Torbay and South Devon NHS Foundation Trust

RA9

Community health services for adults

Quality Report

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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)
RA952	Ashburton and Buckfastleigh Hospital	Ashburton and Buckfastleigh Hospital	TQ13 7AP
RA956	Dawlish Hospital	Dawlish Hospital	EX7 9DH
RA957	Newton Abbot Hospital	Newton Abbot Hospital	TQ12 2TS
RA959	Teignmouth Hospital	Teignmouth Hospital	TQ14 9BQ

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

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

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

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We rated community adults service as outstanding because:

- The trust encouraged openness and transparency about incident reporting and incidents were viewed as an learning opporotunity. Staff felt confident in raising concerns and reporting incidents and near misses.
- There were effective handovers during the shifts, to ensure staff managed risks to patients. Urgent visits were allocated quickly to respond to the changing needs of patients.
- Patients were involved in managing their identified risks and risk assessments were proportionate and reviewed regularly.
- There were defined and embedded systems, in place to keep patients safe and safeguarded from abuse.
- Patients care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation.
- Patients care was coordinated when a number of different staff were involved in their care and treatment. All relevant staff were involved in the assessing, planning and delivery of patient care and treatment. Staff worked collaboratively to meet patients needs.
- Staff were qualified and had the skills they needed to carry out their roles effectively and their learning were identified. Training to meet these needs was put in place and as well as other training to learn new skills pertinent to their roles.
- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.
- Patients were supported by all staff in the delivery of their care and treatment. They were treated with dignity and respect.
- Staff anticipated patients' needs and maintained their privacy and confidentiality at all times.
- The assessed needs of all patients were taken into account when planning and delivering services.
- Patients were able to complain or raise a concern and they were treated with openness and transparency. Their complaint or conern was listened and improvements were made to the quality of the service provided.
- There was an effective and comprehensive governance processes in place to identify, monitor and address current and future risks.
- Senior managers at every level prioritised safe, high quality and compassionate care . All staff felt managers at all levels were approachable and listened to their views and they felt able to report any concerns to them.

However:

- The out of hours community nursing service had difficulty at times in accessing equipment at night as there was central storage facility where all equipment needed was stored and this had led to delays in treatment, for example syringe drivers.
- There were concerns regarding lone working for community nurses in Newton Abbot zone. Between the hours 5pm to 7pm at a weekend as the qualified nurse was alone.
- Appraisal rates for some zones and specialist services were as low as 50%, below trust target.
- Evidence of consent being obtained for procedures was not always clearly documented in the patients' notes within the outpatients department in Newton Abbot.
- Up to March 2016, the trust was failing to meet the national standard for outpatient activity. The reasons were attributed to higher than expected new patient activity in podiatry and orthotic services, staff vacancies and inability to recruit to these posts quickly.

Summary of findings

Background to the service

Torbay and South Devon NHS Foundation Trust was formed in October 2015 when South Devon Healthcare NHS Foundation Trust and Torbay and Southern Devon Health and Care NHS Trust merged. The Trust provides a wide range of health and social care services in integrated health and social care teams in Torbay and Southern Devon in five localities (Coastal, Newton Abbot, Torquay, Paignton/Brixham and Moor to Sea). The Trust runs Torbay Hospital and nine community hospitals. Outpatient clinic are run in seven out of the nine and they are; Ashburton, Bovey Tracey, Brixham, Dawlish, Newton Abbot, Teignmouth and Totnes. This is to a population of approximately 375,000 people, plus about 100,00 visitors at any one time during the summer holiday season. Additionally there are a number of other specialist health and social care teams supporting people at home or close to home in nursing or residential care home settings. The trust as a whole employs around 5170.5 Whole Time Equivalents members of staff.

There were 351,335 patients attended outpatient clinics between November 2014 to October 2015 at community hospital. There was also 500,000 face to face contacts with patients in their homes and community.

For patients living in the Torquay, Paignton and Brixham zones the health and social care budgets were joined, meaning better delivery of integrated care. Patients living in the South Devon area their budgets were separate as Devon County Council held the social care budget. Community staff working in the South Devon area had to follow the procedures and protocols of Devon County Council as well as the trust. During our inspection, we found the outcomes for patients receiving health care were the same.

On this inspection, we visited all the five zones on 1,3,4,5 & 16 February 2016. We visited community nurses, therapy teams and specialist nurses. We spoke with staff, including community matrons, qualified nurses, healthcare assistants, team leaders, zone managers and deputy managers. We also met with some of the senior management team from the community. We talked with occupational therapists and physiotherapists. The total number of staff we spoke with was 51. We met with 27 patients and spoke with 13 of their relatives/carers, we reviewed 18 sets of patients' notes. We observed care and looked at records and data. We also received feedback about some of the community services and outpatients prior to our inspection.

Our inspection team

Our inspection team was led by:

Chair: Tony Berendt, Medical Director, Oxford University Hospitals

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included three CQC inspectors and five specialist advisors who all had experience of community nursing and therapies.

Why we carried out this inspection

We inspected this core service as part of our comprehensive inspection of NHS trusts.

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?

We undertook an announced inspection of Torbay and South Devon NHS Foundation Trust on 1, 3, 4, 5 & 16 February 2016

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit we held focus groups with a range of staff who worked within the service. We talked with people who use services. 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.

What people who use the provider say

- The friends and family test results from the 1 January 2016 to the 31 January 2016 for the whole community was above 97% that patients who recommend their service to their friends and family.
- During our inspection, we spoke with 27 patients and 13 of their relatives/carers. Patients made positive comments to us regarding the care they received and the staff who provided it. We heard staff were kind, helpful and caring. Patients were also positive regarding their involvement in their care and the planning of any care and treatment.
- Two patients provided us with comments prior to our inspection about the self-referral to physiotherapy outpatients. They told us it was "brilliant" as they did not have to wait for a GP referral.
- Patients told us staff were compassionate and caring, "nothing is too much trouble", and "they are wonderful".

Good practice

- The changes made to the management of diabetic patients in the community by the introduction of new care planning documentation and recording of insulin prescribed and administered. The diabetes Specialist Nurse received recognition from the Royal College of Nursing (RCN) for their work in improving the management of patients with diabetes. Their work was recognised nationally and was published by the RCN for other trusts and community nurses to follow.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should make sure all teams receive feedback following the reporting of incidents.
- The trust should make sure all allergies to creams/ medicines are passed on between community nursing teams.

Summary of findings

- The trust should make sure all patients records that are transported in staff vehicles are stored securely and out of sight.
- The out of hours community nursing team should have access to equipment likes beds and alternating pressure relieving equipment to meet patients needs and to prevent hospital admission.
- The trust should review the safety arrangements at the Albany clinic to make sure community staff are safe.
- The trust should review the lone working arrangements for weekends between the hours of 5pm to 7pm for the Newton Abbot zone.

Torbay and South Devon NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of community adult services as good because;

- Openness and transparency about safety was encouraged. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- Staff received up-to-date training in all safety systems.
- There were effective handovers during shifts, to ensure staff managed risks to patients who used the services and any change in the patients condition was identified quickly and acted upon.
- Risks to patients' services were assessed, monitored and managed at each visit. Patients were involved in managing risks and risk assessments were proportionate and reviewed regularly.
- Staff recognised and responded appropriately to changes in risks to patients.
- There were clearly defined and embedded systems, processes and standard operating procedures to keep patients safe and safeguarded from abuse.

However:

- The out of hours nursing service team reported difficulty in accessing equipment at night. They did not have a central storage facility for equipment and there have been delays in treatment due to this, for example syringe drivers.
- There were concerns regarding lone working in Newton Abbot zone. Between the hours 5pm to 7pm at a weekend nursing staff were alone. They were concerned about what would happen if two syringe drivers needed to set up at the same time.

Safety performance

- Safety performance was monitored over time and improvements made.
- Each zone had a safety thermometer. On a set day each month staff recorded the required data on avoidable patient harm to the NHS Health and Social Care

Information Centre. This was nationally collected data providing a snapshot of avoidable patient harms on one specific day each month. This included all and new pressure ulcers (grade two and more serious categories: grade three and four) and patient falls with harm. The report also included catheter and urinary tract infections (UTIs).

