Care Quality Commission

Northern Devon Healthcare NHS Trust

RBZ

Community health services for adults

Quality Report

Raleigh Park,
Barnstaple,
Devon
Ex31 4JB
Tel: 01271 322577
Website:www.northdevonhealth@nhs.uk

Date of inspection visit: 2-4 July and 7-8 July 2014
Date of publication: 11/09/2014

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

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

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

Summary of findings

Ratings

Overall rating for Community Health Services for Adults	Good
Are Community Health Services for Adults safe?	Good
Are Community Health Services for Adults effective?	Good
Are Community Health Services for Adults caring?	Good
Are Community Health Services for Adults responsive?	Good
Are Community Health Services for Adults> well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

The Northern Devon Healthcare NHS Trust provides community healthcare services to a population of around 484,000 and provides services at any one time to approximately 6,000 patients who live in their own homes. The care and treatment is provided under the regulated activities, including: diagnostics and screening, family planning, nursing care and treatment of disease, disorder and injury. We visited community teams based in South Molton, Holsworthy, Bideford, Exmouth, Ottery St Mary, Honiton, Tiverton, Exeter, Crediton, Sidmouth and Okehampton.

We spoke with 129 members of staff, including community nurses, occupational and physiotherapists, specialist nurses, managers, healthcare assistants and administrative staff to understand their experiences of working within the trust.

We contacted and spoke with 76 patients and 12 relatives of patients, to seek their views of the service provided to them.

The inspection teams included CQC inspectors, specialist advisers in community nursing, palliative care specialist nurse, rehabilitation therapist, Allied Healthcare professionals, a sexual health nurse, community matrons and a GP.

During the inspection, we looked at patient-care documentation and associated records, observed care in patients' homes and clinics and spoke with staff and patients individually and as part of groups.

Patients made positive comments about the service provided to them.

Community services for adults provided by Northern Devon Healthcare NHS Trust were judged as good overall.

The services provided safe and effective care and treatment to people who lived in their own homes, or attended clinics run by the trust. Staff were able to report incidents to the trust and found action was taken to address issues, although they had not always received feedback regarding the outcome. The community teams promoted the control of infection and followed trust policies to prevent the spread of infection.

Staff were aware of how to report any safeguarding concerns and support was available to them through dedicated members of staff and their managers.

Staffing levels were sufficient to ensure patients received care and treatment in order to meet their assessed care needs, although there were vacancies in some staff teams. Lone working systems were in place locally to ensure the safety of staff where they worked alone in a department or clinical area.

Identified risks to patients and staff during the provision of community care services were recorded on both local and trust-level risk assessments. Action had not always been taken promptly to address the risks.

Integrated team working was evident across the area and staff were positive about their roles, both within their local team and across the wider multidisciplinary team.

We observed some areas of outstanding care and treatment during our inspection visit. We found a day service for patients with dementia care needs provided excellent care, support and treatment. A community nurse-led clinic provided responsive care and treatment to patients who were able to attend the clinic, thus promoting independence and providing good clinical outcomes for patients. Multidisciplinary team meetings identified care needs for individual patients and ensured these were met by appropriate staff.

Summary of findings

Background to the service

The Northern Devon Healthcare NHS Trust operates across 1,300 square miles and provides adult community care services to people in their own homes. There are nine integrated health and social care community clusters, spanning Torridge, North Devon, East Devon, Exeter, Mid Devon and West Devon. Community-based and specialist staff also work from GP surgeries, community hospitals and in people's own homes. Staff work in 14 teams across the county.

Services provided by the trust include community nursing services, therapy services, such as occupational therapy and physiotherapy, complex care teams which consist of multidisciplinary teams and Hospital at Home® services.

Our inspection team

Our inspection team was led by:

Chair: Jan Filochwski recently retired Chief Executive from Great Ormond Street Hospital for Children NHS Foundation Trust

Team Leader: Mary Cridge, Care Quality Commission (CQC)

The inspection teams included CQC inspectors, specialist advisers in community nursing, a palliative care specialist nurse, a rehabilitation therapist, Allied Healthcare professionals, a sexual health nurse, community matrons and a GP.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme. The trust is an aspirant Foundation Trust.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we held about the core service and asked other organisations to share what they knew. We carried out an announced visit on 2, 3 and 4 June 2014 to staff teams based in the South Molton, Holsworthy, Bideford, Exmouth, Ottery St Mary, Honiton, Tiverton, Exeter and Okehampton areas. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists, administration and management staff. We talked with people who used services during visits to their homes, at clinics and by telephone. 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 used services. We met with people who used services and their carers, who shared their views and experiences of the core service. We carried out an unannounced visit on the 7 and 8 of July 2014 to staff teams based in the Crediton and Sidmouth areas.

