wanted to assess the impact of that. It had previously been part of the initial wave of inspections which was pre ratings which was also an consideration in scheduling this inspection.

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 hold about the core service and asked other

Summary of findings

organisations to share what they knew. We carried out an announced visit on 02, 03, 04 and 05 June 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and non-clinical staff. We talked with people who use services both on the day and prior to the inspection during advertised listening events. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We carried out an unannounced between the dates of 08 to 19 June 2015.

What people who use the provider say

Patients told us they were delighted at being cared for and treated at home, had no concerns about their care or treatment, felt that the nurses gave them plenty of information and that they "couldn't fault them". They described the therapists as "brilliant", "wonderful", "marvellous" and "lovely people" who "go the extra mile".

Good practice

- The innovative therapies provided by the stroke rehabilitation team, the proactive services provided by the hospital at home and the homes in-reach teams and the tenacious, dedicated care demonstrated by the HIV/AIDS therapy service were outstanding.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should review the paperwork used by district nursing teams to record their planned visits to ensure that patients' details are kept safe.
- The trust should review the diagnostic equipment carried by district nurses to ensure that they are able to carry out a full assessment of patients, including blood glucose levels.
- The trust should review its complaint logging system to ensure that numbers of complaints are recorded accurately.
- The trust should examine the compatibility of the IT systems used in the acute and community sections to resolve communication issues.

The Royal Wolverhampton NHS Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We found that patients, relatives and staff were protected from abuse and avoidable harm and that safety was important to all staff. 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.

Staff were trained in and understood the process for safeguarding vulnerable adults and knew when to raise a concern. The safeguarding team was available to give advice by telephone or email if staff had any queries.

Due to sickness, vacancies and other absences such as maternity leave staffing levels had proved to be a challenge in some services, with vacant nurse hours ranging from one per cent in one team to nine per cent in another, however we found that managers were aware of the situation and that plans were in place to improve this. Staff shortfalls were covered by the service's own staff working bank shifts.

There were plans to minimise the effect on the service from risks such as fire, severe weather and outbreaks of infectious diseases and staff were aware of these.

Incident reporting, learning and improvement

- We saw performance against the NHS safety thermometer displayed at district nursing bases. This is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. It measures prevalence of pressure ulcers, falls, catheter-acquired urinary tract infections, venous thromboembolisms (blood clots in veins) and harm-free care. We were given data for the community nursing teams' performance over March, April and May 2015 which showed that they had scored 95% for harm-free care. This is in line with national average figures for the same period.

Good

Are services safe?

- All of the staff we talked to were aware of the trust's incident reporting system and had a good understanding of their duty to report incidents and of the process involved, which they described as 'clear'. We saw nine examples of incident reports that had been properly completed and submitted. These included reports about pressure ulcers, patients found at home with injuries and medicine incidents.
- We were told that records of investigations were selected at random and scrutinised by senior managers to ensure they had been carried out properly.
- One band seven nurse who had recently joined the trust told us they had never seen such a robust incident reporting and investigation system before.
- All of the staff we spoke with told us they regularly received feedback from incidents that had been reported. Feedback was shared during monthly governance meetings attended by department managers and was cascaded down to all staff.
- Feedback from incidents was provided to staff in external organisations such as care and nursing homes when issues were discovered in their practice. We saw an example of a medication error from a care home that had been identified and reported by the district nursing team. After investigation of the incident training was provided for the care home staff to educate them and reduce the chances of a similar incident reoccurring.
- Staff had confidence in the incident reporting and investigation system and were encouraged to report concerns. The system was viewed positively as a way to learn from incidents and to gain knowledge, change practice and improve patient outcomes.
- Two matrons from community services told us that when district nurses first visit patients who had just been discharged from the acute hospital they carried out a risk assessment in the patients' homes and reported any issues with medicines or equipment. Findings from these assessments were fed back to staff in the hospital to improve the way that services would be provided for future patients.

Duty of Candour

- We saw copies of letters sent by different teams from community services for adults to five patients within the 12 months leading up to our inspection. The patients had acquired pressure ulcers which were found to have been avoidable. The letters informed the patients of the initial reports and then of the process and outcomes of the trust's investigations, and told them that the pressure ulcers had been avoidable. They included invitations for the patients to meet with managers to talk about the situation.
- We saw a copy of the April edition of the Adult Community Services Group newsletter which contained information for staff about duty of candour, including what it is and what staff must do. It also contained the name and contact details of the governance representative for community services in case staff had any questions about the process.

Safeguarding

- We were given a copy of the trust's 'Safeguarding Vulnerable Adults in Hospital and Community'. The policy complied with legislation and national guidelines.
- All the staff we spoke to had a good understanding of the need and process for making safeguarding referrals. This meant that vulnerable people who came into contact with community teams were protected from harm or the risk of harm.
- We were given details of six incidents when safeguarding referrals had been made by staff from community services. These alerts were completed appropriately and within the 24 hour time frame.
- We saw records of staff training which showed that all community services staff had completed level two safeguarding training to ensure they can recognise potential safeguarding situations and know how and when to report them. Training records showed that over 99% of staff from community services for adults had completed training on safeguarding adults, and 97% had completed training on safeguarding children.
- All safeguarding issues were escalated to a senior manager who kept a database for the department's own reference so that staff could be aware of any patterns or repeated safeguarding situations in external social care services. This database was kept in addition to the standard safeguarding process.
- Staff told us they had good support from the safeguarding team at New Cross Hospital, who were available to give advice on the telephone or by email in the event of queries.

Medicines management

Good

Are services safe?