- The trust had identified from their monitoring of pressure ulcers that these were increasing and actions were taken to reduce the amount of avoidable grade three and four pressure ulcers. The trusts community dashboard for November 2015 (using data from October and September 2015) stated they had a marked reduction (no figures given) in grade three and four pressure ulcers acquired or deteriorated in their care and no recorded avoidable pressure ulcers**.** For December 2015, the trust reported no avoidable pressure ulcers grade three and four. There were 14 unavoidable pressure ulcers for all zones. This was the same for November 2015.
- For January 2016, 564 patients were included in the safety thermometer. Of these 8% had pressure ulcers (old and new), this was a reduction on December 2015. Falls with harm was 2.3% this was an increase from December 2015. Catheters and urinary tract infection (UTI) was 0.2% and this was an improvement from December 2015.
- For January 2016 the community had a percentage of 89.4% for harm free care overall.
- Community staff told us they were aware of the safety thermometer as they inputted the details each month. Results were shared at team meetings.
- Staff were aware of safety alerts and they were shared at monthly team meetings.
- The trust used the monitored key performance indicators to provide an early warning if essential characteristics of a well performing team were absent or at risk. From a number of questions a score was obtained and level of risk. For each level of risk, a number of interventions were to be followed. Level zero was 'green' and no interventions were required. Level one up to level three (the highest score) had a list of interventions for managers to take. The questions included vacancy rate, sickness levels, number of complaints received and unusual demand on the service. For January 2016, community nursing had one area within a zone that was rated as 'level one' (amber) and some areas for occupational therapy and physiotherapy across the zones were rated as 'amber'. Senior managers told us that this was mostly due to vacancies for therapy staff. The out of hour's community nursing team was also rated as 'level one' amber. The team leader told us they had high sickness levels and two vacancies. A new qualified nurse started in February 2016 and they were in the process of recruiting a health care assistant. The purpose of the tool was to maintain safe and effective care and to protect patients from avoidable harm.

Incident reporting, learning and improvement

- Staff were encouraged to report incidents using the trusts electronic recording system. The appropriate team manager and zone manager saw all incident reports. Staff received feedback from their manager following the reporting of an incident. However, not all services received feedback, for example, the out of hours community nursing team said they did not always receive a response. Zone managers told us that incident reports submitted were reviewed monthly to identify any trends and to share learning within teams. At team meetings, the number and type of incidents were shared with staff.
- Staff told us there was a 'no blame' culture and incidents were viewed as an opportunity for learning by the trust.
- Between December 2014 and November 2015 there was 1,014 National Reporting and Learning System (NRLS) incidents reported by the community. Seventy percent of incidents were reported by community nursing teams and the themes were around care, on-going monitoring and review of patients.
- The trust monitored 'near misses' (this was where no harm to patients had taken place following an incident). From January 2015 to December 2015, they had 51 near misses. Some of the near misses involved other providers, for example, domiciliary care providers. Each had been investigated. Learning from these was shared across community teams. For example, a senior member of staff told us about some near misses and incidents where community nursing staff had missed or

omitted insulin. In one of the zones, they had a meeting each morning where community staff confirmed they had administered patients' insulin and then evening visits were allocated.

- During 2014 there was 50 incidents relating to insulin administration reported. The diabetic specialist nurses following this re-designed the insulin recording sheet and staff who administered insulin had to complete on line training with a pass rate of 80%. Since then the specialist nurses told us the number of incidents involving insulin had reduced as all incident reports were sent to them for review.
- We were told about learning that had taken place across the community as whole following a medication incident. A new medication administration checklist form had been devised.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a new regulation, which was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- All staff that we spoke with understood the principles of openness and transparency that were encompassed by the duty of candour.
- A senior member of staff told us about an incident where they used duty of candour regulations. This member of staff had met with and wrote to the family about the incident and with the outcome. The family had chosen not be involved in the investigation. We did not see the letters or records of this incident.
- We were shown the records of another incident that took place in an outpatient clinic where they applied the principles of duty of candour regulation. The root cause analysis of the incident contained details of when the patient and their family were contacted by the investigator. Brief details about what was said were included. All contact was via telephone and face to face meetings. We were shown the action plan devised following this incident and the date for completion of each of the actions. This was shared with the patient and their family.

Safeguarding

- Staff were aware of the systems they had in place to make sure patients were safe.
- The trust policy on safeguarding was accessed via their computer system and all staff knew where to find it.
- There was one single referral point for all safeguarding concerns. Staff told us they were able to obtain advice and support from this referral point if they were unsure about the referral.
- Staff gave us examples of where they had made safeguarding referrals. For example, one incident was following observations of unexplained injuries to a patient.
- Safeguarding training was provided as part of the induction programme and updates took place yearly, which was via e learning.
- The level of training for safeguarding children for the staff in community health services for adults was in accordance with guidelines published by the Royal College of Paediatrics and Child Health in March 2014. These recommended level two as the minimum level required for non-clinical and clinical staff with some degree of contact with children and young people and/or parents/carers. Ninety five percent of staff had completed level one awareness, level two was 88% and level three was 88%. The training figures were as of October 2015.
- The training figures for adults safeguarding training as of October 2015 was level 1 awareness 96%, level 2 training 78%, level 3 was 91%, level 4 was 89%, level 5 was 81% and level 6 was 100%.
- The trust had a safeguarding lead and senior staff were aware of whom this was.

Medicines

- Medicine arrangements kept patients safe.
- Medication policies and procedures were in place and accessible for staff. The staff we spoke with were all aware of the guidance available to them.
- Staff told us they did not carry medications for patients, only wound dressings if they knew none was present at the patient's home. They did carry anaphylaxis

medication boxes that contained adrenalin in case a patient had an allergic reaction to any medication they administered. Community nurses told us they always checked the expiry date of this medication.

- All medications were obtained by a GP prescription by the patient, their family/carers or delivered to the patient by the chemist. A relative of a patient confirmed they had collected the medication needed for their relative's syringe driver from the chemist after the GP surgery had sent the prescription to them.
- We were shown the medication used for a syringe driver in one patients home. The medication was stored in a box provided by the community nurses. The patient's relative told us they kept them 'out of the way' of all visitors. The community nurse showed us the stock sheets; this was where they recorded on separate sheets for each medication when it was used and the running total. When each medication was used the dose, batch numbers and expiry date was also recorded.
- The community nurse said they had received training on the use of syringe drivers as part of their induction (they had been in post since March 2015). They also had to complete and have signed off competences for using syringe drivers. They felt confident in setting up syringe drivers on their own but could ask another nurse to support them if required. A senior community nurse also confirmed nurses could visit in pairs if required for syringe driver management.
- Ampoules, needles and syringes being disposed of safely once they had been used, in a designated sharps bin.
- We saw in a patient's home 'just in case' medication. This was medication prescribed by their GP to be used at a specific time. For example, the patient we visited had 'just in case' medication for pain relief. The community nurse told us they were able to give a bolus or 'one off dose' to reduce their pain if the syringe driver was no longer effective. This would give them time to contact the GP to review their medication and prevent the patient from having pain. We saw the prescription chart that had been completed and signed by the patients GP.
- We observed a patient having their leg ulcer dressing changed. A member of their family told us their leg was red due to what they understood was an allergy to an ingredient in the cream used. We saw this had been noted in their records and the type of cream to be used instead of the one in place. This had not been passed on to the other community nurses and the wrong cream was being used. The community nurse said they would order the correct cream the patient should be using.
- In some zones community staff told us they had issues with obtaining prescribed dressings as the system used was time consuming and sometimes they had wait two weeks before they arrived at the patients' home. Senior managers were aware of the issue.

Environment and equipment

- We saw appropriate equipment was used to support safe patient care and treatment.
- Staff understood their responsibilities to ensure equipment was safe to use, serviced, and maintained.
- Community staff working in the Torbay, Paignton and Brixham zones, had access to an equipment provider who was able to deliver equipment if urgent within two hours. They worked until 9pm each evening including weekends. This included for example commodes, beds, pressure relieving mattresses and syringe drivers. Syringe drivers were delivered with all the equipment needed for their use, for example, syringes, lines and batteries. For the other zones in South Devon, they had access to equipment from an equipment store who would deliver beds etc. They were able to get equipment for example, a bed on the same day but it cost more for delivery, however to prevent a hospital admission this would be undertaken. Syringe drivers were stored with community nurses or at community hospitals so they had to make sure all the equipment required to set them up was in place. At weekends they and the out of hour's community staff had access to pressure relieving mattresses (non-electric) that they were able to transport in their cars.
- The out of hours nursing service team said they had experienced difficulty in accessing equipment at night. They did not have a central storage facility for equipment and there have been delays in treatment due to this, for example syringe drivers. A business case was being developed to give them access to a central equipment store.

Good

Are services safe?