Summary of findings

What people who use the provider say

During our inspection, we visited patients in their own homes with community staff and met with patients in clinics. We talked to them to seek their views of the service they received. We also telephoned patients who received care and treatment from community staff. In total, we spoke to 76 patients and/or their relatives.

Patients made positive comments regarding their care and treatment. They said the staff were kind and helpful, spent sufficient time with them to meet their needs and performed their jobs well. Specific comments included: "We cannot fault the nurses, the service couldn't improve. We have had support from night nurses when we needed extra help," and, "The staff are wonderful, very kind and friendly," as well as, "The care I have had has been excellent, they are never in too much hurry to answer any questions I have, or give the help I need." Patients also said, "I don't know what time they are coming, but it's generally in the morning. I am always told if they are going to be late and come in the afternoon. They are very reliable."

One patient commented on the nurse-led clinic at Exeter hospital and said, "I can make an appointment when it's convenient to me, my wound has improved greatly since coming here and [the staff] are just so kind and caring to me."

Good practice

- In some community teams, the multidisciplinary team were co-located. In all of these areas, staff were positive about how well the multidisciplinary team worked together and how this benefited the patients to receive a holistic service from different health and social care professionals.
- The out-of-hours community nursing team provided a good service to patients and provided effective and responsive services to patients. We spent time with the night workers from the out-of-hours team and observed them providing a residential home with advice regarding the health and care needs of a deteriorating patient. We were advised that during the night they would 'pop' in to ensure the care home staff were managing the care required.
- We observed multidisciplinary team meetings regarding a 'virtual ward' held by the complex care teams in four areas – Bideford, Okehampton, Tiverton and Ottery St Mary. These were attended by a combination of professionals, including: a consultant geriatrician, community matrons, community nurses, community psychiatric nurses, therapy staff from complex care, rehabilitation and Rapid Response teams, social workers, hospice workers, voluntary sector and GPs. The meeting reviewed patients with complex care and support needs with a purpose of ensuring their care needs were met at home, on discharge from hospital, or if they required a hospital admission.
- The Rowan Unit Day Centre, in Ottery St Mary, for people with dementia care needs, provided an outstanding service, including: a twelve-week assessment period, as well as care and support to patients.
- The community nurse-led clinic at Exeter provided a service that promoted independence for patients who required ongoing treatment and were able to travel to attend the clinic. This service had been recently set up, but already, evidence demonstrated outstanding outcomes for patients.
- Staff were committed to providing a high quality service to patients and demonstrated, throughout our discussions and observations, that the patients were at the forefront of each visit and service.

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust should ensure that the infection control policy and procedure provide specific information and guidance for staff working within patients' own homes.
- The trust should ensure that infection-control training for staff working in patients' own homes related to the community setting, rather than a hospital setting.

Northern Devon Healthcare NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Good

Are Community Health Services for Adults safe?

By safe, we mean that people are protected from abuse

Summary

There were systems in place for staff to report incidents and staff were confident that issues reported would be addressed. Processes were in place to ensure information from reported incidents was disseminated to staff teams to reduce the risk of similar situations recurring, the level of feedback was said by staff to be improving.

Staffing levels and the teams' skills mix were sufficient to meet the assessed care needs of patients. There were some vacancies within teams and we saw that, at times, bank staff were used to provide additional cover.

The safety of staff and patients was promoted by the practices followed by the community staff teams. For example, regarding the control of infection, safeguarding vulnerable adults and healthcare.

Incidents, reporting and learning

- Staff told us they were able to report concerns to their line, or senior, managers and were confident that action would be taken.
- Staff knew how to report incidents and concerns, through the trust electronic reporting system. Staff had not consistently received feedback regarding incidents they had raised, although we were told this was improving. We were shown recently completed incident reports and subsequent action that had been taken to address the concern or incident.
- The trust identified themes from the incident reports submitted by staff. A manager from one therapy service told us that a number of staff had reported concerns around an external organisation, which provided a transport service to patients. This had been escalated as a concern by the trust.
- We found, in some areas, that incident reporting had provided learning for staff, both within their own teams and across teams. For example, we saw evidence of

shared learning following serious incident investigations in four community nursing teams we visited. Incidents that had been reported in other areas of the trust were discussed at cluster management meetings and the learning from the incident cascaded to all staff through team meetings.