- We talked to with two pharmacists who told us that a medicines safety officer had recently been appointed to take an overview of incidents involving medicines and ensure that information about these was shared across all departments in the trust. Medicine incidents from community services for adults were reported to the medicines safety officer.
- We were shown an example of the standard medication administration record sheet used by community services for adults. The sheet was well laid out, simple and easy to understand. This helped to reduce medication errors by clearly showing the type, strength and frequency of doses of patients' medicine and staff told us they found the system easy to use.
- We saw that the date of opening for some medicines stored in patients' homes was not always recorded on the medicine's packaging or in the patients' care notes. Some of these medicines had a useable life of 28 days after being opened. While they were expected to be used well before the 28 day time limit due to the dosage amount and frequency there was a risk of expired medicines being given to patients.
- Community nursing teams do not carry or keep stocks of patients' medication. Each patient's medicines are stored in the patient's home. This means that medicines for different patients cannot be mixed up and improves safety. If additional medicines were required out of hours the on-call GP service supplied small quantities.

Safety of equipment

- We were shown the March 2015 results of the quarterly 'bag and boot' audits that were carried out to make sure that equipment carried in district nurses' bags and cars was in date, properly packaged and safely stored, and that the bags themselves were safe to use. The audit identified a number of areas which needed to be addressed to reduce the risk of injury to staff from carrying bags, to make sure that some items of emergency equipment were carried as standard and to make bags compliant with infection prevention guidance. We spoke with a nurse manager who told us that all the actions identified by this audit had been resolved, were out for consultation with senior nurses or had been cascaded verbally to staff through meetings and handovers.
- We were shown a stock cupboard at one district nursing base. Dressings specific to each patient's needs were marked with the patient's name and the date they were received, and we saw a record sheet which district nurses signed when they drew stock from the cupboard. This ensured that the right dressings were available for each patient and that they received treatment appropriate to their needs. The cupboard also contained a small amount of general stock such as bandages and commonly used dressings to maintain availability over weekends and bank holidays.
- We observed safe and appropriate use of a hoist to transfer a patient in their home.
- One district nurse we accompanied on visits to patients' houses was unable to check a patient's blood glucose level as the team was not supplied with blood glucose monitors. A GP had to be called out to assess the patient. We were shown the 'standard procedure for maintenance of the health care professional bag and equipment for adults within adult community services' which included a list of items to be carried in district nurses' kit bags and saw that a blood glucose monitor was not part of their standard equipment.
- Community services issued blood glucose monitors to patients who were known to be diabetic. We were shown the 'home blood glucose (BG) monitoring guidance for patients with diabetes on insulin managed by the community nursing team'. This guidance contained instructions for registering the serial number of blood glucose monitors with the diabetes specialist nurse who would then manage calibration and servicing of the monitor

Records and management

- Community services used a carbonated paper records system. All records of treatment and care were handwritten and stored in an easily identifiable, standard folder in patients' homes. The carbon copies of the notes from each visit were taken back to the nurses' base locations during their shifts. This minimised the risk of loss of confidential personal information as community staff did not carry patient notes with them, apart from those relating to one visit. The use of carbon copies ensured that records held at the nurses' bases were the same as those at patients' homes and that mistakes were not made by writing notes twice.
- We looked at 28 sets of patient notes and found records of care had been clearly documented. This ensured that staff from different community teams were aware of what had been done for the patients when they visited.

Good

Are services safe?

- We saw several examples of patient notes folders which were in a standard format and an easily identifiable ring binder. This meant that safety was improved for patients as staff knew where treatment and medicine details were recorded.
- We spoke with eight patients by telephone and were told that their care record folders were filled in every time a member of community services staff visited them. One patient told us they read the notes left by visiting staff and described them as written "nicely and professionally as a report".
- We saw containers for secure disposal of confidential personal information in every trust location we visited, and we saw computer screensavers reminding staff to 'stop, check and shred' any confidential personal information that was no longer required.
- We saw that staff had personal issue rubber stamps bearing their name, designation and identification number (registration number for qualified nurses and part of payroll number for healthcare assistants). We saw staff using these stamps in patient records when they had added notes, as well as signing the notes. This meant that staff who have looked after a patient can be easily identified without their handwritten signatures having to be deciphered.

Cleanliness, infection control and hygiene

- In all the locations we visited we saw that handwashing facilities, alcohol gel, gloves, aprons and cleaning wipes were available. We observed staff cleaning their hands before and after contact with patients, with equipment and with the patients' environment and we saw appropriate use of gloves and aprons. We saw equipment being cleaned after use and we were told that larger items of equipment such as syringe drivers and pumps that were left in patients' houses during their treatment were taken back to the nurses' base after use and were cleaned before reuse. This meant that patients and staff were protected from infections.
- We saw used equipment and dressings being properly disposed of in sharps bins and clinical waste bags.
- We visited clinical areas at West Park Hospital, Bilston Health Centre and Primrose Lane Health Centre. All the areas we visited were clean, well-lit, and uncluttered and provided an appropriate environment for safe assessment and treatment of patients.

Mandatory training

- We saw records of staff attendance at mandatory training in the community teams and these were consistently over 95%. This meant that staff received the necessary training to keep patients and themselves safe while at work.
- Training records showed a good uptake of mandatory training by staff. Completion rates were recorded as 94% for fire safety training, 98% for infection prevention, 100% for basic life support, 96% for trust/corporate induction and 99% for bullying and harassment training.
- Most mandatory training was provided as e-learning through a section of the trust's intranet called the 'kite site'. Mandatory courses turned amber on staff members' training records when they were less than two months from their due date. This helped staff to prioritise the training that needed to be completed.

Assessing and responding to patient risk

- We found that community services for adults had a good awareness of risks to their patients and the teams worked well together to minimise and respond to risks. We were shown an example of the community intermediate care team (CICT) recognising a patient who was at increased risk of suffering a pulmonary embolism, a type of blood clot in the lung, who was quickly referred to the anticoagulation team for treatment.
- District nursing staff told us that they had a protected half hour for handover, and that they also shared patient safety alerts from the Department of Health's Central Alerting System during that time. We observed five district nursing handovers and heard safety information being discussed. This helped to ensure that patients were protected from harm by communicating information about equipment and medicines and from reportable incidents that had occurred anywhere in the country.

Staffing levels and caseload

- We were provided with data on bank and agency staff usage across community services for adults. This showed that during the period of December 2014 to May 2015 an average of six percent of nurse hours in the North East team, one per cent in the South East team and nine per cent in the South West team were covered

by bank staff. No agency staff were used during this time. This meant that nursing staff cover was maintained at a safe level for patients, using nurses who were known to be competent.