- If specialist equipment such as an airwave mattress (a special mattress used to in the prevention of developing pressure ulcers) or bed was required overnight, there was not a member of staff available who could authorise this. Staff had to request the day community nurse service to arrange this.
- We visited a patient with two physiotherapists, one had brought a walking frame with them to help mobilise the patient. They told us they had access to certain types of equipment that they could transport to patients homes.
- Community nurses in Ashburton (Moor to Sea zone) told us they had new bags of equipment. They contained for example, blood pressure machine, thermometer, urinalysis sticks, dressing pack and a face resuscitation mask. The purpose of these was to make sure they had all the equipment needed for their visits and to prevent unnecessary return visits.
- Staff were able to obtain equipment for bariatric patients when required. This included specialist beds, commodes and walking frames.
- Contracts were in place for servicing of equipment.
- The trust had identified safety issue with one of the locations where community nurses were based. This was the Albany clinic site. Community staff told us about the safety risks for them due to its location. It was on the trusts risk register.
- The Department of Health and the NHS Commissioning Board recommend that all hospitals, hospices and independent treatment centres providing NHS funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. Patient-led assessments of the care environment (PLACE) took place in August 2015 and included all nine community hospitals run by the trust. These included the outpatient departments. Seven of the nine community hospitals scored above the England average for condition, appearance and maintenance. The 'dementia friendly environment' was a new scoring category for the 2015assessments. Whilst all but one of the community hospitals was above the England average. The trust identified improvements they could make, for example, signage that included pictures, text and toilet doors painted in a single distinctive colour.
- At Teignmouth Community hospital outpatients department the League of Friends had recently purchased a scanning unit and also a number of other items. Staff said they were well supported by their League of Friends.

Quality of records

- We reviewed 18 sets of patient records both in written form and some on their computer system. We found the majority to be up to date with patients current care needs. Patients stored their own community nurse records.
- Records of patients' wounds were up to date with on-going evaluations. The trust had a set format for recording wound care and these were completed after each dressing change.
- Record keeping in the therapy teams included reference to patients' goals for treatment. For example, we visited one patient who had requested help with being able to mobilise again. We saw documented the initial request from the patient and the goal to assess and monitor their progress. After our visit, the physiotherapist was going to update the records on the computer system with the outcome their first visit and follow up needed.
- The computer records we viewed were also up to date with patients current care needs and any treatments being provided.
- Two of the relatives we spoke with said they were aware of what was written in their relatives notes and referred to them for any telephone numbers they might need. For example, to contact the community nurse out of hours team.
- We observed one member of the community nursing team was carrying patient records around on the back seat of their car. They told us they removed them at the end of each shift. However, confidential records were on show and not stored securely.
- Following the introduction of the SSKIN (s = support surface, s= skin inspection, k = keep moving, I = incontinence and n= nutrition and hydration) bundle by the trusts tissue viability service we saw these completed in patients records. On visits with the

community nurses, we heard them ask patients questions relating to SSKIN and some patients pressure areas were observed by the community nurse. Any changes to their care plans were updated.

- Audits of patient records were undertaken monthly on 10 sets in each community team. Issues identified were discussed with the member of staff and then at team meetings to share the learning. We saw records of two audits where in one it had been highlighted that risk assessments had not been reviewed.

Cleanliness, infection control and hygiene

- Policies and procedures regarding the promotion of infection prevention and control were available to staff on the trusts intranet.
- Community nurses all carried protective clothing for example, gloves and aprons. They also had hand-sanitising gel to prevent the risks of cross infection.
- We observed community nurses and therapists working in patients' own homes, and saw they followed policies and procedures relating to hand washing and use of personal protective equipment, for example, the use of hand sanitising gel, gloves and aprons. In some patients homes they had left a separate hand towel for the use of the community nurse. One relative told us they changed the towel after each visit from the community nurse, as they were aware it was for infection control prevention.
- We observed the community nurses disposing of the waste following their visit to a patient in a bag that came in the dressing pack. The patient then disposed of these.
- At Newton Abbot outpatient department staff told us, they had a procedure in place to make sure the scopes used for cystoscopies (camera into the bladder) were sterile to prevent the risk of cross infection.
- In this department when equipment was cleaned a green sticker was applied with the date on it.
- Patient-led assessments of the care environment (PLACE) took place in August 2015 and included all nine community hospitals run by the trust. These included the outpatient departments. All scored above the national average of 97.6% in cleanliness with some scoring 100%.
- Infection control training was rated as 'green' meeting the trust target for the community.
- Monthly infection control audits, which included hand hygiene, were undertaken in the community hospitals, which included the outpatients departments. Where issues were identified actions were devised to address any short falls.

Mandatory training

- Staff were up to date with training in safe practice, processes and systems.
- Each member of staff was given a rating of 'red, amber or green' for each identified mandatory training subject. Red meaning overdue, amber nearly time to re do and green having completed the training. Each zone had a member of staff monitoring when staff training was due. Senior staff were sent spread sheets to clarify the training status of staff and they told us in supervision sessions staff were reminded about completing their mandatory training.
- The mandatory training subjects included fire safety, health and safety, information governance and manual handling. The community service, as a whole as of December 2015 were mostly green for all areas. One area was rated as 'red' and that was information governance for one zone. Senior staff said they looking at ways of improving this figure.
- Staff told us they found mandatory training was easier to complete now it was a one day course and via e learning. They told us at times it was difficult to fit the training in due to the demands of the service.

Assessing and responding to patient risk

- Risk assessments were carried out for patients and plans developed to manage identified risks. For example, a risk assessment in relation to visits was carried out and if this identified community nurses needed to visit in pairs for safety reasons they would.
- We saw risk assessments were in place for nutrition, pressure ulcers and falls. These risk assessments indicated if a patient was at high risk. For example, we saw patients who had been assessed as being at high risk of developing pressure ulcers. They had been provided with pressure relieving equipment for their chair and bed. Patients were also provided with

information leaflets on how to reduce their risks of developing pressure ulcers. We observed risk assessments being reviewed frequently for patients who were deemed at risk.

- When referrals were received by each zone they were triaged to see if the risk to the patient was urgent and then passed to the relevant team who were best placed to meet their assessed need. For example, during our visits with the community nurse they were contacted by the triage nurse to say a patient needed to be visited that day as they had concerns over their medical condition. This patient was visited by the community nurse and treatment provided.
- We attended a morning handover meeting for the community nursing team, in one of the zones. All staff attended and this was where caseloads were discussed and any problems identified and addressed. Staff confirmed they had completed all visits to patients who required insulin that morning and which staff would be doing these visits later that afternoon. This was to make sure no patients who required insulin were missed. Any extra visits were also allocated at this meeting.
- During a visit to a patient, we were not able to gain access to their home. Staff followed their procedure on what actions needed to be taken. We observed this taking place. The police were called and access gained to the property. The patient was found on the floor. The community nurse stayed with the patient whilst additional support was obtained.
- We visited a patient who was referred as an urgent referral to the intermediate care team. They responded within the two hour timescale. Following assessment and review of the patients' needs, it was felt they needed hospital admission. The patient and carer we fully involved in the assessment and decision to admit to hospital.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads had been planned and reviewed, however recruitment for some staff was on-going and teams had vacancies that were not filled.
- The community nursing service had bases in the five zones. Their teams consisted of healthcare assistants, band 5 and band 6 nurses, who were managed by a band 7 nurse. The service provided cover seven days per week from 7am to 7pm. Outside of these hours was an out of hour's community nursing service.
- The trust had completed a nursing workload review in 2012 where for one week all community nursing staff completed details about all their visits. This was reviewed and analysed and resulted in the trust changing the skill mix to 70% non-registered staff to 30% registered nurses. Community nursing staff in some zones felt their staffing needed to be reviewed as they felt the complexity of their patients had increased.
- In the Torquay zone, they had a low turnover of community nursing staff in the last six months. One new member of staff was due to start with the community nursing team shortly. Bank and agency staff were used to cover sickness but they were not on duty out of hours (weekends or bank holidays). This was due to less staff being available to support them. Sickness rate was 6.9%, which was above the trust average of 5%, but a senior member of staff said this was due to long-term sickness.
- In the Ashburton area of the Moor to Sea zone one of their full time health care assistant who was working in the lower limb service had left and had not been replaced. Staff in this zone felt their staffing levels needed to be reviewed as they were the same as five years ago and patients' needs had become more complex.
- In parts of the Moor to Sea zone (Dartmouth area); they had vacancies of 3.3 whole time equivalents (WTE). They also had a band 5 member of staff on maternity leave and bank staff were being used to cover if required. Recruitment of qualified nurses for this area was included on the risk register and it stated bank nurses were being used and staff covering the extra hours whilst recruitment was on-going.
- In Newton Abbot, zone community nursing staff raised concerns about lone working. Between the hours 5pm to 7pm at a weekend they were alone. They were concerned about what would happen if two syringe drivers needed to set up at the same time. This was on-going at the time of our inspection.