- The community services completed Safety Thermometer data, which was reviewed at board-level. This included the collection of data regarding pressure ulcers, falls, catheters and urinary tract infections. Guidance had been provided to staff on how to accurately record data. An analysis of reported pressure ulcers had been undertaken during 2012/2013 through the NHS Safety Thermometer and the trust aimed to reduce pressure ulcers that had been graded as 3 or 4 by 25%. All pressure ulcers were subject to a grading scoring system which identified the severity of the damage to the skin.
- The electronic hand-held devices gathered and analysed information submitted by community nurses through the Safety Thermometer system.
- Results from the analysis of the Safety Thermometer data were provided to individual teams and displayed within community bases.
- The 2013 staff survey identified that the fairness and effectiveness of incident reporting procedures was lower than that of the national average.

Cleanliness, infection control and hygiene

- The trust had developed a policy and procedure to inform and guide staff regarding the prevention and control of infection. This was accessible to all staff through the trust intranet. Staff were aware of how to access policies and procedures.
- Staff were provided with pocket-sized guides, from the National Patient Safety Agency (NPSA) on effective hand hygiene.
- The trust training matrix showed staff had completed infection control training as part of their mandatory training. Staff commented that the infection-control training they had attended was hospital-focused and did not provide information for clinical staff working in patients' own homes.
- Specialist infection control nurses were located within the acute hospital and could provide support to staff based within the community services, although we were not shown evidence to demonstrate this had taken place.
- During our visits to community bases, we saw plentiful supplies of personal protective equipment (PPE) were available. For example, gloves, aprons and antibacterial hand-sanitising gel. We observed care being delivered to patients in their own homes and in clinics and saw the majority of staff washed and applied hand-sanitising gel to their hands regularly and between encounters with patients. However, some areas did not follow this practice and while delivering care in patients' homes only applied hand-sanitising gel to their hands and did not wash them. We were told this was because of the risk of infection from the patients' towels and environment. The infection control policy and procedure did not provide specific information for staff working within patients' own homes, but did state that hands should be washed with soap and water after several consecutive applications of alcohol hand-sanitising gel.
- Once a month, a hand-hygiene audit was carried out and staff were required to do joint visits to patients' homes to observe each other and complete the audit. The data from the hand-hygiene audits showed staff complied with the trust policy and procedure.

Maintenance of environment and equipment

- Staff had access to some equipment through a loan store in order to meet patients' needs. Therapy staff also operated an equipment prescription service, which enabled patients to present their prescription to local suppliers and obtain their required equipment. This service was generally viewed positively by patients and staff who considered it effective in obtaining equipment promptly. Patients and staff expressed concern that there was no system in operation for the equipment to be returned and reused if and when patients no longer needed it. This had caused problems for some patients in disposing of the equipment and comments were made regarding the cost of this. Some areas had experienced incorrect equipment being supplied or fitted incorrectly, which led to the therapists needing to revisit patients to sort out issues. The trust informed us that the responsibility for the operation of the loans store lay with an external provider.
- Therapists and community nursing staff had access to local stores of equipment and were able to deliver equipment to patients promptly. For example, commodes, or a walking frame.

Good

Are services safe?

- Community nursing staff told us they had access to specific equipment in order to meet the needs of some patients. For example, syringe drivers. Syringe drivers are used to slowly and continually administer medication to patients, subcutaneously and over a 24-hour period.
- Systems were in place to ensure equipment was serviced and maintained, as required. Staff were also positive regarding the repair of broken equipment.
- Therapy staff who were part of the complex care team told us that, in some cases, equipment that had been ordered through the loan store could not be obtained quickly enough to meet the patients' needs. The trust informed us that the responsibility for the operation of the loans store lay with an external provider.

