Plymouth Community Healthcare CIC

1-271962340

Community health services for adults

Quality Report

Local Care Centre
Mount Gould Hospital
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Tel: 08451 558100
Website: www.livewellsouthwest.co.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-2078154330	Tavistock Hospital	Team	PL19 8LD
1-2078169826	South Hams Hospital	Team	TQ7 1AT
1-297622270	Local Care Centre Mount Gould Hospital	Team	PL4 7PY
1-297634914	Cumberland Centre	Team	PL1 4JZ

This report describes our judgement of the quality of care provided within this core service by Plymouth Community Healthcare CIC trading as Livewell Southwest. 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 Plymouth Community Healthcare CIC and these are brought together to inform our overall judgement of Plymouth Community Healthcare CIC

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated the community health services for adults as good overall because:

- There were effective incident reporting systems in place and staff reported they received feedback and learning from these.
- Staff had good knowledge of safeguarding procedures and felt supported in raising any safeguarding concerns. Staff had a good understanding of consent and deprivation of liberty safeguards. Consent to treatment was gained in line with legislation.
- There were good medicine management systems in place to keep patients safe.
- Relevant equipment was available, had been checked and was serviced regularly.
- Good infection control systems were in place and staff were seen adhering to them.
- The community adult's service provided care in line with best practice guidance. Staff were given time to attend mandatory training and reported that this was supported by the organisation
- Multi-disciplinary and collaborative working was evident throughout the service. Working in the same building as other teams and social care colleagues had improved information sharing.
- Feedback from patients was positive.
- Patients received care from staff who treated then with dignity and respect. Staff ensured that options were explored to respect the patient's wishes and requests
- The needs of patients were taken into account when planning and delivering services. Staff were flexible
- Teams worked together to provide the most appropriate care at the most appropriate time for patients. Care and treatment was coordinated between the community adult services.
- Patients were given information about how to make a complaint or raise a concern. There were systems in place to investigate complaints and systems in place for disseminating learning.
- There was strong leadership in place. The executive team was visible and staff felt comfortable in approaching them.
- A positive culture was evident in nearly all the services we visited.
- Staff felt they had a voice and we heard examples of when changes had been made following discussions and involvement of staff members.

However:

- Staffing levels were an issue across the community teams and had an impact on staff's ability to manage caseloads, waiting times and morale.
- There was variable access to information and connectivity via the IT system.
- There were issues with the waiting times and waiting lists in some specific areas
- Since patient records had been completed using the electronic patient record system there had been no consistent audit of the records.

Summary of findings

Background to the service

Plymouth Community Healthcare trading as Livewell Southwest is an independent social enterprise organisation that provides community physical and mental health and social care services to a population of around 270,000 people in the urban areas of Plymouth and rural areas of South Hams and West Devon.

The community adult's teams provided care and support in people's own homes, residential and nursing homes, local health centres and clinics, local care centres in Plymouth and community hospitals in South Hams and West Devon. Community nursing and urgent care services were provided 24 hours a day seven days a week.

We spent two days and one evening meeting staff members of the community based teams. We also met with and visited some patients and their carers and relatives. We spoke with 145 members of staff, 41 patients and 16 carers and relatives.

We visited or spoke with staff in the following services: tissue viability team, continence team, Parkinson's Team, Huntingdon's Disease team, community cardiology specialist team, community respiratory specialist team, South, East and West District Nursing teams, South and East Long Term Conditions teams, East and South Therapy team, Yealm/Ivybridge District Nursing team, Yealm/Ivybridge Rehabilitation team, Tavistock area integrated rehabilitation team, West Devon and South Hams District Nurses, West Devon and South Hams Therapy Team, South Hams Outpatient Department, podiatry and prosthetics teams, falls team, District Nurse Treatment clinic at Cumberland Centre in Plymouth, integrated hospital discharge team, Robin Community Assessment hub, Community Crisis Response Team, Recovery at Home and Out of Hours district nursing team. In addition there were organised drop in sessions and/or focus groups open to all community staff across Plymouth, South Hams and West Devon where staff could tell us about their roles and services provided by Plymouth Community Healthcare trading as Livewell Southwest.

Prior to the inspection visit we reviewed information requested by CQC and sent to us by the organisation. During the inspection we looked at patient records and associated documentation and observed some care and support provided in patients own homes.

Our inspection team

Our inspection team was led by:

Chair: Andy Brogan, Director of Nursing, South Essex Partnership Trust

Head of Hospital Inspections: Pauline Carpenter, Care Quality Commission

Inspection Manager: Nigel Timmins, Care Quality Commission

The community adult's team included three CQC inspectors and a variety of specialists: specialist nurse respiratory and older people, Specialist Practitioner District Nurse, palliative care and community nursing nurse, Physiotherapist - Specialist Practitioner, physiotherapist, rehabilitation and safeguarding nurse specialist.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

Summary of findings

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 22, 23, 24 & 29 June 2016. During the visit we held focus groups and drop in sessions with a range of staff who worked within the service, such as nurses, doctors, therapists and support workers. 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

Amongst the comments on comment cards completed prior to the inspection were:

"I find the response of the nurses to be fast, appropriate, caring and compassionate", "When being treated the nurses are careful to ensure that I suffer no loss of dignity", "the curtain is always pulled to close when I am having treatment, they always ask if I am alright when having treatment" and "staff are caring and treat me with a lot of respect".

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should continue to review the staffing levels and skill mix across the core service, particularly within the district nursing service. They should ensure staff are appropriately supported and the wellbeing of staff is improved. Patient safety should be assessed and confirmed staffing levels are not putting patients at risk.
- The provider should put in place a system to audit records that are completed on the electronic patient records system.

Plymouth Community Healthcare CIC

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 safety as good because:

- There were effective incident reporting systems in place and staff reported they received feedback and learning from these.
- The duty of candour regulation was understood by staff and we saw evidence of which supported this.
- Staff had good knowledge of safeguarding procedures and felt supported in raising any safeguarding concerns.
- Good medicine management protocols were in place to keep patients and staff safe.
- Equipment was available, had been checked and was serviced regularly.
- Infection control policies and procedures were in place and staff were seen to be adhering to them.
- Staff were given time to attend mandatory training and reported that this was supported by the organisation

However:

- Improvements were required in the auditing of records following the transfer from paper to electronic records.
- Staffing levels were an issue across the community teams and had an impact on ability to manage caseloads, waiting times and morale. The organisation was actively managing the issues and were working hard to ensure patient safety.

Detailed findings

Safety performance

- The Safety Thermometer (a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care and involves a monthly snapshot audit) was submitted monthly to the NHS Health and Social Care Information Centre. This data included current and new pressure ulcers, patient falls with harm, and catheter acquired urinary tract infections. Individual teams told us they monitored their safety performance and performed well against the national picture.

Good

Are services safe?

- The organisation monitored the incidence of pressure ulcers and had noted a 40% decrease of grade three and four pressure ulcers in the community from the 2014/15 year to the 2015/16 year. When asked why the team thought there had been such a decrease in grade three and four pressure ulcers they said they felt this was due to improved education and training provided to staff.
- The tissue viability team were responsible for advising staff and reviewing patients with grade three and four pressure ulcers, and long standing leg ulcers. The team covered residential care homes and patients at home.
- Community teams had tissue viability link nurses, who were responsible for feeding back safety alerts to their team.

Incident reporting, learning and improvement

- Staff were encouraged to report incidents, via their electronic incident reporting system. Staff said there was a 'no blame' culture surrounding incidents and they were encouraged to view them as a learning opportunity.
- Reported incidents were assessed by the appropriate team manager and another manager (not involved with the team) and investigated by the most suitable person. Outcomes were reviewed by a panel before information was shared via a feedback meeting for those involved in the incident, and to the wider team via team meetings, organisational emails and newsletters. Any identified trends or themes resulted in an action plan to resolve the issue.
- Staff said they found the incident reporting system easy to use. All staff who reported an incident had received feedback. Staff in the South Hams said the system allowed them to detail the incident without restricting word count.
- Between February 2015 and January 2016 community adult services reported 22 serious incidents relating to Grade 3 pressure ulcers, five serious incident relating to Grade 4 pressure ulcers and one patient fall. There was also one incident of confidential documents stolen from a car and one incident of faulty equipment in the prosthetics department.
- A pressure ulcer serious incident panel was held monthly. This panel investigated the incidents and made robust plans. Any learning was shared with staff via the serious incident newsletter.
- One serious incident was reported following a theft of patient confidential information from a community staff member's car, this included 47 patient's names. The staff member reported the incident immediately and was open and honest. The incident was escalated to board level. The information commissioner and all patients were informed. The board put action plans in place to include a contact line for concerned patients, a letter to the patients from the chief executive and a reactive communication statement. All staff were emailed to remind them of their duties towards information governance and confidentiality.
- There was evidence of learning from incidents. For example, in cases of missed insulin administration a medicine management board reviewed the medicines protocol. This resulted in changes being made to prescription pads to make them clearer. Staff reported this had been effective in raising awareness and preventing similar incidents in the future.
- The checkout procedure of limbs within the prosthetic department had been altered following a serious incident relating to a pin sticking out of a prosthesis. This learning was shared throughout the department via team meetings.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the organisation 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.
- We were shown records of an incident in an outpatient clinic where duty of candour had been used and how patients and their families were informed and involved in the investigation.
- One nurse told us about an incident where they used duty of candour regulations. A pressure ulcer was

identified on a patient which required investigation. The nurse informed the patient this was an incident, explaining the process for investigation and kept the patient updated with the outcomes.