Good

Are services safe?

- Senior manager told us the recruitment of therapy staff (physiotherapists and occupational therapists) was difficult and this was included on their risk register.
- In the Paignton and Brixham zone, they were using bank physiotherapists to cover vacancies.
- The trust provided us with their latest sickness rates. Out of the five zones for community nursing Brixham had the highest amount at 8%, which was above the 5% trust average.
- The trusts average staff turnover rate was 16%. The highest turnover was in the Moor to Sea zone Moorlands area at 29%. We were told the trust were investigating the reasons for this.
- The highest use of bank or agency staff from October 2014 to September 2015 was the Newton Abbot zone at an average of 9%. Two zones had none or one percent average bank or agency usage in this timescale and it was Torquay, Paignton and Brixham.
- The out of hours nursing service currently had one vacancy for a health care assistant (HCA). The advert for this post had recently closed and they were in the process of shortlisting applicants.
- The out of hours community nursing service did not hold a caseload of patients as their work was generated by referrals from Lifeline and the Devon Doctors service. This made their workload varied and unpredictable. They reported difficulty in obtaining bank or agency staff due to the shift times they worked and the level of skills that were required. Team members had been working extra hours to cover the shifts.
- Staffing issues had been identified with the podiatry service due to an increase in demand and the time it was taking to recruit new staff members. The trust was not meeting the national standard for outpatient activity due to this.

Managing anticipated risks

- Risks were taken into account when planning services and actions could be put in place to address these.
- One initiative, to prevent admissions to hospital, covered the Costal Locality, was the Proactive Care Team (PACT). The team had a community matron, occupational therapists, GPs, community nurses and social care staff. They met daily to identify the top 2% of patients at risk of going into hospital. This involved working with the voluntary sector to help keep patients at home. PACT started in November 2014 until November 2015 but the budget was extended to continue to the end of March 2016. Feedback from staff and patients said this scheme was very successful.
- The out of hours community nursing team told us they had access to four wheel drive vehicles if there was bad weather. They said they were kept up to date with weather conditions and had always got to their visits.
- Community nurse in some of the zones also told us that in bad weather they had access to four by four vehicles to make sure they were able to get to patients.
- The trust had an escalation plan in place devised with the local Clinical Commissioning Group (CCG). The plan had actions for each part of the trust to follow depending on the rating of the trust (green, amber, red and black). This involved actions for the community services to follow and instigate.

Major incident awareness and training

- Arrangements were in place for staff to respond to emergencies or major incidents.
- We saw in the locations where community staff were based a major incident file, which included guidance on what staff needed to do in the event of a major incident. These included for example, loss of premises and loss of supplies. Scenarios were discussed with staff at team meetings but procedures were not always practised.

Outstanding ☆

Are services effective?

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

Summary

We have judged the effectiveness of community adult services as outstanding because:

- Patient's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This was monitored to ensure consistency of practice.
- There was a holistic approach to assessing, planning, delivering and monitoring care and treatment to patients who used services.
- Benchmarking, research and accreditation were used to improve the outcomes for patients. Information about patient's care and treatment, and their outcomes, was routinely collected and monitored. This information was used to improve care. Outcomes for patients who used services were positive, consistent and met expectations.
- Staff teams and services were committed to working collaboratively and have found innovative and efficient ways to deliver more joined-up care to patients who used the services.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and training was put in place to meet these learning needs. However, staff were mostly supported to maintain and further develop their professional skills and experience.
- Consent to care and treatment was obtained in line with legislation and guidance. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

However:

- Appraisal rates for some zone and specialist services was as low as 50%
- Evidence of consent being obtained was not always documented clearly in the patients notes within the outpatients department in Newton Abbot.

Evidence based care and treatment

- Care and treatment was mostly provided in line with national best practice guidance including National Institute of Health and Care Excellence (NICE) quality standards. Compliance assessments had been undertaken for a number of NICE quality standards, which demonstrated that the trust was fully compliant with guidelines. For example, the tissue viability service was meeting NICE pressure ulcers, prevention and management (CG179).
- The community risk registers had identified where they were not meeting all NICE guidance and actions were in place to address this. For example, in podiatry NICE issued guidance NG 19 'Diabetic Foot Problems Prevention & Management'. This was for patients at moderate or high risk of developing diabetic foot problems. All patients in this category needed to be assessed. However the trust identified they were not commissioned to provide this service to all diabetic patients within the catchment area of Torbay and South Devon and there were not enough staff within the teams to meet this. This was on going at the time of our inspection with discussions with the Clinical Commissioning Group.
- Patients were referred to specialist nurses for advice and support in managing their long-term conditions, for example, Parkinson's, diabetes, heart failure, **chronic obstructive pulmonary disease** (COPD) and epilepsy. These specialist nurses had direct links to consultant care and could refer any patients to them. Specialist nurses told us they attended conferences in their fields to update their skills in the latest treatments available and transferred this new knowledge on when treating patients.
- We were shown the pathway used when working with the local hospice (external provider) when patients needed a referral to the trusts specialist team for oedema (is the medical term for fluid retention in the body).

Are services effective?

- Best practice groups were held as a forum for discussion and countywide dissemination of evidence based practice.

Pain relief

- We saw evidence across community nursing and therapy teams of patients' pain being managed effectively.
- Patients were supported and/or enabled to take their pain relief prior to treatment and care being delivered. For example, one of the community nurses contacted a patient 30 minutes before we arrived as they had extensive dressings that were painful so they were able to take their analgesia and allow it time to work. The patient said this made their dressing change easier as it was very painful before and after the dressing change.
- We visited a patient who had a syringe driver in place for management of their pain. The community nurse showed us the analgesia prescription written by the GP, which enabled them, with input from the patient to increase the dose within a set range. The community nurse said that once they were at the top range the GP would visit and review their pain relief. They were able to give a bolus or 'one off' dose of analgesia as prescribed by the patients GP if they were in a lot of pain. The patient told us their pain was well controlled and they would inform the community nurse if they felt they required more.
- A pain tool was in place as part of the assessment.

Nutrition and hydration

- Patients were assessed for their risk of malnutrition.
- Staff used the **Malnutrition Universal Screening Tool** (M**UST**) to assess patients' risk of malnutrition. Each patient was given a score, which indicated their risk level. We saw in one patient's records where it had been identified they had lost a large amount of weight within a short time. This was following their discharge from hospital. Staff had referred this patient to the dietitian and their weight was being monitored weekly. The patient told us they had been prescribed supplement drinks to have twice a day which they were enjoying.

Technology and telemedicine

- Technology was being used to enhance the delivery of effective care.
- Following a review of information available to patients about their conditions, the trust designed 'Hiblio' or 'Buzz'. It was accessed online and provided films for supporting better health and care. The films had all been made by experts, providing the best information to the public, patients and clinicians. The films covered a wide range health issues, including dementia, diabetes, health living and nutrition and the range was widening all the time. Patient and/or their family/carers could also get advice about how to relieve symptoms associated with specific conditions such as diabetes and psoriasis. Each film was linked back to the official website of the NHS if patients wanted more specialist advice.
- Staff told us they used telecare for patients assessed as being at risk of falls. Pressure mats alarmed when the patient stood on them or got up our of bed. They were able to have the alarm directed to a central location. Patients could also have pendent alarms (either on their wrist or as a necklace) which they pressed if they had a fall and they would summon help. A private company provided these and the patient funded them.

Patient outcomes

- Information about patient outcomes was monitored and changes made to services where needed.
- Following an increase in the number medicine incidents involving insulin administration in the community the diabetes nurse specialists introduced new recording and care plans for diabetes. Staff that administered insulin had to undergo training. The specialist nurses told us the number of incidents had now reduced as they were monitoring all incidents involving insulin.
- As part of a national **Commissioning for Quality and Innovation** (CQUIN) for 2014/15, the tissue viability service across the trust needed to reduce the number of 'avoidable' grade three and four pressure ulcers by 10%. During this time, the trust exceeded this target, which meant 36 patients were not harmed in their care. We saw the community dashboards for January and February 2016 and this showed there was no avoidable grade three or four pressure sores in the community
- The trust set up a lower limb service in June 2015 to standardise the care patients were receiving for the management and treatment of leg ulcers. An inclusion and exclusion criteria was in place for referrals. There had been 439 referrals since the service started. The

senior manager told us that since it had been introduced they had discharged over 200 patients from its service. The service was undertaking on going auditing of referrals, waiting lists and healing rates.