Medicines

- There was a medication policy in place. Staff raised concerns that the medication policy and procedure had been amended to reflect that band 3 healthcare assistants were not permitted to administer medication. There had been concerns raised about the clarity of the new procedure when they were required to visit patients who suffered with dementia who were not able to respond to prompting about whether or not they had taken their medicines. The trust informed us that the policy amendment was in line with national guidance. However, this did not ensure that patients visited by band 3 staff who needed more support than prompting were enabled to take their medication.
- The Rapid Response teams were staffed by support workers who had been provided with administration of medicines training. Concerns were raised that there were no standard operating procedures for administration of medicines to patients who were receiving care and treatment by these teams. While this issue was being addressed, community nurses were required to administer any medications.
- Medication records were held in the patients' homes to support staff when they were required to administer medicines. These identified the medication, dose and time of administration required.
- Emergency bags, known as 'just in case' bags, were provided to patients who were nearing the need for end of life care by primary care teams, for example their GP. The bags contained a limited amount of emergency medication, which could be administered by community nurses in line with strict protocols, prior to obtaining a prescription and required medication. Some concerns had been raised about the use of these bags, with examples given when the wrong medication for the patient had been contained in the bag and that a bag had been provided to a patient who was not nearing the end of their life. The concerns had been raised via the electronic reporting system and escalated.
- Drug errors, including missed doses or administration of incorrect medicines or dose, were reported through the electronic system and investigated.

Safeguarding

- Systems were in place for reporting any safeguarding concerns. The trust had a clear safeguarding policy and procedure that identified the action staff were to take should there be a safeguarding concern in their area.
- There was a named lead person for safeguarding within the trust, but not all staff were aware of who this was or where they were based should they require further assistance. Other staff were able to inform us the safeguarding lead provided information in the regular community nursing bulletin that was distributed by email.
- Staff were clear regarding the process they would follow and provided examples of previous safeguarding alerts, which had been raised by them and the action that had been taken following the alert.
- During a visit to a patient in their home, we observed a safeguarding issue was reported to the member of staff by the patient's family carer. The staff member reported the issue appropriately and promptly, in line with the trust safeguarding procedures.
- All of the staff we spoke with said they felt supported by their immediate line managers regarding safeguarding issues and that they had received feedback and information regarding any safeguarding concerns they had reported.
- The trust provided staff with safeguarding training at different levels, which was appropriate to their role. Training matrices for the teams we visited showed this training was up to date.
- Three safeguarding nurses were appointed by the trust to work with the lead agency for investigating safeguarding alerts – Devon County Council. The purpose for this was to ensure safeguarding concerns that required investigation by the trust could be carried

out in a timely manner, without taking community nurses away from their clinical hours with patients. A detailed report had been prepared regarding the effectiveness of this newly-developed service.

Records

- Paper patients' records were held either by the patient in their own home, or stored securely in the office bases of community staff. Electronic records were also maintained by staff. Staff raised concerns regarding the IT systems in place. Hand-held devices were used to record visits, but there had been difficulties with uploading and downloading information to the hand-held device. Staff confirmed these issues were improving. Therapy staff identified that poor IT connectivity was a barrier to effectiveness of contemporaneous recording as, often, the staff were not able to get online promptly. We were given examples of where it could take up to 20 minutes to connect and staff said they sometimes did not have time to wait that long and would, therefore, have to 'catch up' with their recording at a later time.
- All staff completed records to demonstrate the care they had delivered to patients. We saw that these were clear, concise, dated and signed.
- Care plans were in place to direct and inform staff of the actions they were required to take in order to meet patients' assessed care needs.
- Records showed improvements in the patients' condition, where appropriate. For example, when treating wounds. We saw that community nurses mapped wounds by the use of diagrams, measurements and photographs.
- We reviewed documentation, which showed community nurse and therapy team leaders audited the standard of completion of care documentation for a set number of patients each month. Action was taken by the team leaders to ensure improvements were made. We saw audits, which some team leaders had completed and showed that records were completed well.
- Where the multidisciplinary teams were co-located, we were told accessing each other's records was not an issue. However, other teams told us there was no system for reviewing records maintained by other professionals, which, at times, did not ensure continuity of care for the patient. For example, the therapy notes were not always left in the patients' homes, but returned to the office for safe storage. This meant that other professionals visiting the patient did not have access to the multidisciplinary notes.