- We did not see or hear of any evidence of staff working excessive hours on bank shifts or becoming burnt out.
- Staffing shortfalls were not recorded as a risk on the service's risk register.
- We visited a clinic run by the community anticoagulation team and spoke with staff and patients. We saw and were told that there were sufficient staff and skill mix to meet the needs of patients attending the clinic.
- We observed five handovers between district nursing teams. These were attended by team leaders, qualified and student nurses and healthcare assistants and were supported by administration staff. The time for handover was protected and was not interrupted. Each member of staff gave a comprehensive update on all of the patients they had visited. The handovers were conducted in an unhurried way, giving each member of the team time to provide their report without pressure to rush through it.
- The information given by each nurse during handover was presented in a structured format using the 'SBAR' (situation, background, assessment, recommendation) tool which is endorsed as best practice by the NHS Institute of Innovation and Improvement. Use of this tool helped to present information in a way that staff were used to and which made changes or omissions easily noticeable.
- During evening and night shifts community staff worked in pairs. This increased staff safety.
- A Lone Working Policy was in place, all of the staff we talked to were aware of the policy and used the safety methods stipulated, such as ensuring that electronic diaries were kept up to date and operating a 'buddy' system which involved staff booking in at appointments by phone and telling their buddy how long the appointment should last. If regular contact was not maintained the buddy would check on the lone working staff member's safety.
- Community services for adults did not use agency staff. Any shortfalls on shifts were covered by the department's own staff working on the nursing bank, so risks associated with employing temporary staff were minimised.
- We looked at staff rosters covering a 42-day (six week) period in May and June 2015 at one district nursing base, and saw that on 12 of those days there were fewer than eight qualified nurses on duty. Eight qualified nurses was the minimum number that should have been rostered onto the day shift according to local policy. Staff told us that those days were difficult as they could have over 15 visits on their lists.
- Community nursing was managed in three 'virtual wards', defined by geographic areas. Virtual wards were a system where patients were nursed in their own homes but thought of as being on a hospital ward, spread out in the community. Workload for each of the wards was monitored daily and staff from each location flexed to assist in other areas if workload was unequal. This helped to ensure that patients received appropriate care.
- Each district nursing locality was managed by a band seven nurse Monday to Friday, and a band six nurse on weekends. We spoke with two band six nurses who told us that they work co-operatively and support each other on weekends, and that they did not feel isolated.
- A lead nurse from a specialist team told us that the service had experienced problems recruiting suitably qualified and experienced band six nurses. To address this they had provided training for their substantive band five nurses to bring them up to band six level, then recruited new band five nurses to replace them. This meant that skills developed in the department were retained and a process for succession planning was created.
- Between the hours of 10pm and 8am district nursing services provided a responsive service. No visits to patients were planned during that time but nurses were available to deal with issues such as blocked catheters or problems with medicines. This shift was staffed by one qualified nurse and one healthcare assistant. We were told that there was no policy in place to ensure that this service could be provided in the event of short term vacancies due to staff sickness. When it had occurred in the past that situation had been managed by contacting all of the off-duty staff until someone was found to cover the shift. Senior nurses told us that they were aware of the situation and that it had been risk assessed, and a more formal process to roster an on-call backup nurse was being developed to ensure that night cover was maintained.

Good

Are services safe?

Managing anticipated risks

- We were told that the biggest anticipated risk for community services was adverse weather as that could affect staff members' ability to get to work and to visit their patients. The service has a bad weather policy in place to mitigate this risk and staff are advised of roads that are being gritted or otherwise kept clear to assist their route planning to and from and while at work. We were shown a copy of this plan and found that it contained clear guidance both on advice on self-care for patients and for actions to be taken by staff, well-defined trigger points for actions to be carried out and procedures for communicating with patients and staff in the event of bad weather.
- We were shown a copy of the heatwave plan used by community services for adults. This plan included specific actions to be taken by community nurses in the event of a heatwave to protect patients at risk of harm from hot weather.
- Staff had been warned in advance of a the route of a protest march and of the possibility of civil disorder. This allowed them to plan their journeys to avoid the affected areas and to get to their appointments on time.

Major incident awareness and training

- We saw records which showed that over 95% of staff in community services for adults had completed their major incident training.
- We asked 21 of the staff we spoke with about major incident procedures and they all demonstrated a good understanding of their role and the procedures involved.

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 found that evidence based care and treatment was widely used in all community services for adults, together with support from national organisations and peers in other NHS trusts. We spoke with qualified staff who had received appropriate induction training on joining the department. They were encouraged to take on further development to enhance the treatment they were able to provide to patients and to develop their knowledge and skills.

We saw that a culture of multi-disciplinary working was well embedded in community services for adults and that other services from the acute hospital, community services and partner organisations were regularly involved in planning the best possible care and seamless discharge processes for patients.

Staff were well-trained in the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and we saw the principles of both being put into practice.

Evidence based care and treatment

- We saw outstanding practice in the stroke rehabilitation services provided by the community neurological rehabilitation team. Patients were encouraged to take part in activities such as gardening, fishing, swimming, exercise classes and cycling. These activities were based on evidence of rehabilitation activities that are focused on developing and providing treatments that assist in the recovery and maintenance of physical, cognitive and communicative functions.
- Community services for adults used a recognised tool, the Walsall Community Pressure Ulcer Risk Assessment Calculator, known as the Walsall Score, to assess patients' risk of acquiring a pressure ulcer. We saw properly completed examples of this assessment in nine sets of patients' notes.
- We spoke with a lead nurse for multiple sclerosis (MS), who told us that the treatment provided by community services for MS sufferers was based on the National Institute for Health and Care Excellence (NICE) guidance and education packages provided by the MS Trust.