Safeguarding

- Staff were aware of the safeguarding systems that were in place to keep patients safe. The organisation's policy was accessible to all staff via the organisations intranet and staff knew where they could find this.
- Staff were aware of their responsibilities in relation to safeguarding. They knew who the safeguarding lead was both locally and within the organisation. They could contact these individuals for safeguarding advice. Staff in South Hams and West Devon reported any safeguarding concerns to Devon County Council but also let the Plymouth Community Health trading as Livewell Southwest safeguarding team know a referral had been made.
- One member of staff gave us an example of when they were involved in a safeguarding incident. They explained the processes in place to protect and support all of those involved. The safeguarding meeting that took place in response to this involved social workers, care agency staff, district nurses, safeguarding team and the family and patient involved.
- All staff we spoke with said they had completed their safeguarding adults and children training, and also completed deprivation of liberty and mental capacity assessment training. Level 1 – 99%, Level 2 – 86%, Level 3 – 81%. There were ongoing training sessions to ensure all eligible staff completed their training.
- When visiting patients staff asked appropriate questions which would allow them to identify if there was a safeguarding concern. For example, the regularity of carers visiting and what carers were doing on their visits.
- We saw evidence that a patient's electronic patient record contained a record of any safeguarding concerns and a record was held that a referral had been made.

Medicines

- Medicines were obtained by a GP prescription by the patient or their relatives/carers and in some cases the medicines were delivered to the patient's door by the local pharmacy. Using a computer system, staff could order a prescription whilst in a patient's home, meaning medication could be accessed in a timely manner.
- A list of medicines the patient took was recorded on the electronic patient record.
- Although we did not observe staff administering any medication during our inspection, we saw staff asking patients about their medication on all visits. They also checked if there had been any changes to the patient's medication since the previous visit, to ensure their medication was available and that the patient was confident in self-administration.
- Training was provided on the use of syringe drivers. This meant there was always a member of staff on duty across community nursing services to ensure a syringe driver could be set up when required.
- The medicines in South Hams Hospital outpatient clinic were securely stored and arranged in an orderly manner. Expiry dates were clearly identified and none were out of date.
- The out of hours district nursing team said some GPs and pharmacies were open late if a prescription was required urgently. The team communicated via the local out of hours GP service for a prescription to be faxed to a pharmacy or to a GP. During a home visit we observed the specialist nurse calling a GP from the patient's home to discuss their medication and possible changes. The call was made with the patient in the room so they were aware of the discussion and the outcome.
- Some nurses reported there were occasionally delays in obtaining dressing materials. To overcome this they were using the 'first dressing initiative' which involved taking a basic range of dressings with them on visits. They also reported they were looking into 'total purchasing' which would mean dressings could be ordered online and delivered within 24 hours. A business case had been made for this and had been submitted to the local clinical commissioning group (CCG).
- Staff informed us that if there was a risk of patients accidentally taking their medication, or the medication

was prescription only, they would be stored in a lockable container in the patient's home. Only the district nurse and doctors would have knowledge of the code required to open it.

- Nurse prescribers carried 'just in case' medicine bags. These contained two to three doses of certain medication that might be needed, this included pain relief and nausea medication. Some patients had' just in case' medications at their home.
- We were informed that the long term conditions teams visited patients to educate them about the medication they were taking and why. They reviewed the stock and with the patient's permission return any medicines that were no longer required to the pharmacy. Where patients had a large amount of stock, they discussed this with the patient's GP. This helped prevent patients from taking the wrong medication or being over prescribed medication.
- The cardiac service had a folder that contained up to date flow charts and protocols for medicines management of patients with specific cardiac conditions.
- We attended a home visit with a respiratory specialist nurse. They explained, to the patient, how their inhalers worked and how to use them to get the best effect. They also arranged for an oxygen assessment as the patient was on continuous oxygen and had not been reviewed recently.

Environment and equipment

- Equipment was used to support safe patient care and treatment.
- Staff said the equipment they were using was checked by the relevant external contractors. We looked at a variety of equipment across the teams we visited and found stickers in place to indicate the equipment had been serviced.
- Consumables, for example: cleaning wipes, gloves, aprons and sharps boxes were readily available to all staff. Stock was held at community bases and collected by staff as required.
- Equipment which was used regularly for home visits, for example: blood pressure machines were transportable. If patients required treatment or care using equipment that was not transportable arrangements were made for them to visit a clinic. This included, for example, sit on scales.
- Community teams could access equipment for patients through an external community equipment provider. This included pressure relieving mattresses, commodes, beds, bed levers, and bariatric equipment. The tissue viability lead and rehabilitation teams said they had built a good relationship with this provider. District nursing teams across Plymouth told us equipment could be ordered out of hours, at weekends and on bank holidays. There was an extra cost incurred for an out of hour's delivery, but staff said if a clinical need was documented they had no trouble getting the equipment delivered to people.
- We saw that staff provided necessary equipment to patients during visits. For example: a physiotherapist fitted a bed lever to provide a patient with support when they were getting in and out of bed. Also the out of hour's district nursing team had access to equipment bags which they took out on visits.These were checked to ensure they were fully stocked and with manual handling in mind to ensure that they were not too heavy for staff to lift.
- The prosthetics department had recently converted to using computer aided design and new lightweight materials in the design and construction of prosthesis. This occurred due to safety issues surrounding the manual handling of heavy materials. The lighter cast was used to ensure safer manufacturing processes for the workshop technicians.
- We saw records showing the resuscitation trolley within the Robin Community Assessment Hub and the Cumberland Centre were checked on a daily basis in line with the trust policy. We saw the trolley were stocked against the stock list and were tamper evident.

Quality of records

- An electronic patient record system was used across most areas of the service. Roll out of this system began in April 2015 and at the time of our inspection only a few teams in the South Hams and West Devon were using paper records because the electronic system had not yet been introduced.

Good

Are services safe?

- The electronic system provided a secure centralised system and ensured legible records.
- We saw 19 sets of patient paper and computerised records. All records were complete, accurate and legible.
- Records seen included clear detailed information about the patient's care and treatment needs and included risk assessments such as skin, manual handling, nutritional and pressure area care.
- If risk assessments were not completed they remained coloured grey on the system to alert staff they needed completing.
- There were warning notes on the electronic system. For example for when a patient did not attend an appointment, or if the patient had a history of drug abuse. Staff said this helped in planning if two staff were needed on visits or to explore why a person did not attend an appointment – had they forgotten or did they have transport issues for example.
- There were differences in the use or regularity of record audits. Some teams told us they completed record audits monthly and feedback was shared at team meetings. Staff also mentioned their quality of records completed were discussed at one to one meetings and annual appraisals. We were told in the past regular audits were completed on paper records, however this had not been continued since electronic records had been introduced. One staff member said they were waiting to hear about the process of how to audit patient records on the computer system.