Lone and remote working

- A clear policy and procedure regarding lone working was in place to reduce the risk to lone workers.
- Staff teams used buddy systems to ensure colleagues were aware of the whereabouts of staff.
- Community nurse teams met at lunchtime each day to review their work. We observed concern was shown for one worker who had not returned from their morning visit. A telephone call was made to ensure the safety and wellbeing of this member of staff.
- The out-of-hours community nursing teams worked in twos whenever staffing levels enabled this. During our visit to the out-of-hours community team based in Exeter, we saw attention was paid to the whereabouts of their colleagues and the two teams telephoned each other following visits.
- One staff member described to us an incident where their safety had been compromised when lone working. They were positive regarding the support the trust had provided and the systems that had been put into place to reduce the risk to themselves and other staff in the future.
- On-call managers were on duty in each area and staff were aware of whom and where to telephone, should assistance be required.
- Staff were compromised when lone working by the poor mobile telephone signals in some areas. Although the trust provided mobile telephones for use when working, staff across the region told us there were many "black spots" where they would not be able to use the phone successfully.

Adaptation of safety systems for care in different settings

- The infection-control policy and procedure did not provide specific information for staff working within patients' own homes and staff also told us the infection-control training was more appropriate to the hospital setting than the community. Staff had developed systems to ensure colleagues were safe when lone

working. As described above, there were buddy systems in operation that ensured another team member knew the whereabouts of their colleagues and the expected time of return from visits.
- The lone-working policy and procedure supported staff working in the community.
- It was not consistent that risks relating to the environment of the patient were recorded. We saw one member of staff had experienced a problem with a patient's dog, which had not been recorded in the individual's risk assessment.

Assessing and responding to patient risk

- Each community nursing team held a patient handover each day. In some areas, a pilot was taking place with these handovers, known as the 'patient safety handover'. This ensured all members of the team were aware of vulnerable patients, or those with complex care needs. Additional visits were planned, and referrals made, to other members of the multidisciplinary team as necessary. The safety handovers were recorded on a specific template, which identified any determined actions, who was responsible for the completion of the action and the date by which it was agreed to be completed.
- Information regarding vulnerable patients was highlighted through the electronic system used by the trust and downloaded onto each staff member's electronic tablets.
- Individual risk assessments were in place for patients and identified the risk of falls, pressure damage, mobility and nutritional risks.

Staffing levels and caseload

- Staff we spoke with told us there were generally sufficient staff and the skills mix was appropriate to enable them to manage their workloads. However, some community nursing teams had vacancies due to maternity and sick leave. Where managers considered the staffing levels to be a risk to patient care due to vacancies, an entry was made on the risk register. The caseloads of community nursing teams had been reviewed in some areas and an assessment carried out of the caseload had led to increased staffing hours.
- Teams had access to bank staff to provide additional staffing cover. We were told the bank staff used were regular staff who knew the areas well.
- Recruitment for new staff took place each month at the headquarters of the trust and, if successful, applicants were matched to a team that had a vacancy, providing they had sufficient skills for the job. For example, the manager of the out-of-hours nursing team was able to ring one successful applicant to discuss a vacancy they had in the out-of-hours team, working at night.
- Staff of all grades and across all areas raised concerns about the length of time the recruitment process took to complete. Examples were given regarding delays in filling posts as a result.
- The trust used an electronic system with hand-held tablets that provided information regarding workload activity increases. For example, long visits and visits requiring two members of staff for people with complex care were monitored.
- The community nursing teams worked over seven days a week with the day staff working from 8.30am to 5pm and the Eastern out-of-hours teams providing cover from 2.30pm until 8am. The Northern out of hours nursing service worked from 5pm – 10.30pm for the evening shift and 10pm – 8am for the overnight service.
- The Okehampton community nursing team were taking part in a pilot for an electronic rostering system, which was set up to ensure an even number of staff throughout the year. The aim of this was to negate the risk of lower staffing levels during the peak holiday periods. The results of this pilot were not complete at the time of our inspection.
- The role of the complex care teams had been developed and had incorporated a Rapid Response service. This aimed to respond within a short time frame, to patients who needed urgent assistance to enable people stay in their own homes when unnecessary admission to hospital or long term care could be avoided. Therapy staff informed us this service was provided in addition to their previous workload and, at times, they felt pressured to complete all visits.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- However, staff completed Deprivation of Liberty Safeguards training as it was part of the safeguarding training for clinical staff.
- Consent was sought by staff prior to the provision of care and treatment. Therapists obtained written consent prior to using acupuncture and we evidenced completed consent forms in patient notes.

Good

Are services safe?