Nutrition and hydration

- Patients' risk of malnutrition was assessed using the Malnutrition Universal Screening Tool (MUST) which is recommended as good practice by the National Institute for Health and Care Excellence (NICE).
- We saw properly completed MUST assessments in ten sets of patient records. Community nurses had scales available to weigh patients as part of this assessment, and concerns were referred to dieticians or GPs according to individual patients' circumstances.

Use of technology and telemedicine

- Community nurses on one virtual ward were piloting the use of tablet computers for mobile working. This would improve the service's efficiency through access to information and patient notes and would improve security of confidential personal information.

Approach to monitoring quality and people's outcomes and outcomes of care and treatment

- Community services used the Modified Early Warning Score (MEWS) to identify deteriorating patients quickly, which allowed them to recognise patients in need of enhanced treatment before they had become very ill.
- The Community Neurological Rehabilitation Team (CNRT) used the Wellbeing Star, an evidence-based tool for supporting and measuring change, to assess how patients were feeling about themselves and coping with their long-term conditions. We were shown an example of a completed wellbeing star. It was made up of scores out of five for the patient under the headings 'lifestyle', 'looking after yourself', 'managing symptoms', 'work, volunteering and other activities', 'money', 'where you live', 'family and friends' and 'feeling positive'. The star was updated each time the patient was assessed, and action plans were written to help to improve any areas where the patient had given a low score.
- The CNRT used the Barthel ADL index to assess patients' needs for assistance with activities of everyday living.

This provided a standard means of assessing how well patients were coping in their own homes and identified when additional assistance may have become necessary.

- The CNRT also used the Therapy Outcomes Measures (TOMs) score, which is based on the World Health Organisation's international classification of functioning disability and health to assess the effectiveness of their treatment of patients. The TOMs score assesses patients' psychological wellbeing, physical disability, participation and activity. We were shown a TOMs assessment for a patient who had been discharged from community services for adults. It included details of the patient's ongoing problems with mobility, speech and swallowing, listed goals for improving their quality of life and independence and set out the actions needed to achieve these improvements.
- Throughout all of the district nursing handovers we observed there was an emphasis on maintaining patients' independence and dignity.
- Community service for adults did not contribute data to the National Audit of Intermediate Care. This meant that we were unable to compare standards provided locally against those elsewhere in England. Participation is encouraged by NHS England but it is not compulsory.

Competent staff

- While observing district nursing handovers at two location we heard nurses discussing and offering advice on specialist alternative products to care for patients with urinary incontinence. This demonstrated a thorough knowledge of one of their areas of speciality.
- Twelve therapy assistants within community services for adults had completed a 40-credit course on stroke competencies, aimed at non-qualified staff, at the University of Wolverhampton. The course covered several topics including types of stroke, care of stroke patients and swallowing assessments and was a combination of academic work and observed practice. This improved the assistants' knowledge and meant that they were able to provide better care for their patients.
- Healthcare assistants (HCAs) working within the community matrons' team were given competency workbooks on starting with the trust. The workbooks had to be completed by the HCAs and signed off by a senior member of staff as part of the HCAs' induction training. This ensured that all new HCAs had a minimum level of knowledge on completion of their induction.
- Rehabilitation technicians, who did not hold a professional qualification, maintained competency folders that were reviewed by qualified therapists. These contained a range of competencies such as communication, swallowing, bladder and bowel problems, environmental factors, functions of the brain and structured note writing. This provided staff with knowledge and skills to understand the conditions of their patients.
- Band six staff within community services were offered face-to-face leadership development sessions, including training on emotional intelligence and action-centred learning. This training was mandatory for band seven staff. This improved their team management skills.
- Training provided by the Dementia Action Alliance formed part of community services' mandatory training, which improved staff's understanding of dementia and the effects on sufferers and allowed them to provide better care for people living with dementia.
- A lead nurse for MS told us that nurses in similar roles in neighbouring trusts provided a peer support network to share good practice and innovations, and that they held bimonthly meetings to discuss the condition and advances in research. The MS nurses also attended the MS Trust's national conference annually. We observed a clinic for a patient with newly diagnosed MS and saw the nurse demonstrating a thorough knowledge of the condition, its treatment and ongoing research.
- Staff from the community neurological rehabilitation team told us that representatives from manufacturers always provided them with training on new items of equipment and that this made them feel safe and competent in its use.
- Band seven and eight staff held monthly forums to share knowledge and good practice. These were attended by guest speakers such as tissue viability nurses, dignity champions, dementia services and end of life specialists. The band seven and eight staff were expected to cascade their learning to other staff in their own departments.
- All the staff we spoke to told us they had regular appraisals with their managers. We saw records in the community anticoagulation team which showed that

89% of staff had had an appraisal this year and in the community nursing team based at Bilston Health Centre which showed that 100% of staff had had their appraisal.

- Staff at two district nursing bases told us that they were trained to carry out Doppler ultrasound assessments of blood flow in patients' legs. This helped them to assess chronic wounds, apply appropriate treatment and to know when patients needed to be referred to specialists such as tissue viability nurses.
- All community nurses were trained in cannulation, and attended the endoscopy clinic to refresh their skills under supervision, and we saw competency records to support this.

Multi-disciplinary working and coordination of care pathways

- The HIV and AIDS service accepted referrals from a range of other sources such as the Blood Transfusion Service, the genitourinary medicine clinic, the maternity department and from patients' families. This meant that people at risk of contracting the disease but who were not aware of the possibility could be identified and assessed quickly.
- The HIV and AIDS service held multidisciplinary meetings at least once per month, or more often if specific patients' needs meant they would be of benefit. The meetings involved two consultants, a pharmacist and the HIV lead nurse. They were held in a structured format and used to discuss patients with complex needs.
- The tuberculosis (TB) service accepted referrals from a large number of sources, including GPs, wards, practice nurses, and from patients contacting the service direct. This meant that patients at risk of TB would be identified and referred to the specialist service.
- The respiratory service had provided a TB screening clinic in partnership with the Immigration Service at a help centre for migrant workers. The trust were in talks with Public Health England to make this screening facility a long term service and to integrate HIV testing into the clinic. This increased the likelihood that TB and HIV could be identified in workers who had come from countries where those diseases are more prevalent and allowed health and safety precautions to be followed and treatment to be provided.
- The heart failure service provided an education facility to teach hospital nurses, hospice staff, district nurses, nursing home staff, patients and patients' families about the condition. This meant that patients and carers were able to understand and manage the condition outside hospital and allowed patients to stay in their own homes for longer.
- We observed a multidisciplinary meeting held between community nurses and social services which resulted in a safeguarding referral being made.
- In an MDT focus group we were told all departments within community services for adults worked together as a team to ensure patients were given the best care. We were also told that all the staff in the service valued the others' opinions and expertise.
- A lead nurse for multiple sclerosis told us that they had close working links with the continence team, the community neurological rehabilitation team, occupational therapists, physiotherapists and the healthy lifestyles department, which allowed them to provide a multidisciplinary care package for their patients.