Cleanliness, infection control and hygiene

- Policies and procedures relevant to infection control practices were available to staff on the organisation's intranet. Staff were able to find these when we asked to see them. We saw staff adhering to handwashing procedures and being bare below the elbows during clinics and home visits.
- Aprons and gloves were readily available and we saw staff using them when attending to patients dressings. Alcohol gel was available to all adult community services staff. We saw staff using it between patient visits.
- Each community nursing team had an infection control link nurse who attended infection control meetings and then fed information back to their teams.
- Some equipment used, for example, dressing packs, were in tamper evident packages to ensure it was sterile and safe for use.
- The outpatient clinic at South Hams and Tavistock Hospital appeared visibly clean as did the district nurse treatment clinic at the Cumberland Centre in Plymouth. Equipment was identified as being cleaned using 'I am clean' stickers.
- We saw completed cleaning rotas that included a regular deep clean. Hand washing facilities were available in all areas we visited and had soap dispensers, alcohol gel, no touch rubbish bins and a posters displaying hand washing techniques.
- Infection control audits were completed in community hospitals, which included the outpatient clinic at South Hams and Tavistock hospitals and the district nurse treatment clinic at the Cumberland Centre. The most recent audit of South Hams Hospital in June 2016 identified aprons were not being worn and the cleaning schedules were not being signed off. An action plan was in place as a result to remedy the areas identified for improvement.
- Instruments used in the podiatry service were barcoded and were recorded on a computer system. This meant that they could determine if there was a cluster of infections whether it came from a certain batch of equipment. They could then locate the other instruments in that batch to prevent further infection. Used equipment was packaged and sent to a contractor for decontamination.
- The Robin Community Assessment Hub had a side room and toilet which were used by patients who were an infection risk. This reduced the chances of cross infection occurring.
- There was an infection control committee. This was a subcommittee of the board chaired by the director for infection prevention and control. The committee directed all infection prevention control action within the organization; providing the chief executive with relevant information, advised and monitored progress of the annual infection prevention and control

programme, reviewed infection control policies, procedures, guidance and service level agreements and reported on infection surveillance data, monitored performance and made recommendations for improving patient safety.

Mandatory training

- All staff, across adult community services, said there was good quality training and they were mostly up to date or awaiting dates to book training. The majority of training was face to face with some online training available. Nursing and therapy staff commented that the organisation tried to make the training interactive and therefore more engaging. However, data showed that only 83% of staff had undertaken corporate mandatory training, with only 81.9% having completed the 'emergency' mandatory training day. The total number of staff, working across adult community services, who had completed mandatory training was 86.6%.
- The out of hours district nursing team had access to mandatory training and said they were supported to complete their training. Staff based with Tavistock community services told us they sometimes had to go to the training centre at Mount Gould Hospital in Plymouth for their training but that often training was arranged locally so staff had to take less time out of their day to attend. This was appreciated by staff.
- Mandatory training subjects included basic life support, pressure ulcer management and prevention, infection control and health and safety training.
- The organisation made sure additional training was available to staff, for example catheter associated urinary tract infection training, bladder scanning training and a leg ulcer management course.

Assessing and responding to patient risk

- Staff completed risk assessments as part of the electronic patient record, this included nutrition, pressure ulcers and falls.
- Staff could record warnings on the electronic patient record to alert colleagues of any identified risks. For example, if staff were required to visit in pairs for safety reasons or if a patient was at risk of drug abuse.
- On home visits staff across multidisciplinary teams were observed asking patients about their skin condition and if they had any sores. Where applicable the use of pressure relieving equipment was in use or discussed with the patient for future use.
- Teams held regular handover meetings to discuss caseloads and patient risks. The out of hour's district nursing team said the day teams effectively communicated risks associated with particular patients. We observed detailed district nurse handovers.
- The continence team had designed and launched a patient urinary catheter passport to help patients look after their urinary catheter and reduce the risk of catheter associated urinary tract infections.
- The community therapy teams assessed patients who had been referred to them to decide if they needed a four hour or five day response.
- Staff across the adult community services told us if they received an urgent referral and a patient was deemed to be at risk then they would prioritise the patient for a visit.
- Patients within the prosthetic and podiatry service were risk assessed and triaged to determine if they required urgent or routine treatment. Those deemed to be urgent were seen within two days in the prosthetic department and two weeks in the podiatry service.
- We visited a patient, with a member of staff, who had been triaged by the community crisis response team and seen within the two hour targeted timescale.
- We saw examples of patient allergies documented on the electronic records system.

Staffing levels and caseload

- Staffing levels and skill mix were of concern across the organisation in nursing and therapy teams. There were vacancies across the community and therapy teams across Plymouth, with less in Tavistock and South Hams. This caused a potential risk for patient safety.
- Staff turnover between 1 February 2015 and 31 January 2016 was 14.7%. The total percentage of vacancies (excluding seconded staff) was 9.5%. Locality managers told us they continued to advertise vacancies and promote working for the organisation but recruiting remained a challenge. Managers and team leaders told

us they were looking forward to a number of staff who had completed their nurse training joining the organisation (preceptees) who would be supported by experienced nurses (preceptors) whilst they gained experience themselves.

- Staffing levels in the community nursing teams were listed on the organisational risk register. Board meeting minutes showed that safe staffing levels and particularly district nursing vacancies had been reviewed. The organisation had introduced a clinical support team; this was a permanent bank of staff that had been introduced in early 2016 to support community nursing teams whilst recruitment was ongoing.
- Efforts had been made to reduce the workload of community nursing staff. The 'Hub' was set up in February 2016. This was described as one single point of access for telephone calls so calls were not going to individual district nurse, for example, who then had to keep stopping their work to answer the telephone. The 'Hub' was staffed by trained nurses (band 5) who took calls and after taking details from the caller ensured the person was referred to the correct team which may have been a district nursing team, therapy team or GP. Nurses told us this had taken pressure of them as they were not constantly stopping to take calls. District Nurse teams that had administrative support, that took phone calls and ensured stocks of supplies and documentation were available, also helped staff manage their workloads.
- A Plymouth wide phlebotomy (blood taking) service had been set up in April 2016 to take routine blood tests away from District Nurse teams to help them manage their caseloads.
- The continence service was expanding and as a result was going to take new referrals and routine continence assessments away from the district nursing teams across the whole organisation freeing up time to help district nurse manage their caseloads.
- Concerns with low staff numbers and skill mix were identified in the North Plymouth community nursing teams and as a result these teams had been integrated in to the East, West and South Plymouth teams to ensure staff were appropriately supported.
- District Nurses in Plymouth said staffing levels and skill mix was their biggest challenge in working for the organisation. An example of vacancies for the Plymouth district nursing teams included 40% trained nurse vacancies for the North and South Plymouth localities, and 25% trained nurse vacancies for the East and West Plymouth localities. Staff were in agreement that their work load had increased and they were being required to work weekends more frequently and had restricted time for or no breaks in their working day. A number commented how they would take work home to complete in the evenings.
- We were told and saw duty rotas that showed agency staff used across teams were regular staff. Recently there had been a few problems with agency staff but these had been escalated appropriately and those staff had not been used again. The Ivybridge/Yealm community nursing team commented there were a lot of agency staff and this could be a challenge as they are unable to support permanent staff in daily jobs for example ordering equipment and medication. The out of hour's district nursing team said they tended not to use agency due to the competencies required to work out of hours safely.
- There was no standard acuity tool in use, for caseload management, at the time of the inspection, staff identified this was a weakness due to differences in practice across the localities. The Kingsbridge and Ivybridge/Yealm community nursing teams used the Benson model; this model looked at district nurse dependency levels. They said this allowed them to manage a large geographical area effectively. The locality manager told us this model was being introduced across all the community nursing teams.
- In the Ivybridge/Yealm community nursing team a band five nurse was responsible for managing caseloads, overseen by a band six nurse. Staff said caseload working had reduced staff travelling time.
- Nursing teams across the organisation were aware of the pressures being experienced by the district nursing teams and where possible try to provide additional support. For example the district nurse treatment clinic was fully staffed and encouraged patients to visit the clinic. The long term conditions teams undertook visits for the District Nurse where appropriate. The urgent care teams supported the out of hour's district nurses when relevant.

Good

Are services safe?