- The community undertook an audit of indwelling urinary catheters from April 2015 to December 2015. They looked at a number of areas to include how many catheters they had in the community, the gender of the patient and how many had urinary tract infections. They were monitoring the effective use of catheters and making sure the patient had a clear need for insertion of a catheter. This audit was on-going.
- The out of hour's community nursing team was auditing all their activity, for example, type of visits from April 2015 to March 2016. The most visits were to attend to catheter management at 408 visits. This number had reduced from the previous year. The purpose of this was to see where their time was mostly spent. We were told changes to the way catheters were managed in the community had changed after these audits with more teaching of patients on how to manage their catheter and by contacting the community nursing service sooner when they discovered issues with their catheter.
- The trust participated in the yearly National Intermediate Care Audits except for 2015. They felt the information they got back did not improve their service, however they plan to participate in the 2016 audit.
- The trust sent us data of how they were monitoring their intermediate care service for 2015 both as a trust and by zones. We were unable to compare most of this data to the National Intermediate Care Audit 2015 (NICA), as some was not comparable and others did not have targets. The number of intermediate care referrals was meeting the trust target, however there was not a national target to compare this with in the NICA 2015. The number of intermediate care placements was just under the trust target and again we were not able to compare this as there was no national figure. The average length of stay in the intermediate care service was rated as 'red' by the trust as it was higher than their target. In the NICA 2015 they gave targets for three different types of intermediate care service, for example, crisis response. The trust gave us their overall figures, which were not broken down into the three services. However, when compared the trust average length of stay was a lot lower than the national average. The trust had 2995 referrals to their intermediate care service and of these 126 were the number of placements resulting in an emergency admission to the acute trust within seven days. There was no target on the trust figures and no figures within the NICA 2015 to compare this with. The trust told us they used the data they collected to review the performance of the service and to help with the planning and development of a new care model of the new care model for the Integrated Care Organisation. Senior staff from the trust meet quarterly with Intermediate Care peers from other areas of Devon to share and discuss best practice. Plymouth and Exeter Universities have undertaken a piece of scoping work across the South West in 2015; Torbay and South Devon Intermediate Care services took part in this; providing service information and data to the research staff. The output report of this piece of work is due to be shared with the Trust in May 2016. Over the past year the service has also had a CQUIN in place with Torbay and South Devon Clinical Commissioning Group; taking learning from service information, in order to improve the patient experience and outcome.

Competent staff

- Staff had the correct qualification, skills and knowledge to undertake their roles.
- Appraisal rates for each zone and specialist service ranged from 50% to100% . Senior staff told us some of the lower percentages were due to staff on long-term sickness being added into the numbers.
- Staff told us they had regular one to one meetings with their manager where they could discuss their progress and training needs.
- Community nurses told us they had to complete a number of competences in their role before they could undertake certain tasks. For example, syringe drivers, compression bandaging on leg ulcers, male and female and supra public (catheter directly into the bladder through the abdominal wall) catheterisation and verification of death.
- Training records for other additional training included flu immunisation and dementia.
- Health care assistants (HCA) were able to take on additional tasks once training and competencies had been completed. For example, urethral catheterisation, insulin injections (on patients whose diabetes was stable) and four layer compression bandaging.
- The out of hours community nursing team reported they felt supported in undertaking additional training. Three members of the team were trained as non-medical

prescribers and a further two were undertaking the training in 2016. However, one team member reported that since qualifying as a non medical prescriber, there had been a delay in being able to use this skill due to not receiving the correct paperwork. This has resulted in a loss of confidence in this new skill by the member of staff.

- The out of hour's community nursing team said that both face-to-face and online learning was easily accessible. The trust had funded some academic training but it was difficult to have time off for this due to staffing issues. The team said that they were paid for their study time if they are unable to take time off whilst on duty and had to do it in their own time.
- The team reported that they were mostly up to date with their appraisals and supervision. They were supported and encouraged to develop their knowledge and skills.
- There were procedures in place to monitor staff that were not performing to the required standards. The human resources department supported the manager in how to monitor and support staff to improve.
- Team leaders told us they were aware of qualified nurses who were due to revalidate with the Nursing Midwifery Council (NMC) from April 2016 onwards . As this is a new process for qualified nurses, they wanted to support and guide them. The trust had set up meetings for qualified nurses to attend and find out more details about revalidation.
- Community nursing teams had 'champions' where nurses attended meetings for certain specialities for example, tissue viability. Community nurses attended a monthly meeting with the tissue viability specialist nurses and then they shared the information with the rest of their teams at their meetings.

Multi-disciplinary working and coordinated care pathways

- All the necessary staff were involved in the assessing, planning and delivery of patients care and treatment.
- Throughout our inspection of the community services for adults, we saw excellent examples of multidisciplinary team (MDT) working, both within internal teams of professionals and working with professionals from outside of the organisation. One example was where a patient had difficulty getting on and off their bed. The community nurse referred to the intermediate care team and an occupational therapist visited and immediately arranged for the height of the patients bed to be increased.
- In the Torquay zone, they had a 'single point of contact'. This was where patients, their family/carers or professionals could make a referral to the joint health and social care team. The referral was then reviewed and sent to the most appropriate team. The teams included community nurses, occupational therapists, physiotherapists, social workers, intermediate care and long-term care. A triage team were based at the location and were able to respond quickly to referrals, they would decide on which team would be best to meet the needs of the patient. For example, the intermediate care team could visit a patient with a social worker to review their care needs and to determine with the patient and their family/carer the best place to meet their needs(at home, care home or hospital). A similar single point of contact system was being trialled in the Paignton and Brixham zone. In parts of the Moor to Sea zone, they also had a single point of access where patients and professionals contacted one telephone number and this was triaged to the most suitable professional to deal with. A senior community nurse in this zone carried a mobile phone so they could be contacted with urgent visits. In other areas of this zone, referrals for the community nursing team were telephoned to their base or received via their computer system. In other zones were this was not taking place referrals did reach the correct team of professionals but not always as quickly as the single point of referral. However, the outcomes for patients in all areas were the same once the most suitable professional had been identified.
- We undertook a visit with a community nurse and physiotherapist. We observed the patient was included in the assessment of their needs and goal setting. Further joint visits were arranged to follow up the patient progress.
- Community staff had access to social workers within their zones. In the Torbay, Paignton and Brixham zones, the health and social care budgets were pooled and staff were based together at the same locations. In the South Devon area, which was covered by Devon County Council budgets for health and social, were separated. Staff were not based together but still had access to each other to make sure patients' needs were being met.

Are services effective?

- Community matrons told us their role was to support patients with long-term conditions and they worked closely with the community nurses in their areas and therapy teams.
- In one of the zones, a 'hub' meeting took place weekly based at one of the community hospitals where all members of the multi-disciplinary team attended. This was to discuss patients in the community and those waiting for discharge from the community hospital.
- In part of the Moor to Sea zone staff told us about an independent (charitable agency) provider who employed two staff who worked between the local community hospital and community. Their role was to facilitate discharges and to support patients leaving hospital. The community matron from this area supervised them.
- In the Coastal zone, we met a community nurse whose role was to work with care homes to improve standards of care. They taught and supported staff in the care homes to use the same risk assessment tools as the community nurses and this helped to identify at risk patients earlier.
- The community neurology and stroke team were able to support early discharges from hospital. They assessed patients whilst they were an inpatient then provided them with treatment and support on discharge.

Referral, transfer, discharge and transition

- All staff worked together to assess plan and implement care and treatment to patients.
- Where there was a single point of contact community teams felt they had greater information about patients' needs as the health and social care teams that dealt with the referrals had access to additional relevant information. Where this was not taking place some community teams felt they did not receive all the information they needed about patient's needs.
- Staff told us they mostly received all the information they needed when a patient was discharged from the acute hospital. Some community teams had access to discharge information from the acute trust on their computer system.
- Community nursing teams, intermediate care and therapy staff told us they all worked as a team to provide the best support to patients. Some teams were in the same office, which meant it was easy to discuss patients.
- Community nursing teams told us they had good communications with local GP's and they kept each other up to date with the condition of the patients.
- There was clear referral processes in place for community nurses and therapy staff, for example, if a patient was referred to the intermediate care team urgently they had to be seen and assessed within two hours.
- Community nurses told us they mostly saw all referrals to their service on the same day. We witnessed a community nurse receive a telephone call to visit a patient that afternoon due to a change in their care needs.
- The out of hours community nursing team told us they had a referral process in place which was either via Devon Doctors out of hours service or by Life line. If the patient was known to the community nursing service, they were able to access their notes via the computer system. They would contact the patient prior to visiting to obtain more details. If the patient was known to the community nursing service their notes were held in their home. The out of hours community nursing service told us a morning handover of care was given to Devon Doctors, Lifeline and the daytime community nursing team. The team reported their overnight activity and any follow up that was required.
- The specialist nurses told us about the transition arrangements they had in place when younger people were transferred to adult services. They told us each younger person was assessed to decide on the timing of the transition. For example, with diabetes they had a specialist team who worked on the transition pathway with the younger person and their parents/carer.