Referral, transfer, discharge and transition

- Senior nursing staff told us that the acute trust recognised the importance of liaising with community services about patients with complex needs who were due for discharge, and that multidisciplinary meetings were held to ensure the process ran smoothly for the patients.
- We were told that there was a matron based in the acute hospital to co-ordinate discharges between the hospital, community services and partner organisations. The discharge matron liaised with services such as community nurses, respiratory nurses and tissue viability specialists to ensure that necessary services were in place to support patients discharged into the community.

Availability of information

- The community neurological rehabilitation team had set up a section on the trust's intranet to increase awareness of neurological conditions, treatments and therapies among staff in the wider trust. The intranet site also included downloadable documents such as referral forms. We were told that the site was going to be made available to GPs for education and referrals.
- The heart failure service used a database that was a legacy from a previous trust and was only available on five computers in one office, which had a negative

Good

Are services effective?

impact on staff's access to information. We were told that a new heart failure database was being brought into use in the community which would improve nurses' use of time and reduce duplication of paperwork.

- Community services' staff moved to the trust from a previous organisation in 2011. We were told that the IT system used in community services was still not the same as that used in the rest of the trust and that this sometimes caused delays as staff had to log off one system and log onto the other to complete their work. Two areas of work that were particularly affected by this were patient records and pharmacy prescribing. Staff told us that the situation had been reported several times and escalated but that it had not yet been resolved. We saw a copy of the service's risk register and this problem was not recorded as a risk.

Consent

- The Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) formed part of community services' mandatory training. Across the three district nursing areas 70% of staff in the south east team, 82% in the south west team and 88% in the north east team had completed this training. One hundred percent of foot health services' staff had completed the training.
- We saw the trust intranet provided a section with guidance and statutory forms relating to the MCA and DoLS. Staff told us that this was a useful resource and was easily accessible at all sites. We spoke with eight district nurses who all demonstrated a good understanding of the MCA and of DoLS.
- We saw documented assessments of patients' capacity to make decisions in all of the 28 sets of patient notes we looked at.
- During six home visits with four members of the community nursing team we saw patients being asked for consent before they were examined and on one occasion that the patient's refusal to give consent was respected.
- We spoke with eight patients by telephone and they all told us that community services staff always explained what they were going to do and asked permission to carry out procedures.

Outstanding ☆

Are services caring?

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

Summary

Patients and relatives who used community services for adults were universally positive about the care they received from nursing and therapy staff. Patients used terms like "marvellous", "brilliant", "wonderful" and "lovely people" to describe the staff. None of the patients or relatives that we spoke to had anything negative to say about staff from community services for adults.

Staff and managers we spoke with displayed a visibly caring attitude towards their patients and took genuine personal interest in their welfare, comfort, treatment and, where possible, recovery. We saw staff treating patients and relatives with dignity and respect throughout our inspection.

We saw staff actively involving patients and their relatives in plans and decisions about their care and we saw staff respecting patients' rights to make their own informed choices about treatment.

We were told about and witnessed many examples of staff providing care that was above and beyond what was expected by patients.

Dignity, respect and compassionate care

- One patient told us that he "couldn't fault the nurses" and another told us he "couldn't believe his luck with the service".
- Patients we spoke to described the physiotherapists as "wonderful" and "lovely people".
- We spoke with one patient's wife who told us that they could not have wished for better help and that the physiotherapists, speech and language therapists and occupational therapists were all "brilliant" and "marvellous". Another patient's wife told us that the community staff "gave 110% and their care and commitment was second to none".
- We observed district nurses visiting two new patients for the first time. The nurses introduced themselves by name and took time to explain how the district nursing service operated and the services they provided before starting to treat the patients.
- We attended a home visit with an occupational therapist and saw that she had developed an excellent rapport with the patient and her family and that they were all on first name terms. The patient's family praised the therapist and her team and said they interacted with the patient in a kind, tolerant, caring, patient and respectful manner.
- We observed a clinic for a patient with a newly diagnosed condition. The nurse holding the clinic introduced themselves by name and treated the patient and his brother with respect throughout their appointment. The nurse explained the patient's condition in simple, unhurried terms, using illustrations to clarify complicated areas and frequently checked that the patient understood what he was being told. The patient was asked to tell the nurse how the condition was affecting him that day and was then given advice on dealing with his specific symptoms.
- We spoke with eight patients who all described staff from community services for adults as understanding, friendly and caring and told us that they were very happy with their care.
- Two patients told us that community services staff always asked about their general wellbeing as well as treating them for their main conditions.

Patient understanding and involvement

- We spoke with six patients who told us they had no concerns about their care or treatment and felt that nurses and therapists gave them plenty of information and kept them informed about how their treatment was progressing.
- We saw nurses on eight home visits and in two clinics answering patients' and relatives' questions clearly and providing information about patients' conditions and treatment in terms they understood.
- We visited a patient's home with a member of the community neurological rehabilitation team. This visit had been arranged with the patient, the patient's family and a palliative care nurse from a hospice and all of those people were present at the same time. This allowed discussions about the patient's care and treatment to take place with the patient's involvement and consent and for a care plan to be agreed.
- During a home visit with a member of the community neurological rehabilitation team we observed

discussions between the therapist, the patient, the patient's family and a palliative care nurse regarding decisions about the patient's care. There was an absolute regard for the patient's wishes throughout this process and the therapist was seen to check every point discussed with the patient before moving on

- One patient told us that their nurse visits had been reduced from three per week to two per week. The patient told us that the nursing staff had told them why their visits would be reducing and why it was happening before the change took place.