- The district nurse treatment clinic was run from The Cumberland Centre in Plymouth. People who needed community services, not able to be delivered at their local surgery, such as specialised dressings or urinary catheter changes, but were not housebound were able to visit the clinic which ran from 9am to 5pm five days a week and between 9am and 2pm at weekends.
- The cardiac specialist and respiratory specialist nursing teams worked with people to help them recover/ maintain their conditions and manage their own health where possible.
- A caseload review had taken place to ensure all patients who did not need to be seen by the community nursing teams had been discharged from the caseload or referred to more appropriate services.
- The out of hours district nursing team covered the Plymouth localities 5pm-8am and South Hams and West Devon from 7pm-7am. The Kingsbridge community nursing team and Tavistock community team provided their own cover in the South Hams and West Devon areas from 5pm-7pm, however there was no cover for the Ivybridge/Yealm team covering parts of South Hams. The out of hour's district nurse manager said they could not provide this cover safely. We were told an audit of referrals during this time period took place and it was determined the number of referrals were minimal in the Ivybridge/Yealm area. We were told once staffing levels had increased in the out of hours district nursing team there may be the opportunity to provide this cover. Following the inspection we were informed cover was provided between 5pm and 7pm to the Ivybridge/Yealm team.
- The podiatry service had one vacancy at the time of the inspection; however there was a backlog of patients with 160 people waiting at least 32 weeks to be seen and 1700 people currently on the waiting list. Staff reported that this had been put on the risk register and although changes had been made to try and deal with this, for example evening clinics and changing the access criteria, this had not had enough of an impact.
- The prosthetic service reported caseload and waiting times had increased due to staff vacancies within the service.
- The community rehabilitation team in Tavistock had fewer physiotherapists than it should have and as a result the waiting times to see a physiotherapist had risen to 18 weeks. This had been placed on the local and organisational risk register in April 2016.

Managing anticipated risks

- Some staff were not aware of plans that were in place should there be adverse weather that would prevent them from visiting patients. One staff member mentioned shoe covers to walk safely on the snow. One staff member said they would expect that all staff would visit patients local to where they lived regardless of which team was caring for the patient.
- The out of hours team provided an example in recent months where they were not able to operate due to staff sickness, this was appropriately escalated and the decision made it was not safe to operate the service.
- The Robin Community Assessment Hub was established to try and prevent hospital admissions offering a 'community based service that has been specifically designed to enable treatment and tests to be completed without the need for a hospital stay'.
- Staff within the Acute Care at Home team had access to pool cars which all contained satellite navigation systems and were linked to the electronic lone working device system.
- Lone working was taken seriously by the organisation and as a result an electronic lone working device system had been introduced. The system was linked to a 24 hour a day seven day a week incident management centre and has GPS tracking so if staff indicate they are at risk they can be found and the relevant managers or emergency services (if required) can get to them quickly.

Major incident awareness and training

- Staff spoken with were aware of the plans if there was a major incident in their area of work.
- Major incident training awareness was delivered to staff during their induction.
- The Major Incident and Business Continuity Plan was available to staff on the organisations intranet system. However this would not open when trying to access it via the organisations own website

Good

Are services effective?

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

Summary

We rated effective as good because:

- The community adult's service provided care in line with best practice guidance.
- Multi-disciplinary and collaborative working was evident throughout the service. Working in the same building as other teams and social care colleagues had improved information sharing.
- Staff had the skills and qualifications to carry out care and treatment in line with best practice.
- Staff had a good understanding of consent and deprivation of liberty safeguards. Consent to treatment was gained in line with legislation.

However:

- There was variable access to information and connectivity.

Detailed findings

Evidence based care and treatment

- Care and treatment was delivered in line with national best practice guidance. This included the National Institute of Health and Care Excellence (NICE).
- The Parkinson's team developed a document based on NICE guidelines and Parkinson's UK guidance. The document covered checks to be completed for example blood pressure and areas to discuss with the patient to understand how they were feeling and if there were any complications.
- Two members of the long term conditions team were NICE leads, they were responsible for looking at guidance and making decisions about what was to be included in policies and procedures. Alerts from NICE were discussed at team meetings.
- The tissue viability lead attended the Westcountry Tissue Viability meeting on a quarterly basis. This enabled dissemination of evidence based practice.
- The community cardiac specialist team used the British Association for Cardiac Prevention and Rehabilitation Guidelines to inform local policies and practice.
- The Huntingdon's Disease service worked with the Huntingdon's Disease Association (HDA) to ensure local practice was in line with recognised national good practice.
- Community Adults policies and procedures were developed using (NICE) guidance. Staff in Tavistock and South Hams areas, who moved to the organisation in April 2015, were still working with some of their previous organisations policies and procedures. These were being reviewed and replaced by Plymouth Community Healthcare (Livewell) on an ongoing basis.
- The organisation had a programme internal clinical and non-clinical audits and took part in a number of national clinical audits for example Parkinson's disease national audit.
- All the organisational policies we looked at referenced the sources of information used to create the policy.

Pain relief

- Nursing and therapy staff asked patients asked about their pain levels and discussed their pain relief medication. This allowed them to identify any additional needs for the patient. One physiotherapist provided examples of how pain could be managed through other means, for example heat or ice dependent on what worked best for the patient.
- Patients were supported to take pain relief prior to treatment, if required. We saw one district nurse contacting a patient prior to their appointment so pain relief could be taken giving it sufficient time to work before the district nurse visited to change their dressings.
- The district nurse treatment clinic was able to arrange prescriptions for pain relief from the pharmacy on the same site. Other patients were advised to take their pain relief before attending the clinic so it had time to work prior to their procedure.

Good

Are services effective?

- Patients records reviewed had pain assessments carried out and specific care plans for pain management if required.

Nutrition and hydration

- The malnutrition universal screening tool (MUST) was completed as part of the standard nutritional risk assessment for patients.
- On home visits the multidisciplinary team discussed the amount of food and drink the patient was consuming. This allowed any concerns to be identified and a plan put in place. One physiotherapist explained to a patient how they could be referred to a dietician if they were not managing to meet their nutritional needs.
- The Parkinson's nurse told us they do not ask patients to weigh themselves due to the risk of falls; however should they have concerns about malnutrition they can request the patient to come in to the clinic and use the sit on scales.

Technology and telemedicine

- The use of technology and telemedicine was not in use across the organisation.
- Staff members on the twilight team had access to equipment that enabled them to have live access to the computer system. This meant they had access to the most up to date patient information and could add details of appointments without having to return to base to upload it. The other teams across the adult community services did not have access to these devices.
- Some GPs had access to a computer system used by the district nurses. This enabled information to be shared amongst professionals. This helped the district nurses be more effective and reduce the amount of time spent waiting to get information whilst on visits. Staff reported it would be beneficial if other teams such as the long term conditions team could access the same system so information could be shared.
- Staff in the Tavistock community nursing team were looking forward to being able to use the electronic patient record system used across Plymouth. They had training booked and had heard from colleagues using the system saved time and led to consistency of record keeping.

Patient outcomes

- Patient outcomes were being monitored in some areas of the organisation to improve the services being provided. The tissue viability team told us they completed annual reviews according to NICE guidelines.
- Insulin prescription and medicines administration records were being piloted in the Ivybridge/Yealm area due to the increase in diabetic patients. This document allowed administration of medicines to be recorded to ensure safety of patients. GPs were happy with this pilot as it reduced errors. We did note this document was branded for the previous organisation.
- The Parkinson's team worked closely with Parkinson's UK. The 2015 UK Parkinson's audit helped healthcare professionals measure their services for people with Parkinson's against national guidelines. Staff informed us the organisation performed better than the national average, the results are yet to be released.
- The respiratory specialist nurse told us that in the past month an average of 3 patients under the teams care were admitted, to hospital, each week with exacerbation of heart failure, from a caseload of between 500 and 600 patients, compared with 6 or more 6 months ago (this does not include the number of patients being admitted waiting to be seen by the cardiac service).
- Both the cardiac and respiratory services had above average completion rates for their rehabilitation exercise and education classes, with over 80%of patients recording significant improvement in their physical activity and general wellbeing. Unfortunately the data had not been able to be recorded on the electronic recording system so the evidence could not be produced.
- When the tissue viability team received referrals, they were provided with photograph evidence of pressure ulcers. It was not common practice to give advice on the photograph alone. The tissue viability team visited the patient to enable them to provide accurate advice and improve the patients' outcomes.
- We were unable to confirm if the district nursing service reviewed their caseloads for details of patient admissions to hospitals and the reasons why.

Good

Are services effective?

- In the East locality therapy team physiotherapists had a generic outcome measure which they audited, and the occupational therapists were trialling a similar outcome measure.