Access to information

- Information needed to deliver effective care and treatment was mostly available to staff in a timely and accessible way.
- Community nursing patients held their notes at their home so all professionals had access to them when visiting.
- Not all zones had the same access to computer systems. In Torbay, Paignton and Brixham zones, they had access to a computer system where all staff recorded details of visits to patients, assessments and referrals to other professionals. Staff were also able to provide other information on this system that was pertinent to all staff who were visiting this patient. For example, if access to

the property was difficult. In some of the zones, they were also able to access discharge information from Torbay Hospital on their computer system and some information from GP surgeries. In other zones for example, Coastal, where they did not have access to the computer systems above they felt obtaining information was often difficult. They only had telephone referrals, which provided limited information and was not always reflective of the patient's condition or needs.

- The out of hour's team reported they received information from the day teams via the computer system.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance.
- Through discussions with staff and inspection of records, it was clear staff had an understanding of the Mental Capacity Act 2005 and consent. We saw in records a form where patients signed to give their consent for visits from the professional teams and to sharing of information. Staff also knew about best interest decisions that had been made on behalf of a patient if they lacked capacity to make a certain decision. We did not see any documented best interest decisions during the inspection.
- We saw capacity assessments had been undertaken and were in patient's records.
- We observed staff asking for consent to start treatment at all the visits we attended with them.
- The trust had a policy on consent. In this policy it gave advice to professional on how to obtain consent, when to use a consent form and when a patient's lacks capacity to consent. It states that verbal consent must be obtained prior to any procedure being undertaken and that at any time patients can withdraw their consent. Patients must be given enough information for them to make a decision about their procedure and that it was good practice to document consent had been obtained.
- However, In the outpatients department at Newton Abbot Hospital we saw that verbal consent was obtained prior to procedures being undertaken, for example, cystoscopies. We saw staff had documented consent when it had been obtained in the patients records, but no consent form was in place. We reviewed six other patient records that we were told had undergone a procedure (three for urology and three for ear, nose and throat). We found two had evidence of written consent, two others patient records made no reference to whether a procedure had taken place, one had evidence of verbal consent and the last set of notes had reference to a procedure taking place but no records of consent being obtained.
- Staff had knowledge of Deprivation of Liberty safeguards for when they visited patients in care and nursing homes.

Good

Are services caring?

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

Summary

We have judged caring of community adult services as good because:

- Patients were supported, treated with dignity and respect and were actively involved in their care.
- Patients and their relatives/carers were involved and encouraged to be partners in their care and in making decisions, with any support they need. Staff spent time talking to patients and those close to them. Patients and their relative/carers were spoken with in a caring manner and received information in a way that they could understand. Patients understood their care, treatment and condition, worked with staff to plan their care, and shared decision-making about their care and treatment.
- All community staff responded compassionately when patients needed help and supported them to meet their needs. Staff anticipated patients' needs and maintained their privacy and confidentiality at all times.

Compassionate care

- We observed staff introduce themselves to the patients if they had not met them before.
- Staff interactions with patients were friendly and welcoming. Where patients had built relationships with staff, first names were used. We also observed this where staff knew the patient's family/carers.
- All of the patients we spoke with told us the staff treated them very well. All praised the staff for the work they did. They told us the staff were compassionate and caring, "nothing is too much trouble", and "they are wonderful".
- We observed patients receiving treatment in their homes. All staff showed empathy, kindness and care towards their patients and their relatives/carers.
- When patients received treatment, we saw the staff treat them with dignity and respect. Staff assisted them to go through to their bedroom in order to maintain privacy; however, staff always asked where the patient wanted to receive treatment first.
- Staff spoke with patients and their relatives/carers in a respectful manner, taking time to explain what they were doing and the treatment they were receiving.
- We observed an incident where a patient had fallen prior to the nurse's visit and was still on the floor when the nurse arrived at their home. One of the community nurses stayed with the patient until extra support arrived to provide care for them. The community nurses in the wider team covered for the nurse until they were able to leave the patient.
- The friends and family test (FFT) is a feedback tool that gives people who use services the opportunity to provide feedback on their experience. The results from the 1 January 2016 to the 31 January 2016 for the integrated teams covering Moor to Sea, Newton Abbot and Coastal zones had a combined number of 158 responses and all said (100%) they would recommend the service to their family and friends. The teams covering Paignton and Brixham had 54 responses and 98.2% said they were likely to recommend the service to family and friends. The integrated team covering Torquay zone had 23 responses and a 95.7% likely to be recommended. The trust wide community physiotherapy and the community neurological team also scored 100%. The trust wide podiatry service had 109 responses and a 97.3% likely to recommend their service to family and friends.

Understanding and involvement of patients and those close to them

- Patients and their family/carers were included in the discussions about their care and treatment.
- We observed patients in their homes and at outpatient departments were given full and detailed explanations of their care and treatment.
- Patient's relatives/carers, where appropriate, and care workers in a residential care homes were also given detailed guidance and instruction regarding the care required.
- Patients were included in their care and treatment and given time to discuss any concerns or queries they had. Staff checked the patient understood in a discreet manner and explained aspects of care again if needed.
- Patients confirmed they were involved in their care and treatment and their relative/carer with their consent. Staff asked them for their views and offered them choices about their treatment if able. Patients and their relatives/carers said they were able to ask questions if they were unsure about anything.

Good

Are services caring?

- During a visit to a patient who required leg ulcer dressing change, the community nurse involved them in deciding how they wanted this dressing to be applied to make sure it was comfortable for them. The community nurse explained to the patient what she was doing at all times and stopped when it became uncomfortable for the patient.
- We reviewed patients' community nursing care records in their homes. We saw patients were involved in the planning of their care. Patients told us they had been involved in developing their care plan and in any reviews.

Emotional support

- Emotional support was offered to patients and their relatives/carers to help cope with their condition. There were more than 32,000 people across Torbay and South Devon who supported a friend or relative. The activities varied from help with shopping or meals, attending appointments with them, or just making sure that they were ok. The trust believed that all carers were important and they wanted to actively support and work in partnership with carers, to get the best outcomes for both them and the person for whom they care.
- The trust had set up a carers support programme where carer support workers were part of a GP surgery but funded by the trust. Their role was to identify the carer and offer them support and help.
- Patients and their relatives/carers told us they were cared for with compassion and staff responded to their needs.
- We observed one of the community matrons offer information to a patient about attending a pulmonary rehabilitation group where they would have access to clinical psychologist for support.
- For patients who had experienced a stroke there was the stroke patient and public forum they could join for support and guidance. Patients' carers had access to telephone numbers where they could receive extra information and support.
- A patient's relative told us they felt supported by the community nursing staff. Community nursing staff allowed time during the visit for the relative to talk and they were able to ask any questions. Staff had sign posted them for extra support from the local hospice.
- All community staff told us they always allowed time for the patient and their relatives to ask questions about their condition and treatment. If they felt the patient required support of the mental health services, they would ask their GP to refer them.

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 the responsiveness of community adult services as good because:

- Patients' needs were met through the way services were organised and delivered**.** Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
- The needs of different patients were taken into account when planning and delivering services.
- Patients were able to access the right care at the right time and access to care was managed to take account of their needs, including those with urgent needs.
- Care and treatment was coordinated with other services and other providers.
- Patients were able to complain or raise a concern and they were treated compassionately when they did so. They were treated with openness and transparency in how complaints were dealt with and complaints and concerns were always taken seriously, listened to and responded to in a timely way. Improvements were made to the quality of care because of complaints and concerns.

However:

- Up to March 2016the trust was failing to meet the national standard for outpatient activity. The reasons were attributed to higher than expected new patient activity in podiatry and orthotic services, staff vacancies and inability to recruit to these posts quickly.