Emotional support

- One patient told us that the community nurses always chatted to them while treating them and made sure they were feeling alright. They told us they were comfortable talking to the nurses about their feelings.
- One patient's spouse told us that the therapists had supported their needs as well as their partner's and had helped them to cope with the situation after their partner had had a stroke.
- We observed a physiotherapist and an occupational therapist on a home visit advising a patient who had told them they were having trouble sleeping which was affecting their emotional wellbeing. They gave advice on the patient's positioning and explained why they may be experiencing trouble sleeping, and explained options for further treatment to help them.
- We heard therapists advising a patient and their family on how to find holiday locations with facilities to support them after the patient's stroke.
- We were told about three patients who attended the HIV/AIDS clinic and still travelled back to Wolverhampton despite each of them now living between 100 and 150 away, because of the excellent support they received there.

Promotion of self-care

- One patient's spouse told us that the community therapists were helping the patient to walk and gave them physical and psychological support to boost their morale and help them to progress on their own.
- One patient told us that the community physiotherapists were helping them to apply for their driving test to improve the patient's independence.

Good

Are services responsive to people's needs?

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

Summary

The population served by community services for adults was provided with care and treatment that was appropriate to their needs, at the times and in the places that they needed it.

Community services for adults was aware of the needs of differing communities, ethnicities and religions within its area and staff were given resources to look after a wide range of patients effectively.

We saw a number of areas of outstanding practise, including the innovative services provided by the HIV/AIDS clinic, the hospital at home team and the homes in-reach team.

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

- The hospital at home team were working with GPs and practice nurses to educate them about patients who had chronic obstructive pulmonary disease (COPD), a type of long-term breathing condition. This meant that GPs and practice nurses had a better understanding of when the condition could be managed in the patients' homes and were aware of the community services they could call upon, so that fewer patients were referred to hospital.
- Community matrons also had training about COPD from the hospital at home team and were assisted by a treatment pathway which had been written by respiratory consultants. They had contact numbers for the respiratory team, both in and out of normal working hours, to provide advice about patients.
- Respiratory consultants were available to carry out home visits to patients if required.
- Patients of the heart failure team were never discharged from the team's care, only stepped down to care from their GP. This meant that patients could contact the heart failure team at any time if they needed to, without having to contact their GP for a new referral.
- The homes in-reach team provided a proactive service to nursing homes to assess and treat patients and provide training to staff at the homes. This meant that admissions to hospital from nursing homes were avoided where possible and that patients could be treated in their own homes.
- The homes in-reach team also provided a reactive service to nursing homes when calls were made to the Wolverhampton Urgent Care Triage Assessment Service (WUCTAS). WUCTAS had the option of sending community services staff to assess and treat appropriate patients instead of sending out of hours GPs. This meant that out of hours GPs were kept available for more serious cases.
- The community anticoagulant team, who dealt with patients at risk of blood clots in their veins, operated from six sites across the city and ran a walk-in clinic on Saturdays for patients who needed regular blood tests. This gave patients the choice of location and time for their treatment, and they did not have to travel to the hospital. The service also provided a telephone help line on weekdays.
- Community nursing had carried out an evaluation of wound care products which had led to the introduction of 'grab packs' for different types of wounds. This meant that stock levels were reduced and that nurses could be confident that they had all the equipment they needed to treat patients by picking up the pack relevant to the patient's need.
- We were told about plans to look at integrating the social services' Home Assisted Reablement Programme (HARP) team with community services' Community Intermediate Care Team (CICT) as they provided similar services. This would reduce duplication and be more effective use of time and resources.
- Community nurses told us that some doctors in the acute hospital had been discharging patients home needing a form of treatment that had to be administered four times a day by nurses. This was

impacting on the community nurses' ability to provide a service to their other patients and the issue was raised with managers. As a result the doctors in question now discharge patients with a form of medication which is equally effective but can be self-administered so community nurses are no longer required to visit.

Equality and diversity

- Senior nurses told us that about 80 languages were spoken in the local community. An interpreter service was available for community staff to use if needed and staff told us that it was easy for them to access this service and they had used it on several occasions.
- Some community services staff understood more than one language and where possible those staff would visit patients whose languages they spoke. This meant that third parties did not have to be involved in patients' care and reduced the risk of misunderstandings in translation.
- Information leaflets about community services were available in the most common languages used in the area. Referrals to the service contained a prompt to indicate if an interpreter service was required for the patient.
- Community services had encountered problems accessing an interpreter for a group of patients from Eritrea as none could be located, however they overcame this by using a family member to translate, with consent from patients.
- The population cared for by community services for adults was a diverse one with patients from many cultural and religious backgrounds. Staff demonstrated a good understanding of the differences in groups of the community and told us that they never had any problems adjusting the way they worked to respect the needs of different ethnic groups.

Meeting the needs of people in vulnerable circumstances

- We were told about a 'barber shop' scheme operated by the HIV/AIDS community service. Through this scheme staff from the service visited barber shops in an area of the community at higher risk of the disease but where male patients were less likely to seek treatment due to their cultural background. This meant that patients who would otherwise have not been diagnosed and treated were identified and could be helped.
- The HIV/AIDS service had a robust pathway to follow up on hard to reach, vulnerable patients who did not attend appointments, and allocated time each week for emergency appointments when contact was made with those patients.
- The HIV/AIDS clinic provided facilities for prisoners to attend appointments and remain secured without prison officers being in the same room. This meant that they were able to discuss their condition in private without risk of escape.
- The respiratory service worked with the Immigration Service to provide tuberculosis (TB) clinics for immigrant workers and to trace and combat the spread of the disease amongst those living, working and travelling close together.
- We saw a therapist communicating with a patient who was unable to speak. The therapist spoke to the patient normally and allowed the patient to reply by writing things down or using hand signals.
- Staff told us that their patients' individual needs took priority over their protocols. One example of this was the application of support hosiery which did not meet the service's criteria. Community nurses told us that they would continue to assist patients with care like that if the patients were unable to do so themselves as the patients' welfare was paramount.
- Community services for adults used a recognised symbol, the 'forget-me-not' flower, to identify patients living with dementia. This meant that community staff would be aware that patients had the condition and would provide extra support.