Competent staff

- Staff had the qualifications, skills and knowledge to undertake their roles.
- Staff told us the organisation had a robust recruitment system and would only employ staff who were competent.
- Staff had received appraisals from their line manager. They felt the appraisals were very useful in their development to highlight their progress and development needs. At the time of our inspection, 14.5% of staff within the community adult's team had not had an appraisal within the last 12 months.
- Staff told us they had regular one to one meetings with their managers.
- Competencies were signed off once staff were qualified. For example competencies for managing syringe drivers and urinary catheterisation.
- Staff applied for study leave and were encouraged to undertake professional training and given opportunities to develop their skills. Specialist training was available for example peripherally inserted central catheter training.
- Staff reported there was a central training fund to which individuals could apply. This meant that training was not taken out of the individual's team funds and staff felt this meant training was more accessible and supported.
- The organisation had allocated three days protected time for nursing revalidation. Staff felt supported during or in preparation of their revalidation. Nursing staff agreed they had been provided with revalidation training but some staff said due to low staffing levels in the district nursing teams they were unable to book the protected time. The out of hours nursing team had a revalidation board displayed in their office for information for the team.
- Staff informed us clinical supervision was encouraged however for some teams it was difficult to get time to do this. Some staff received clinical supervision and this tended to be dependent on capacity. Staff said they received a lot of peer support.
- In the district nursing service there was an expectation that higher band nurses shadowed those of a lower banding to check their competencies. However, with low staff numbers there was not always the capacity for this to happen.
- Staff received corporate induction. They said this was a good induction, with one staff member saying it was fantastic. Following induction there were four weeks protected to ensure they were appropriately trained and had the opportunity to shadow other teams. All staff in the South Hams and West Devon who were transferred from their predecessor organisation were provided with Plymouth Community Healthcare trading as Livewell corporate induction.
- Administrative staff in Plymouth said there were no training opportunities for their staff group.
- Student nurses told us they were given the opportunity to attend extra training sessions so they could develop greater competencies.
- Health care assistants were supported to gain qualifications so that they could carry out additional tasks, by attending training courses at the district nurse's treatment clinic. This included urethral catheterisation and in some cases reduced the district nurses caseload.
- Support workers in the community crisis response team were supported in gaining extra skills such as therapy assessments, bladder scans and venepuncture.

Multi-disciplinary working and coordinated care pathways

- Staff were extremely positive about the multidisciplinary working across the organisation. All necessary staff were involved in assessing, planning and delivering care and treatment to a patient.
- Good multidisciplinary team working was achieved both internally within the organisation and externally outside of the organisation.

Good

Are services effective?

- Teams worked effectively within their own localities and with their sister teams in other localities.
- Internally, different professional teams co-ordinated and communicated with each other to deliver the most effective care for patients, for example referrals to the tissue viability team and nurses requesting physiotherapists to visit patients.
- External multidisciplinary working was achieved, for example the Parkinson's disease nurse specialist told a patient they would talk to their GP about their medication. A physiotherapist told a patient they would discuss their medication with St Luke's hospice.
- The East long term conditions team (LTC) attended GP clinical meetings to raise awareness of their role. They met monthly meeting with all the other LTC teams. All the LTC teams worked closely with their localities district nurses, therapy teams and social workers, they thought this was effective and allowed patient centred care to be provided. The LTC teams had link nurses for example tissue viability, continence, NICE, risks which enabled information to be disseminated to staff.
- The Ivybridge/Yealm community nursing and rehabilitation teams held virtual ward meetings monthly to flag and monitor patients.
- A number of staff commented how the links with the social workers, when they were in adjacent offices, had improved the service that could be provided for the patient. For example advice could be easily sought and joint visits could be arranged more easily.
- Following a physiotherapy home visit with the East Plymouth locality therapy team the physiotherapist returned and emailed the district nurse to ensure they picked up the comments on the patient's notes. They informed them of the need to take off a boot and check a toe, this reflected learning from the tissue viability team where a pressure ulcer had been a result of a boot which had not been checked.
- South Hams and West Devon community nurses said they had a good working relations with the tissue viability team despite the geographical distances.
- The Ivybridge/Yealm and Tavistock community nurses were based at GP practices and they said this helped with communication.
- The out of hours district nursing team had a good relationship with Devon Doctors (out of hours GP service) and could offer each other appropriate support.
- A member of the East Plymouth locality therapy team said therapy services were inundated and not well co-ordinated, however this was being reviewed.
- Tavistock rehabilitation team worked as a well-established multidisciplinary team of therapists, trained nurses, social workers, healthcare assistants, support workers and administrative staff. All levels of staff thought their teams worked well together and were effective in managing patient's needs.
- The Robin Community Assessment Hub involved nurses, South West Ambulance Foundation Trust paramedics, pharmacists and GPs working together to prevent hospital admissions.
- In response to issues surrounding the communication between Derriford hospital and the hospital discharge team, Plymouth Community Healthcare trading as Livewell set up a tactical control centre. Staff reported this gave them a forum to raise concerns and work with Derriford hospital to move things forward. This meant band seven nurses were spending less time on the phone and more time with patients.
- Staff within the hospital discharge team said working alongside their adult social care colleagues had resulted in more effective and timely treatment of individuals. Information and knowledge was shared and they felt they were one team working towards one goal.
- A member of the cardiac team told us they had made a referral to social services to arrange for equipment to be delivered to a patient's home and adaptations. This resulted in a quick response and the patient now had a raised chair, raised toilets seats and hand rails on the staircase.
- The Recovery At Home Service was a newly developing service commissioned by the local acute hospital. One of the care pathways was to provide early discharge for some post-operative patients. The patients stayed under the care of the hospital consultant and that process was described in the operational policy. However there has been varied success with consultants agreeing to continue to manage the patients that could be discharged. The operational policy stated if the

consultant did not agree to continue to care for the patient at home the patient could not join the scheme. Plymouth Community Healthcare trading as Livewell had added this to their risk register although there had been no patient safety incidents with patients who had gone home and in effect had no consultant cover.

Referral, transfer, discharge and transition

- Referrals were received through the district nursing hub. This had been created to take referral calls directly meaning community nursing staff were spending less time managing phone calls and more time with patients.
- The Kingsbridge community nursing team had no central referral system. Referrals were received from a number of sources to include GPs, hospitals and the out of hour's doctor service.
- The out of hour's district nursing team were on-call and received referrals from the out of hours GP service. They also received non-capacity referrals from the day teams, when they had not managed to visit a patient. Additionally, the team held a small regular caseload. The district nurse manager said they had a vision, like the district nursing hub, to be able to take and triage their own calls and referrals.
- The Ivybridge/Yealm rehabilitation team were working to facilitate early discharge and set up a rapid response team.
- The tissue viability team were able to refer directly to the local acute hospital vascular team rather than going through the patients GP.
- The community crisis response team received referrals about patients that have been seen by a health or social care professional in the last 24 hours. This ensured that treatment had been started and people seen who were acutely unwell and needed hospital admission.
- The integrated hospital discharge team coordinated the discharge of patients from Derriford and Mount Gould hospital. They assessed the patients' medical and social needs and ensured the appropriate care packages were in place for the patients continuing care. This could include a district nurse care package or a recovery at home package. This meant beds within the hospital were available and patients could continue their recovery in their own homes.
- A physiotherapist and occupational therapist from the Tavistock Rehabilitation team carried out a home visit to a new patient together. We saw them ask what the patient wanted to achieve now they were home from hospital, they offered advice, gave the patient simple exercises to do to help them achieve their goals, provided advice and support to a family member.

Access to information

- Staff were aware of where to find the organisations policies and procedures.
- Staff were able to access the information they needed, via the organisations intranet, to deliver effective care and treatment.
- An electronic system for patient records was introduced in April 2015, and was still being rolled out in West Devon and South Hams. Champions were in place to represent staff and provide feedback on the new system. Training was available for teams and new staff before they moved to the system. Due to the infancy of the system there was still areas that could be developed to improve the quality of records. We noted the system was not quite joined up and there were some issues in seeing what other teams had recorded if access was not granted. Some staff in Plymouth area said they were able to see the GP notes, if the GP practice used the same system.
- A number of staff said the electronic system had been a challenge and they still faced frustrations with the system, particularly with the speed of the technology and the connectivity. District nurses said feedback was being taken on board and accessibility improved. Some nurses said when they used the mobile electronic system up to date information was not always on the system as it had to be downloaded from the 'live system' when the computer was connected at their base. However some staff said the electronic system had improved access to information. Different teams could see each other's notes. For example the out of hours district nursing team said they could now read notes before arriving at the patient's home, which allowed them to be more prepared.
- We reviewed some electronic patient records and saw information was not always loaded correctly, for example risk assessments had been completed in the

tabulated record but had not been pulled across in to the templates and therefore could not be easily accessed without scrolling through all the record entries.