Planning and delivering services which meet people's needs

- Planning and delivery of services was meeting people's needs.
- Staff told us they encouraged patients to be actively involved in the planning and delivery of their care and they were moving away from risk management to risk enablement.
- Community nursing teams told us they accommodated patients' needs in relation to visits as far as possible. For example, one patient had a hospital appointment in the morning so the visit took place in the afternoon. Certain visits needed to be undertaken at set times for example, insulin administration and the renewing of syringe drivers. Community nurses in the daytime were available from seven am to seven pm every day of the week to meet the needs of their patients.
- We were provided with examples to demonstrate how the intermediate care teams, occupational therapists, physiotherapists, community matrons and community nursing teams worked together to ensure the most appropriate staff provided care and treatment to patients with complex needs. This meant patients were not receiving duplicate care visits and instead received personalised care and treatment. For example, we visited a patient with a community matron who took their blood and changed their wound dressing. This meant the patient only had one visit and not two.
- A patient told us about exercise groups, based in Paignton and in Newton Abbott in community centres, for people with **multiple sclerosis** (MS). These were set up many years ago and now had input from the community neurology team. Normally a physiotherapist and their assistant were present at the classes. The idea was to maximise capability and exercises were for maintenance and trying to prevent deterioration. Patients said from these classes they were able to refer onto other professionals for support, to include speech and language therapists. They were able to do this without waiting for GP referral.
- Clinics were held at local community hospitals to reduce the distances for patients to travel and were provided by specialist nurses for example, Parkinson's nurse, bladder scans and community nurses held catheter clinics. Consultants from Torbay Hospital also had clinics at community hospitals.
- Patients were able to self-referral themselves to physiotherapy at community hospitals. Appointment telephone numbers were available. This service was to reduce the amount of time patients had to wait to see a physiotherapist following a referral from their GP.
- The lower limb service held clinics across eight community hospitals to enable patients to attend at a time suitable for them.

Good

Are services responsive to people's needs?

Equality and diversity

- Services were planned to take into account the different needs of patients.
- Staff told us they had access to interpreter services and this was available via telephone but usually a person was able to come to do the translation, but this needed to be booked.
- There were pictographic resources for people with cognitive difficulties and for those living with a learning disability. Easy read leaflets were also available. There was a range of communication aids available through the local council.
- The community stroke and neurology team were able to assess patients whilst still in hospital and then support and treat them once home. Each patient received different levels of support depending on their assessed needs. No timescales were placed on how long the team were able to visit and support them until they could manage independently.
- In order to take account of the needs of people with restricted mobility, the community nursing service and therapy teams visited patients in their own homes. This meant that people with disabilities were able to access nursing and therapy services on an equal basis to others without disabilities.
- Equality and diversity training was available to staff as a means to address inequalities within the care provided in the community health services for adults. The community had achieved 'green' status in this training which meant they were above the trust target of 90%.
- Access for people with disabilities had been considered in all of the clinics and outpatient departments that we visited.

Meeting the needs of people in vulnerable circumstances

- Services were planned and delivered to take into account patients with complex needs.
- Staff had or were undertaking training in dementia care.
- Community staff told us they had access to specialist nurses for learning disabilities that would provide support. There were three community learning disability teams which where multi-disciplinary. The teams helped adults living with learning disabilities and their families/carers to access mainstream health care, address accommodation and support needs and work with individuals in person-centred way. The trust also worked closely with Devon Partnership Trust in meeting the needs of patients living with a learning disability.
- A senior manager told us about how they coordinated the care of a person living with a learning disability to meet their own needs and preferences. This person was attending a day centre but felt this was not meeting their social or care needs. They requested to be able to attend other activities to improve their well-being. The trust worked with this person and their family/carer to enable them to attend activities of their choice.

Access to the right care at the right time

- Patients had access to timely assessment, diagnosis and treatment.
- We spoke with staff at one of the care homes we visited with the community nursing team. They told us whenever they contacted the community nursing service they always visited promptly whether it was the out of hour's or the daytime service.
- A self-referral system was in place for physiotherapy at the community hospitals. Patients were able to ring the appointment line to make an appointment up to 72 hours in advance. We had feedback from two patients prior to the inspection who told us this service was 'brilliant' as they were seen much quicker than going through their GP.
- Staff in the outpatient departments we visited said they kept patients up to date with waiting times, for example, at Newton Abbot Community Hospital they recorded the waiting time on a white notice board in the waiting area.
- The trust did not monitor urgent or non-urgent referrals to the community nursing service. Senior staff for community nurses told us they did not have any waiting lists and that patients referred to them were triaged and seen as required due to their need. The vast majority of referrals were seen the same day.
- The out of hours nursing service team reported that patients were referred to them via Devon Doctors 111 service and by Lifeline. Existing patients were able to directly access the team and were provided with contact numbers. The team indicated that the trust was working towards having a single point of contact for this service in the future.
- For the out of hours community nursing team patients were triaged over the telephone by a registered nurse and prioritised as requiring urgent or non-urgent care.

Trust policy was that urgent cases should be visited within two hours and non-urgent within four hours. The team reported they met these targets the majority of the time however this was not audited. They reported delays were usually due to a lack of readily available equipment and sometimes they travelled long distances to reach patients and had difficulty finding them especially in rural areas in the dark. They completed an activity log but the team reported this did not always give an accurate reflection of their activity due to the time they spent travelling.

- The Medical Admissions Team (MAT) operated a hospital-at-home service and this was run from Torbay Hospital. The type of patients that MAT took on had various medical problems for example, deep vein thrombosis , pulmonary embolism, cellulitis, heart failure and chest infections. MAT did not have a fixed eligibility criteria as each patient was assessed individually and their suitability for hospital-at-home care was a joint decision between the consultant and the team. Patients were discharged home and receive daily visits from the team which operated 7 days a week from 8.30am-6pm weekdays and 9am-5pm at weekends and covered the trust's geographical catchment area (South Devon).
- The Torbay Hospital Outreach Team (THORT) was a hospital-at-home scheme for some patients with Chronic Obstructive Pulmonary Disease and ran seven days a week. This teamconsisted of a specialist nurse, two other qualified nurses, a physiotherapist and a health care assistant. A hospital consultant or specialist registrar oversaw the service. Referrals were by the patients GP to the emergency assessment unit where patients were assessed for suitability. Some patients that were admitted to hospital may have received the THORT service when they returned home. Patients were only included on this scheme with their consent.
- The trust did not audit community nurse referrals either urgent or non-urgent.
- The lower limb service had 45 patients on its waiting list at the end of January 2016. They had plans in place to reduce their waiting lists.
- Up to October 2015 the trust was failing to meet the national standard for outpatient activity. The reasons were attributed to higher than expected new patient activity in podiatry and orthotic services, staff vacancies and inability to recruit to these posts quickly.
- Totnes Hospital reported the highest Did Not Attend (DNA) rate between July 2014 and June 2015.The other sites that undertook outpatient clinics reported DNA rates close to or below the England average.

Learning from complaints and concerns

- Patients' concerns and complaints were used to help improve the quality of care.
- The Patient **Advice and Liaison Service** (PALS) for services in the community was provided by the trusts Customer Service Centre Advisers (CSC). Their role was to give immediate first line guidance, advice, information and signposting to services. If the concern/ complaint was sensitive or complex, the CSC advisers would suggest contacting a PALS adviser. Talking to PALS was confidential and patients concerns would not be passed on without their agreement.
- We saw in patient's notes a leaflet about how to make a complaint.
- A zone manager told us they reviewed all complaints received and ongoing ones weekly. This was to make sure trends were monitored and complaints responded to within the trust's timescales.
- Staff told us about learning that had taken place from a complaint. This also involved an external contractor. Changes were made to the information given to patients and their family/carers when alterations were made to their home. We were shown a copy of the action plan and all actions had been completed.
- We were also told about learning from another complaint regarding the care of a patient living with a learning disability. Learning objectives were identified for the member of staff and the whole community team. Training was provided by the learning disability specialist nurse.

Outstanding ☆

Are services well-led?

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

Summary

We have judged well led for community adult services as outstanding because:

- The leadership, governance and culture promoted the delivery of high quality person-centred care.
- There was a clear statement of vision and values, driven by quality and safety. Staff were aware of the trusts vision, values and strategy.
- There was an effective and comprehensive processes in place to identify, monitor and address current and future risks. Performance issues were escalated to the trust board through clear structures and processes. Clinical and internal audit processes functioned well and had a positive impact in relation to quality governance, with clear evidence of actions needed to resolve concerns.
- Leaders at every level prioritised safe, high quality and compassionate care . Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported. Staff felt leaders were approachable and listened to their views and they felt able to report any concerns to them.
- A systematic approach was taken to working with other organisations to tackle health inequalities and obtain best value for money and outcomes for patients

Service vision and strategy

- Staff were aware of the trusts values and visions.
- The senior management team told us the trust's vision and strategy was the provision of services tailored round the individual needs of patients and building on the strengths of their own networks, supplementing as necessary. Community staff will be moving away from risk management to risk enablement with a shared understanding and ownership with the patient of risks identified. They also want to work in partnership with the private and voluntary sectors.
- Community staff were aware of the trusts vision for integrated work and to include the private and voluntary sectors in this. They also said they included the patient and their family/carers in the assessing, planning and delivery of care.
- Staff told us they were aware of the trusts values, which included respect and dignity, commitment to quality care, compassion, improving lives, working together for people and everyone counts.
- The community nursing out of hour's team had a five-year plan in place. This included becoming a nurse led service with non medical prescribers to reduce their dependence on Devon Doctors out of hour's service. Another scheme was to work with the intermediate care teams to prevent admissions to hospital and to look at placing patients in care or nursing homes for treatment until able to return home.