Access to the right care at the right time

- The HIV/AIDS community service operated an evening clinic to improve access for patients who were not comfortable taking time off work to attend appointments. It also allowed patients to enter the premises through an entrance not normally used by the public, by prior arrangement, if they were not happy to use the main waiting area.
- COPD patients were provided with 'rescue packs' to keep at home, which contained medicines to treat a sudden worsening of their condition. Patients were educated to understand when to use these medicines and had to inform their GP whenever they did.

Good

Are services responsive to people's needs?

- The respiratory team were providing training for general ward staff to coach patients in inhaler technique. This meant that patients did not have to wait for the community team to be available before receiving this guidance.
- The hospital at home team were able to administer intravenous steroids to patients in the community, which meant patients remained at home for their treatment.
- Community services were training younger patients who required regular intravenous medicine to administer it themselves through a reusable implanted access device. This meant that patients requiring several doses of medicine in a day no longer had to wait for community nurses to visit and administer it, enabling independence.
- Respiratory services saw any patients diagnosed with infectious TB within two days of diagnosis. They also provided screening clinics in newly-diagnosed patients' workplaces to give advice and ensure that any of their colleagues who were at risk of contracting TB were identified quickly.
- Community matrons were all nurse prescribers, which meant that their patients were able to obtain medicines without having to wait for a prescription from their GP.
- We saw that a longer appointment time had been booked for the first consultation for a patient who had just been diagnosed with a complex neurological disease. This allowed the nurse specialist to take time to explain the condition to the patient and answer questions without rushing or delaying patients who had appointments afterwards.
- One patient told us that his condition meant that he had to rest in the afternoons so had requested that the community nurses visit him in the morning. He told us that this request had been agreed immediately and all his nurse visits since then had been in the morning.
- Another patient told us that he occasionally had to ask the community nurses to change the day they visited him and that this was always accommodated without any problems.
- One patient's wife told us she was "amazed" at how quickly the package of physiotherapy care had been arranged for her husband after he was referred to community services from the emergency department.
- Community services for adults used an appointment system that allowed different lengths of time for different procedures. Allocated appointments more accurately reflected the time community staff needed to spend with each patient. This allowed community staff to see patients closer to their allocated appointments.
- During evenings the lead nurse at each community base carried a dedicated out-of-hours telephone. They aimed to respond to messages left by patients and relatives within 15 minutes. We saw this happening during two visits to the service.

Complaints handling (for this service) and learning from feedback

- Apart from two who had no information on the complaints procedure, all of the patients we spoke with told us they had been given a leaflet on how to make a complaint. None of them had needed to do so.
- We were given details of complaints received against community services for adults over the last ten months. There were ten complaints in total. Five were about delays in clinic appointments, four were about quality of care provided and one was about the attitude of a member of staff. We saw details of the investigation of these complaints and where appropriate the actions that were taken. All had been properly investigated and patients had been informed of the outcomes.
- Two senior nurses told us that the majority of complaints received by community services for adults related to delays in visits. They told us that these complaints were normally caused by a lack of communication when visit schedules had to be reorganised at short notice to prioritise patients who needed urgent visits.
- A group of 26 senior nurses told us that complaints were normally resolved locally between managers and complainants, and were only logged with and monitored by the trust's patient advice and liaison service (PALS) if this process did not resolve the issue. No register was kept of complaints resolved in this way.

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

Staff in community services for adults were aware of the spirit and meaning of the trust's vision and strategy and their personal role in achieving it, and felt engaged and involved in the process of working towards it.

A systematic plan of working with other NHS and private health and social care organisations was in place to work towards improving outcomes and quality of life for community patients. All departments within community services for adults worked together, supported each other for the benefit of patients and provided an integrated, holistic package of treatment and therapy.

The trust executives were visible and regularly met with staff at all levels to provide information and to discuss ideas and opportunities to improve the way the service was provided for patients. Staff told us that their opinions were valued and acted upon where possible.

Staff had confidence in the governance structure of the service. Safety incidents were promptly reported and rigorously investigated.

Staff felt valued, respected and supported by managers and told us that they were an important part of the team. Staff were given opportunities to attend leadership and management training when appropriate.

Service vision and strategy

- All of the 122 staff we talked to had a good understanding of the trust's vision of being an NHS organisation that continually strives to improve patients' experiences and outcomes and the trust executives' strategy, and of their role in delivering it. Staff told us they felt part of the team who were delivering the service planned by the trust board. The 'ChatBack' survey results showed that 83% of community services for adults staff were aware of the trust's values and what those values meant to staff in their roles.
- A matron from the respiratory service told us that one of the improvement goals of the community team was to reduce the need for in-patient wards for patients with respiratory conditions from three to two, by improving the facilities they were able to offer in patients' homes.
- We spoke with an audiologist who told us his department had been asked to develop a five-year plan for their staffing requirements and to include details about how it fitted in with the trust's vision.