- Moving away from the use of paper records had resulted in patients and their relatives/carers not having access to their own patient records. The East Plymouth long term condition team said as a result they had left crisis plan documents/records with the patient.
- The community crisis response team used a different computer system to other teams. This system was unable to separate each team member's caseload for the manager. This led to difficulties in senior staff being able to manage their team's caseload in an efficient way.
- The community crisis response team did not have access to any mobile devices. This meant that notes had to be recorded when they returned to their base and meant they were not always contemporaneous.
- Two members of the hospital discharge team had been waiting for four months to be given the correct access to their computer system. They had to rely on others to input the information from their visits and document that they were undertaken by someone else. This could lead to errors in the recording of information and prevented those staff members accessing information in a timely manner.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff had an awareness of consent and mental capacity issues and could demonstrate how they would apply their knowledge. Staff also understood about deprivation of liberty safeguards which was applicable when visiting patients in care homes.
- Nursing staff said should a patient be identified as not having mental capacity they would be referred to the GP for an assessment. Patients could also be referred to the organisation's memory service.
- We saw staff of all levels and specialities asking patients for verbal consent during home and clinic visits. We heard therapists making suggestions to improve patient wellbeing and the patients were asked if this was ok and if that is how they would like to proceed. Therapists and nursing staff explained to patients what they were going to do before physically examining them and gained verbal consent before doing so.
- During home visits with the out of hours district nursing team nurses asked patients for verbal consent throughout their care and treatment.
- The East Plymouth long term conditions nurses said patients did not always want help. They showed an awareness of patient choice and said they respected patients' rights and decisions. In these circumstances they would engage with the patient to get them to effectively manage their condition. When reviewing patient's clinical records we saw occasions where staff had clearly recorded that verbal consent had been gained.
- If a patient refused equipment that had been recommended for them this was recorded and the patient signed to say they had declined the equipment. If a patient lacked capacity then the nurses would liaise with the GP's and request for them to perform a memory test and capacity assessment.

Good

Are services caring?

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

Summary

We rated caring as good because:

- Feedback from patients was positive.
- Patients received care from staff who treated then with dignity and respect.
- Staff ensured that options were explored to respect the patient's wishes and requests.

Detailed findings

Compassionate care

- We accompanied a variety of staff on visits to patient's homes and saw them interact with patients in clinic settings. Staff were seen to be kind, compassionate, discreet and understanding. They dealt with challenging patients in the same way.
- Staff introduced themselves to patients if it was the first time they had met. It was evident some staff had built up a relationship with the patient and in these instances first names were often used.
- The Parkinson's disease nurse specialist had a friendly manner with the patients and their relatives when attending a home visit. They reassured the patient when the patient raised concerns about how they were feeling. It was evident the nurse knew the patient and their family well, and the patient's condition and their interests. The patient and their relative were complimentary about the care provided by the nurse. They commented it was good to have a contact to phone if they needed advice. Despite the patient being cared for by the multidisciplinary team the Parkinson's disease nurse specialist was the main point of contact for the patient. This ensured continuity of care. Staff who ran the Huntingdon's Disease service also said patients liked to have one point of contact as it provided reassurance that their needs were understood.
- We attended home visits with community nursing staff, specialist community staff and therapists and the out of hours district nursing team in all cases staff members provided excellent care to the patients. They interacted with the patients in a respectful and considerate manner, and ensured the patients understood their care and treatment. Privacy and dignity was respected during intimate care. They responded appropriately to the patients who showed signs of pain and discomfort or were anxious about having staff visit.
- Staff introduced themselves and explained their role to all patients. They positively engaged with patients and asked what their preferred name was.
- The patients we spoke to reported that the staff were helpful and friendly with one stating "Nothing is ever too much trouble". Another said "I really don't know what I would have done without their help, they have put me on the right track".
- Comments from comment cards completed prior to our inspection (district nurse treatment clinic = seven responses, Kingsbridge community services = 3 responses, podiatry = 1 response, West District Nurse team = one response) were consistently positive. Amongst the comments were "I find the response of the nurses to be fast, appropriate, caring and compassionate> When being treated the nurses are careful to ensure that I suffer no loss of dignity", "the curtain is always pulled to closed when I am having treatment, they always ask if I am alright when having treatment" and "staff are caring and treat me with a lot of respect".
- One staff member told us whilst they were visiting a person to provide support and advice to a person they encouraged their carer to go out for a short while to have some time to themselves. A number of staff we spoke with described how important it was to ensure carers were also cared for and their wellbeing was monitored.

Understanding and involvement of patients and those close to them

- On all visits we observed patients being included in discussions about their care and treatment, where applicable relatives and carers were also involved.
- A physiotherapist in the Ivybridge/Yealm rehabilitation team the provided excellent care to a new patient, they had a lovely manner, asked appropriate questions,

maintained good eye contact with the patient and used visual aids to explain what they were talking about. The physiotherapist took time to understand the patient and their interests and needs, discussing their goals and explaining different ways these could be achieved, providing the patient with options. The physiotherapist ensured the patient had an appropriate support network of family and friends. The patient commented the rehabilitation team was very good and they were able to book appointments at their convenience. The patient was provided with a leaflet which detailed information on the aims of the service, the services provided, the team, consent, the staff involved in the care, contact numbers and how to make comments and suggestions.

- A tissue viability nurse showed good communication skills when visiting a patient in a care home and provided them with reassurance.
- A physiotherapist from the East locality therapy team had a lovely manner with patients and the care was completely patient centred. They provided advice to the patient and communicated well. The patient and their wife said the care had been wonderful.
- A physiotherapist and occupational therapist from the Tavistock rehabilitation team carried out a home visit to a new patient together. We saw them ask what the patient wanted to achieve now they were home from hospital, they offered advice, gave the patient simple exercises to do to help them achieve their goals, provided advice and support to a family member. They were respectful, interactive with each other and the patient. They left relevant contact details and information about the services they had discussed. The family member said "they have been a life saver for me".
- We witnessed patients and family members being included in decisions about their treatment and being given the time to question and discuss any concerns they may have.
- We were told of an occasion where a member of staff took time out of their own time to assist a patient on a trip as the patients carers were unable to do attend.
- A staff member said they always ensured that when dealing with patients living with dementia or confusion that they respected when they' had had enough' and ensured they were given breaks during assessment and treatment.
- One staff member commented that now electronic patient records were in place, paper records were not available for the patients and carers to keep them involved.
- We were told the Meridian Health questionnaire was used to obtain further patient feedback, if results were under 90% team managers were required to put an action plan in place.

Emotional support

- We observed emotional support being given to patients during home and clinic visits.
- An occupational therapist in the Ivybridge/Yealm rehabilitation team provided excellent emotional support to a patient. They were considerate to the patient's needs and held their hand when they were upset, coming down to the patient's level and telling them how they would work together to achieve the patient's goals, pointing out what was important for the patient. The patient commented how lovely the occupational therapist was and how helpful they were.
- The Parkinson's team ran information and education sessions for newly diagnosed patients. This provided patients with the tools to take control of their disease. It was a five week course and involved both the patient and their relative or carer. Multidisciplinary team staff for example nursing staff, physiotherapists, occupational therapists, speech and language therapists and the continence team all provided information sessions during the course.
- Staff working in specialist services provided within the community including cardiac, respiratory, district nurse treatment centre, Huntingdon's service and long term conditions were able to recognise when people's emotional wellbeing was being affected by their conditions. Staff were observed interacting appropriately with a person who was receiving services for the first time and felt overwhelmed by the situation.The staff member was able to reassure the person and provided them with contact details for a

number of other organisations they would need to make contact with to support them going forward. The person told us they were very grateful for the advice and felt reassured and empowered to start to organising services they may need. Staff were also able to refer people and their relatives/carers to support services that were able to help with emotional issues.

- We were told of a patient who became distressed by people they did not know. Staff ensured that at least one of the two staff that attended the appointments was known to them. This reduced patient distress and increased patient co-operation.
- Staff within the Robin Community Assessment Hub ensured that all patients who visited the hub were given a hot or cold meal before they returned home so that patients had one less thing to be worried about when they were discharged.

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 responsive as good because:

- The needs of patients were taken into account when planning and delivering services. Staff were flexible
- Teams worked together to provide the most appropriate care at the most appropriate time for patients.
- Care and treatment was coordinated between the community adult services.
- Patients were given information about how to make a complaint or raise a concern. There were systems in place to evaluate and investigate complaints.

However:

- There were issues with the waiting times and waiting lists in some specific areas.