Governance, risk management and quality measurement

- An effective governance framework was in place to monitor performance and risks and to make sure the executive board were aware of these via the trust wide governance reporting.
- A risk coordinator managed and coordinated each zones risk register. The zone risk registers fed into the corporate risk register as necessary. Senior staff decided which of their risks was added to the corporate risk register. All risks were rated green, amber or red. If the risk was 'red', it was added to the corporate risk register. Green and amber were managed at directorate level or by the manager of the team/service. We were shown the risk registers for the community, which included one for therapies. However, community nursing staff were unsure as to why lone working for one of the zones from the hours of 5-7pm at weekends had been removed from the risk register without it being addressed. We were not able to get response from the managers about this.
- The senior managers for the community told us their top risks and these included recruitment of

occupational therapists, physiotherapists and social workers and to manage the development of their service effectively. However, not all zone managers were able to tell us their top three risks.

- Specialist nurses told us they were able to add their risks to the risk register.
- Each of the community teams reported their capacity and staffing levels every morning to their zone manager. Following these discussions took place on where extra recourses were needed and what support each of the zones could offer to other zones that had issues.
- There was a programme of audit within the community and we saw in the minutes of the meetings discussions about some of these. The therapies risk register had identified areas where NICE guidance was not being met and actions were in place on how to address this.
- Monthly dashboards monitored performance, for example, activity rates against targets set. We saw community nurse activity was meeting the projected target but podiatry follow up visits were below target.
- Senior staff were able to describe the organisation's governance arrangements and they told us they participated in monthly zone meetings where audits, complaints and performance issues were discussed. Minutes of these meetings were available and showed the issues discussed and actions taken.

Leadership of this service

- The leadership within the community reflected the visions and values of the trust, which promoted good quality care.
- There was a structured management arrangement within the community and staff at all levels understood how this management structure worked.
- The out of hour's community nursing service team said their team leader was visible and approachable and they felt valued and supported by them. They also said that their team leader was instrumental in the changes made to the service and their future plans.
- Staff were positive about the local management support available to them and told us that their line
- managers were accessible to teams and supportive. Community nursing staff said if they felt any patient needed to be reviewed by a more senior staff due to changes in their condition, their team leader or band 6 nurse would always come and support them. Staff were also positive about the zone management arrangements and knew who they were if the needed to speak with them.
- The Chief Executive was visible to staff in the organisation and had attended team meetings and met with staff

Culture within this service

- Staff told us they felt valued and respected by their line managers and zone managers. In some areas the morale was better than others as some staff felt they had a heavy workload and were concerned about how changes to the service they worked in would affect them.
- In one of the zones newsletters, it provided staff with real life examples of how the trust values were being embedded in to their everyday practice. For example, the intermediate care team visited a couple in their home who were having difficulties managing. The intermediate care team assessed the couple and provided them with support and equipment to enable them to stay at home which was their preferred choice. The feedback they received was the couple felt listened to by the staff. This reflected their value of 'everyone counts'.
- Staff were told of compliments and feedback about their care and treatment.
- The trust had a lone working policy. Community staff were able to tell us how it worked in the different zones. There was a system to escalate concerns about a member of staff and how this would generate a managers response or if more serious a 999 response.
- The community nursing out of hours nursing service were aware of the lone worker policy but indicated that it was not always effective. They always worked in teams of two comprising of one registered nurse and a HCA. There was a safety escalation plan in place but the "safe word" used when telephoning to inform colleagues of their personal danger was not always recognised. The trust had looked at ways of using other methods for

safety escalation and work was ongoing in respect of this. There sometimes was poor mobile telephone signal coverage due to the rural nature of some of the areas they cover.

Public engagement

- Patients were encouraged to give their views on the services provided to help improvement and with the planning and shaping of future services.
- Patients were able to feed back their views on the community via the NHS Friends and Family Test to say if they would recommend the service or not.
- The lower limb service had conducted a patient survey to get their feedback. Patients were asked as one of the questions if they would recommend the service 59% said strongly agree (27 patients) and 39% (18 patients) agreed.
- There was a carers forum in Paignton and Brixham where they were able to provide feedback about community services.
- Patients took part in PLACE (patient-led assessments of the care environment), although the results did not relate solely to outpatients in the community hospitals. The results, which were mostly above the NHS averages, were encouraging for staff, patients and the hospital trust.
- There was a Patient Experience and Community Partnership Engagement and Experience Committee, we saw minutes of one of these meetings.

Staff engagement

- Views of the staff were actively sought and acted upon.
- Staff told us they were able to share their views at their team meetings or with their line manager.
- In the community staff locations, we saw posters advertising 'see something, say something' initiative encouraging staff to report concerns.
- Staff told us they would always report any concerns they had to their line manager and they felt they would be listened to and action taken. Staff gave us examples of where they had reported concerns, for example, one member of staff had raised concerns about the conduct of another staff member and action was taken.
- One of the zone managers had devised a newsletter that was issued about every three months. This asked staff to provide articles as well as updating them on the changes that had or were due to take place. The newsletter also included a section on compliments that had been received from patients and their families/ carers about staff members.
- Staff told us they had weekly bulletin from the trust and an e-mail from the Chief Executive to keep them up to date with developments.
- The out of hours community nursing service reported that due to working night shifts they did not always feel engaged in shaping and improving the overall service. They were working towards improving this and the team leader now worked some day shifts to attend meeting and events. The outcomes from these were then cascaded to the team. The team considered that they were well supported by the trust and other team members in service development.
- In the 2015 NHS staff, 73% of staff were 'likely' or 'extremely likely' to recommend the trust as a place to work. Eighty eight percent of staff were 'likely' or 'extremely likely' to recommend the trust as a place to receive care/treatment.

Innovation, improvement and sustainability

- Developments to services were assessed and monitored prior to any changes.
- In one part of the Moor to Sea zone, they were a pilot site for an NHS innovation for integrated personal care scheme. The purpose of this scheme was to identify different ways to encourage patients to improve their health. For example, one patient was depressed as they were unable to continue doing gardening since becoming a wheelchair user. This pilot scheme provided funds to build raised flowerbeds to enable them to enjoy and take part in gardening again.
- A pilot scheme in the Torquay , that was ongoing during our inspection, involved having GP input for five sessions with the intermediate care team. They provided medical support and reviewed patients. They then fed back to the patients own GP.
- In the Ashburton area, which is part of the Moor to Sea zone, the lead community nurse had set up meetings

with representatives for local care homes to help support their learning. These took place every months. They planned to extend this to domiciliary care agencies in the future.

- The out of hours community nursing team were focused on helping patients to continue living in their own homes. They were planning to work with the Emergency Department (ED) staff at Torbay Hospital to highlight to them patients who could be seen at home rather than attending A&E. They were also planning to develop team skills so that more patients can be managed in their own home. The plan was for the team to become nurse-led with trained non-medical prescribers leading to less dependency on the Devon Doctors service.
- During our meeting with senior managers, they told us about their 'in reach' service into hospitals and back out into the community. This was where occupational therapists as part of the intermediate care team were able to assess and treat patients whilst in hospital and then continue their care once home. This was for continuity of care and treatment of the patient.
- The community matrons told us their roles would be changing with the implementation of Local Multi Agency Team. They would be using their skills to review and care for more acutely ill patients.
- A community nurse in Paignton was awarded the title of Queens Nurse by the community nursing charity The Queens Nursing institute. This was for high standards of patient care and leadership.
- One of the members of the out of hours community nursing service team had been awarded a WOW Award in recognition of their work. The WOW Awards were a way of the trust recognising the hard work and commitment of their staff and to publicly say thank you to them in the workplace and then share that award on their internal and external websites.The team had also been nominated for the Blue Shield Award, which is part of the trusts recognition scheme for outstanding work.
- The podiatry service had been awarded a green apple award for sustainability. The Green Apple Environment Awards were launched in 1994 by The Green Organisation and recognise, reward and promote environmental best practice around the world.This was for switching to patient held instruments.
- One of the diabetes Specialist Nurses received recognition from the Royal College of Nursing for their work in improving the management of patients with diabetes. Their work was recognised nationally and was published.