Governance, risk management and quality measurement

- We saw copies of quarterly document audits that were carried out by an administration manager. These audits checked that records were completed accurately and fully so that details of the care provided for patients can be verified. 30 patient records were examined as part of the documentation audit and all of them were found to be in an acceptable condition.
- A community matron told us that the level of governance provided by the trust made her feel safe at work.
- We were told about medicines management scrutiny meetings that were held to investigate clinical incidents. We saw minutes of monthly and extraordinary scrutiny meetings held between August 2014 and June 2015. The meetings involved senior staff from community nursing, podiatry, pharmacy and practice education. They checked on the progress of actions that had been agreed in previous meetings, reviewed new incident reports and root cause analyses and agreed any action to be taken as a result of those and discussed national alerts about medicines. They also considered any new medicines that could be introduced into community services. These were described as uncomfortable but fair, and were welcomed by staff as means to improve practice.
- We were given details of audits that were in progress in community services for adults during the 2015/16 financial year. The areas being audited were documentation, based on guidance from the NHS Litigation Authority; equipment carried in community

Good

Are services well-led?

healthcare professionals' kit bags and car boots; adherence to the National Institute for Health and Care Excellence guidelines on caring for patients with COPD, for example.

- New treatment and medicine protocols were ratified at trust governance meetings before they were authorised for use by staff. This maintained an oversight of treatments being provided by community services staff and ensured that patients were kept safe.
- A group of five therapists told us that the department carried out yearly training needs analyses to recognise any gaps in the staff's knowledge and arranged training to cover any areas identified.
- We saw a copy of the risk register for community services for adults, which was maintained by matrons and senior nurses. The register detailed potential risks to information governance, staff, patients and to delivery of community services for adults as a whole. It included information about the risk, how the risk was being managed, evidence that the management plan was effective, and evidence that the plan was not effective and anything else that could be done to reduce the risk. This showed that risks to the service were recorded, assessed and reviewed and plans were made to mitigate risk.

Leadership of this service

- One matron who had moved to the trust from another NHS hospital told us that she felt far more supported by senior managers at the Royal Wolverhampton Trust than she had in her previous position.
- We spoke with two lead nurses who told us that the senior management team were frequently visible in the community setting and were all very approachable. One of the nurses told us about a safety incident where the Chief Executive had personally intervened to resolve the situation. The nurse told us that she had been impressed with the manner in which he had responded.
- A group of 14 community therapists also told us that managers were all approachable, and that the chief executive and chief nurse in particular were often visible and easy to speak to.
- We spoke with a group of 14 community therapists who all told us they felt proud of the team they worked with and felt well supported both by colleagues and managers.
- Two senior therapists told us that they had regular one-to-one meetings with their matron and felt well-supported and encouraged to work autonomously in their practice and development.
- Community nurses spoke highly of local managers and described them as supportive, proactive and accessible. They told us managers regularly checked on their safety and progress and offered help where needed.

Culture within this service

- We talked to a member of domestic staff who had worked in community services for over 20 years. She told us that the managers promote a family atmosphere and really care for the staff, with whom they are on first name terms.
- All of the staff we talked to and observed demonstrated a culture of providing high quality patient care with an emphasis on respecting patients' dignity and encouraging and maintaining their independence.
- A group of 26 senior nurses, two doctors and one senior therapist told us that there was a culture of trust-wide leadership support.

Public and staff engagement

- We were given adult community services' results from the trust's internal staff survey, 'ChatBack', for 2014. 75 staff from this department had responded to the survey, which was 22% of the people working in community services for adults. This was slightly lower than the trust's overall response rate of 22.6%. The survey compared the answers to 31 questions and statements to those received the previous year. Questions were asked on subjects such as the quality of care given to patients, whether staff were made aware of what was happening in their department and the trust, whether communication between senior management and staff was effective, whether staff were encouraged to report incidents and near misses and whether feedback was received on incident reports. Overall community services for adults scored an average of 74% positive replies, which was slightly higher than the overall trust score of 72%.
- Monthly forum meetings were held between members of the trust executive and band seven and eight staff to share lessons learned and best practice and discuss any issues. Staff described this as a two-way communication

Good

Are services well-led?

between them and the trust board, and told us that the meetings were well-attended and informative, and that when possible action was taken on suggestions they made to improve services.

- Similar forum meetings with trust executives were held for band six staff and for band two staff, and staff told us these were also well-attended. Staff told us the forum meetings were open-access and personnel from each of the groups were free to attend without prior arrangement, and that they were actively encouraged to attend. Presentations used during the meetings were uploaded to the trust's intranet so that staff who were not able to attend the meetings could be kept aware of what was discussed. We saw agendas from and staff notices about forum meetings for band seven and eight staff and for healthcare assistants. The meetings contained a mixture of training and open discussion sessions.
- A group of six therapy staff told us that the service had been experiencing difficulty recruiting physiotherapists for a one-year contract. They had told the human resources (HR) department about the problem and the vacancies had been changed to permanent posts, which were easier to fill. They told us that this demonstrated that HR were listening to them and respecting their understanding of their specialised work sector.
- At all of the community nurse bases we visited we saw a display board titled "You said – we did" with examples of ideas suggested by staff and of the trust's action in response to the suggestions. This demonstrated that senior managers were listening to staff and making changes to improve services where possible.
- Patients told us they were given the opportunity to give feedback on the care and treatment they had received. All of the patients we spoke with told us they would know how to make a complaint if they wanted to, but none of them had had any need to do so.

Innovation, improvement and sustainability

- We spoke with a group of 26 nurses, two doctors and one podiatrist from community services who told us that the trust appeared to be forward-thinking and innovative. We were given examples of three new community teams that had been set up over recent years to improve services to patients and were told about a business case that had been submitted to introduce new community anticoagulant therapies. This demonstrated that the trust maintained a constant process of development and encouraged innovative practice.
- Occupational therapists from community services for adults had assisted with research into the Birmingham Cognitive Screen assessment tool which was developed by cognitive neuropsychologists at Birmingham University. It had produced cognitive profiles for over 800 stroke patients in the West Midlands and was used to facilitate treatment and care planning.
- Community nursing staff told us that mobile IT systems were being piloted to improve their efficiency and the care they were able to provide for patients, and that this scheme was being championed by the Chief Executive.
- Community staff told us about plans to change the way patients with a certain type of infection were treated. The group of patients in question were normally treated as hospital in-patients but arrangements were being negotiated for these patients to be treated by the community team while in nursing homes. This plan was to be led by community matrons and was intended to help reduce the pressure on the acute hospital and improve waiting times and flow for other patients.