Detailed findings

Planning and delivering services which meet people's needs

- Teams carrying out home visits said they would try to accommodate patient's needs and book appointments to suit the patient where possible. We were given numerous examples of how different teams worked together to ensure patients received the most appropriate care at the most appropriate time. This meant patients were not receiving multiple appointments or visits.
- One patient had a hospital appointment in the early afternoon, when a district nurse was due to come out and change the patient's dressings. The district nurse appointment was rearranged to ensure the patient could attend their hospital appointment and have their dressings changed.
- We observed an occupational therapist discussing the time a support worker could visit the patient so the time was different to the carer and would enable the patient to be helped to make a hot drink.
- There were no tissue viability clinics. The tissue viability lead said they were collating data from the district nurses to see how many people had leg ulcers to determine the need for a leg ulcer clinic. They commented it was better to be proactive rather than reactive, preventing leg ulcers rather than treating them once they have occurred.
- Social workers within the community crisis response team were being trained in bladder scans to prevent the need for both a social care worker and district nurse visit.
- The Robin Community Assessment hub had sometimes arranged alternative transport for their patients, through a local ambulance provider, which meant they received patients within an hour of referral. This meant patients started treatment quickly and there was less chance of deterioration and the need for hospital admission. Bariatric beds were also accessible if required (a bariatric person is defined by healthcare organisations as a person whose weight, body dynamics or weight distribution exceeds the safe working load and dimensions of a support surface).
- The Ivybridge/Yealm rehabilitation team referred patients to a falls/balance group held locally on a weekly basis. The venue was moved to enable free parking for patients, due to an increase of patients receiving parking tickets.
- We met with the staff who provided the Huntingdon's Disease service run from Mount Gould Hospital. They provided care and support to people in their own homes or in specialist Huntingdon's units in the local community. When patients were referred to the service they were seen that day or on the following day as staff said they did not like to keep people waiting. The service also provided a fortnightly drop in session at the Local Care Centre at Mount Gould Hospital which was described as 'working really well'. It enabled people and their carers to meet other people with Huntingdon's and share their stories and provide support to each other. Staff described their service as flexible to meet people's needs.
- In Tavistock a regular meeting was in place for people who had Motor Neurone Disease (MND) and their

relatives/carers. This had been started in response to a recognised need following comments made by a carer of a person with MND. Staff described the meetings as well attended and appreciated by those who attended.

- The cardiac service, that included specialist nurses, exercise physiologists, therapists and support staff,provided care and support to patients and training to staff across Plymouth, Tavistock and South Hams. Referrals to the service had increased from 420 in 2014-15 to 1079 in 2015-16 There had been one complaint about the cardiac service in the last 12 months. There had been an average of two letters of praise and thanks every month for both the cardiac and respiratory services.

Equality and diversity

- Equality and diversity training was included in the corporate mandatory training that all staff were expected to complete. As of 29 February 2016 83% of eligible staff had completed this training.
- Community teams visited patients in their own homes. This meant people with disabilities/mobility difficulties were able to access nursing and therapy services on an equal basis to others without difficulties.
- Translation and interpretation services were available. Not all staff were aware of how these services could be accessed due to not requiring them in the past, however they felt they had appropriate contacts internally and externally who would be able to advise them.
- There was level access for people with disabilities at all of the sites we visited that patients accessed.
- When staff visited patients in their own homes and accessed a key safe for a key to let themselves in staff respected the patient's privacy by ringing the door bell and calling out for the patient before they entered the patient's home.
- A staff member informed us that the organisation had provided them with the support required for them to continue working whilst dealing with a medical condition, however their redeployment had not been handled well and added stress to an already stressful situation.

Meeting the needs of people in vulnerable circumstances

- Staff were able to refer patients to the organisation's learning disabilities team. The team had advised staff how to make reasonable adjustments in order to meet the needs of people who had a learning disability.
- Outpatient's clinic staff said if a patient was unable to read the alphabet during a sight test animal pictures could be used instead.
- We saw information being provided to patients and their relatives that included contact numbers of the department and the name of the person undertaking their care.
- The podiatry service gave lessons in diabetes and its management to prevent damage, especially to feet, later in life.
- All staff we talked with had a knowledge of dementia and services their local communities offered. Information was shared with patients and their carers appropriately. There were dementia link staff across the teams who were able to access the Plymouth Community Memory Assessment, Treatment and Diagnostic Service run but the Older Persons Mental Health team, if necessary.

Access to the right care at the right time

- Patients were provided with the contact details for their main point of contact should they need to access care or advice.
- Staff, across the community adult specialities, said if patients required an urgent appointment they would be fitted in as a priority.
- The out of hour's service prioritised referrals based on pain level and end of life patients.
- Staff felt the electronic system worked really well in the clinic and had improved the booking system for patients.
- Staff in the South Hams and West Devon commented it was better for patients now the teams were employed by the Plymouth Community Healthcare trading as Livewell as there were improved links with Plymouth teams and it was easier to liaise with other specialities, providing clearer pathways of care for patients and access to appropriate teams.

Good

Are services responsive to people's needs?

- The tissue viability team aimed to respond to referrals within 72 hours, as recommended by NICE guidelines. They told us there had been no breaches.
- Therapy teams waiting lists varied across the organisation. We were told waiting times were discussed monthly at performance meetings. Those with longer waiting lists provided reasoning behind this, for example the Ivybridge/Yealm rehabilitation team had staff involved in an in-reach pilot which had impacted on the waiting list, the pilot was due to finish soon. They said patients were being appropriately triaged and those requiring immediate care were identified. Tavistock rehabilitation team told us the non – urgent physiotherapy waiting list had increased in length. The waiting list was triaged to ensure those with most need were seen first.
- The South Hams and Tavistock therapy and rehabilitation teams said they responded quickly reacting to urgent referrals within four hours.
- Staff told us there was a limited service over the weekend in the Ivybridge/Yealm team, with no hub, occupational therapy or physiotherapists or access to intermediate care beds. Some services were not available, for example 5-7pm district nursing cover in Ivybridge.
- The outpatient clinics in South Hams and Tavistock hospital and at the district nurse treatment centre in Plymouth said they normally ran on time however if there were delays they would keep patients informed and record the delay on the notice board in the waiting area or tell people in the waiting room about the delay.
- The community crisis response team received referrals seven days a week between the hours of nine am to five pm Monday to Friday and nine am to three pm on Saturday and Sunday. Treatment was provided between the hours of nine am to eight pm Monday to Friday and nine am to five pm on Saturday and Sunday.
- The prosthetic department had 16 people breaching their 18 week treatment to completion time, with the longest wait being that of 46 weeks. There were also 131 people waiting for an initial appointment.

Learning from complaints and concerns

- There had been 49 complaints between 1 February 2015 and 31 January 2016. Of these 32 were upheld. All of the complaints were thoroughly investigated using the organisations complaints procedure. There were no themes or trends identified during the investigations. Outcomes were shared with the person who made the complaint and the relevant staff.
- Staff said if complaints were received learning would be shared individually or at team meetings.
- Formal complaints were lodged with the organisations customer service team. Who documented the complaint and sent it to the manager for the service who identified the most suitable person to investigate the complaint.
- Leaflets provided to patients included customer service contact details should they want to raise a concern.
- One patient reported they had made a complaint in regards to the attitude of a member of staff. They told us they felt listened to and were happy with the way their complaint was dealt with and the outcome.
- We observed information leaflets in most public areas explaining what patients could do if they were unhappy with their treatment and how they could make a complaint. The outpatient clinic in South Hams hospital did not have leaflets about how to make a complaint displayed, however the nurse was aware of this and was obtaining more leaflets.

Good

Are services well-led?

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

Summary

We rated well-led as good because:

- Staff were aware of the trusts vision, values and strategy.
- There was strong leadership in place. The executive team was visible and staff felt comfortable in approaching them.
- A positive culture was evident in nearly all the services we visited.
- Staff felt they had a voice and we heard examples of when changes had been made following discussions and involvement of staff members.

However:

- There was inconsistency in the way medical and emotional needs of the staff were met and dealt with.
- Since patient records had been completed using the electronic patient record system there had been no consistent audit of the records.

Detailed findings

Service vision and strategy

- All staff were aware of the Livewell's vision and strategy: to keep people safe, well and at home. The five strategic aims were displayed in team bases and on the computer screen savers. Staff were aware of these aims.

Governance, risk management and quality measurement

- Risk registers were held electronically by each team. We saw evidence of appropriate risks on risk registers across different teams. Risks were added by those trained in risk assessment and named as organisation risk assessors. The risks were sent to the risk management team and the locality manager, and reviewed at the monthly risk monitoring and moderation group. We found that the risk register items matched issues staff told us they worried about.
- Most teams held monthly team meetings where risk and governance issues relating to their fields of work were discussed.
- Feedback from people who used the adult community services was displayed at team bases and discussed at team, divisional and senior management team meetings.
- Staff at all levels described the lines of accountability through the organisation. They knew who to raise their immediate concerns with and felt they would be listened to and the issues escalated if appropriate.
- Staff said they received an organisation newsletter and added that the chief executive officer (CEO) also sent emails to staff updating them on relevant issues.
- There was a systematic programme of clinical and internal audit which was used to monitor the quality of the service provided. However since patient records were being completed using the electronic patient record system there had been no consistent audit of the records. Staff thought information about how to carry this out going forward was soon to be provided to staff. We saw meeting minutes where outcomes of audits were shared and any actions needed to be taken as a result discussed.
- There was a robust complaints system and individual complaints were investigated and discussed within the organisation to establish lessons learnt. These were then shared with relevant staff to ensure learning was put into place.
- Clinical policies and guidelines were available for all staff via the organisations intranet. They were available to staff at all times. Staff showed they knew how to access relevant policies.

Leadership of this service

- The visibility of the executive team differed between localities and teams. Staff in a variety of teams we spoke with had met the chief executive. Most said the chief executive was contactable and available if needed. For example we were told by a member of staff that the

Chief Executive had helped run weekend flu clinics. One staff member said they had raised an issue directly with the Chief Executive who responded quickly and appropriately. They reported they felt listened to and involved. Staff said the leaders were helpful and supportive in driving positive change.

- Staff were aware of the 'meet the executives meeting' however found the times of the meetings were not convenient.
- Staff overall were complimentary about their locality managers and deputy locality managers and found them approachable and supportive. Most staff agreed there was an open door policy.
  The out of hours district nursing team had an opportunity to meet the locality managers who accommodated their working shifts by visiting the team at 6pm and 7am.
- Teams in the South Hams and West Devon had been transferred across from a different organisation one year prior to the inspection. All staff spoken with said this was a smooth transition and seamless transfer and they were well supported by the organisation both leading up to, during and after the transfer. Staff felt supported by managers and commented they were very responsive. They also said managers were approachable.
- The Ivybridge/Yealm and Tavistock rehabilitations teams commented the therapy managers were approachable and dynamic.
- Two staff members told us they had felt supported by the organisation during a family bereavement and when their children were poorly.
- In the district nursing service there was a lack of streamlined management across the localities. One district nurse team manager provided examples of how they were supporting their team but this was an individual approach rather than an expected or directed approach. A band 8a modern matron vacancy was currently being advertised and it was hoped that this would achieve an element of standardisation across the localities. The district nurse team managers met monthly and weekly about allocation of staff for the weekends and at the same time assessing the skill mix required and available.
- One deputy locality manager said "it is a supportive organisation to work in and there is openness within the organisation". They said they "liked the range of services available and there are a lot of dedicated staff".
- Staff said community nursing team managers were generally very involved and completed clinical home visits to support staff and helped out clinically when they were short of staff.
- Staff in the tissue viability team commented there was a lot of re-organisational upheaval and not adequate communication during this period.

Culture within this service

- Some staff told us that the low staffing levels throughout the district nursing teams across Plymouth was affecting their wellbeing.
- Staff were unanimous in saying they felt well supported by their colleagues, with many mentioning it is 'like a big family'.
- One healthcare assistant commented there was no hierarchy in the teams, everyone felt involved. Student nurses and physiotherapists said they felt supported by their teams.
- All teams visited said they felt safe in their working environment. The organisation had a comprehensive lone working policy. Staff demonstrated locally how they kept each other informed of their whereabouts and called in at the end of shifts if they were not returning to the base. The organisation provided all community staff with an electronic tracking device, this was a lone worker personal alarm which had two way audio and GPS technology. Some staff told us their managers ask them to randomly test their devices to show they were working. Staff were encouraged to use the electronic tracking device in any environment during work where they might not feel comfortable. For example if they are walking through a car park late at night after visiting a patient.
- The out of hour's district nursing team worked in pairs and shared a tracking device. They informed us the tracking device was supported by a 24 hour service. Additionally the teams had close links with their local

out of hours GP service and would inform them if they were visiting a patient and were likely to be out of signal. They gave an expected time to return and made contact on return.

- The Ivybridge/Yealm and Tavistock community nurses said there were issues with loss of signal in some of the areas they visited, however they communicated well amongst their teams to ensure the safety of staff. One staff member was responsible for knowing where their colleagues were.
- One deputy locality manager highlighted a challenge retaining staff, particularly in the district nursing service which had seen staff leave, we were told, as a result of increased expectation of working weekends and organisational change. The organisation had recently put in place formalised exit interviews to obtain feedback as to why staff were leaving.
- Some staff told us they had been assessed for stress as standard organisational practice. A number of staff members came out as high risk but nothing further was done about this. The provider informed us that following a risk assessment where concerns were identified for staff, staff would be referred to the staff health and well-being service. Staff could also self-refer to this service. Specific stress questions were also included as part of the staff audit.
- One healthcare assistant explained a situation where they were required to attend a road traffic accident and provide cardiopulmonary resuscitation. Following the incident the staff members involved were provided with support from the chief executive and management, and appropriate psychological support was available if they required it.
- Senior members of staff were seen to be supportive of staff wellbeing. One senior member of staff ensured that a junior member of staff had adequate time off following a late finish the night before.
- We saw posters displayed, in sites across Plymouth, advertising yoga, running clubs and fitness classes run by the organisation to promote staff wellbeing. Whilst these were not yet available in South Hams and West Devon community nursing staff told us they understood this was being looked into.

Public engagement

- There was a service user and carer engagement forum which was held quarterly. Information for this forum was displayed on the organisation's website and offered patients the opportunity to contact the forum to share their experiences.
- Patients were able to feed back their views on the services provided via the friends and family test to say if they would recommend the service.
- People were encouraged to share their experiences. We saw evidence of this on the information leaflets where patients were directed to the contacts for sharing their concerns or compliments.

Staff engagement

- Staff were aware of the 'Our Voice' forum and their teams could name colleagues in their locality who were representatives for the forum. This forum met monthly and staff told us their concerns, thoughts and suggestions were discussed at board level with solutions often being found.
- The majority of staff spoken with felt they had a voice and they were able to raise concerns and suggest areas for improvement.
- Staff were aware of the organisation's staff awards which enabled staff to celebrate successes and hard work.
- Staff were sent weekly bulletins to keep them updated on organisational business.
- There was a district nurse forum. Representatives from teams across the organisation attended this forum.Similarly therapy staff were able to meet together regularly to discuss role specific issues.
- The out of hours district nursing team had a 'friends and family moments of glory tree' to celebrate the positive feedback from patients and their relatives. Incentives were used for staff who got the most positive feedback. Comments were held on staff personnel files.
- Staff completed the annual staff survey and received the results in a timely manner.
- One senior manager had devised a system where staff could highlight a case they were finding difficult. This meant staff were aware of issues for colleagues and

supported all members of the team. When staff had successfully managed or dealt with the area they were finding difficult they were given a small gift provided by the senior manager.

- Due to the high workload staff reported they had been unable to complete the staff survey on time. This was raised with their managers and board and they were given extra time to ensure they had the time to complete it and have their say. Extra time was also given to staff that had not had time to complete their mileage claims within the three month allocated period.

Innovation, improvement and sustainability

- The 'pressure 2' trial was in its second year, patients were recruited from inpatient wards and started on a static mattress, as soon as marking on the skin was seen the mattress was upgraded. Patients were followed up in the community.
- Professional and clinical leads were prevalent throughout the organisation. We were told they were approachable and supportive.
- To help deal with the workload of district nurses, the phlebotomy (blood taking) team was developed into a single team which was centrally managed. This meant district nurses were not visiting people solely to take bloods and could therefore be seeing people where their skills were more useful.
- Robin Community Assessment Hub were nominated and shortlisted for a Nursing Times award by NEW Devon Clinical Commissioning Group, who said: "In January 2015 patient-centred organisations in Plymouth demonstrated a passion for rapid service improvement and exceptional care when the health and care system was under extreme and sustained pressure, developing an effective service that provided an alternative front door to the acute hospital emergency department, and supporting over 30 acutely unwell people to remain at home."