- The mental capacity of patients was considered prior to delivering care and treatment. Staff demonstrated a good understanding and gave examples of when and why mental capacity assessments had been conducted and how the choices made by patients with capacity were respected.

Managing anticipated risks

- Risk assessments were completed for individual patients and detailed the action to be taken to protect the patients and staff. We saw risk assessments that related to identified risks from pets, volatile home situations and environments. We were given an example of an occasion where a member of the community staff did not risk assess prior to their visit and suffered a dog bite in the patient's home.
- Team risk assessments were completed by managers. For example, we saw the Exeter East and Mid District teams had developed a risk assessment that provided information on identified risks that had yet to be addressed. These detailed the actions to be taken, who was responsible for the action and a timescale.
- Where necessary, risks were escalated and included on the trust risk register. We were told that some concerns, for example, unsatisfactory office space, had been on the trust risk register for long periods of time. Staff were not clear how these issues were being addressed, or when the risk would be reduced.

Major incident awareness and training

- The trust had major incident plans, policies and procedures in place. Staff who worked in the community were aware that these were in place, but stated that these measures did not apply to them. Staff informed us of the action taken in the inclement and wet weather during the winter and how visits to patients in the community were carried out, despite the widespread flooding.
- When there was a widespread issue that affected a number of teams, such as poor weather, staff told us the teams communicated well to ensure that staff and patients were safe and priority patients were unaffected.

Good

Are Community Health Services for Adults effective?

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

Summary

The community services for adults were meeting the assessed care needs of patients through evidence-based practice and by ensuring staff were trained and competent within their roles.

There was good evidence, which demonstrated multidisciplinary team working was effective and initiatives were in place to support people at home and within community-based clinics.

Quality monitoring of the services provided took place and audits showed an effective service was provided to patients.

Multidisciplinary team working was excellent in many areas and this benefited patients, who were receiving an effective care service.

Evidence based care and treatment

- Care and treatment was evidence-based and staff accessed up-to-date information regarding good practice recommendations.
- The therapy staff had been provided with guidance on reducing and managing falls. This guidance was based on national guidelines.
- Therapy staff attended a rehabilitation clinical interest group. Best practice issues were discussed and disseminated to the staff teams from this group.
- The trust updated staff with practice guidelines on its intranet and through the monthly trust newsletter.
- The Rowan Unit Day Centre, for people with dementia, was run in concordance with the NHS 2014 National Dementia Strategy for England.

Pain relief

- The trust had taken part in a national bereavement survey (VOICES). This had been conducted by the Department of Health and assessed the quality of care delivered in the last three months of patients' lives. The results from the combined 2011 and 2012 survey showed the trust was in the middle 60% of local area teams for providing complete relief of pain.
- Staff were aware of the need for some patients to receive pain relief prior to treatment, for example, before wound-dressing changes. We observed this was discussed with patients during the visit.

Nutrition and hydration

- Care plans were in place to support patients with their nutrition and hydration, when necessary.
- A nationally recognised malnutrition universal screening tool (MUST) was used for patients considered to be at risk of malnutrition and weekly weights were taken. Appropriate referrals were made as a result of these assessments and care plans reflected additional support needed by individual patients.
- During our inspection, the weather was very hot. We observed that community nurses reminded patients of the need to take additional fluids in order to keep hydrated. We saw that one community nurse expressed concern that their patient had not drunk their morning cup of tea as it was cold. The nurse made them another cup during their visit.

Patient outcomes

- The national bereavement survey (VOICES) identified that the trust was in the top 20% of local teams for providing excellent quality of care to patients in their last three months of life at home.
- Patients who received care from community nurses were asked to complete quality surveys regarding their view of the service received. These surveys were audited and staff informed of the outcomes of the audits. We spoke to 76 patients and/or their relatives throughout the inspection. Positive comments were received regarding the service they were provided with.
- The Mid Devon Rapid Response team commissioned Age UK to undertake an independent quality survey of 22 patients who had used, or were using, the service in May 2013. The subsequent published report of the outcome of the survey showed a high standard of care had been provided to patients who had expressed satisfaction with the service.

Good

Are Community Health Services for Adults effective?

Performance information

- The community rehabilitation teams requested feedback in the form of quality questionnaires from patients. The findings from recent questionnaires found the service to be of high quality and appreciated by patients.

Competent staff

- Trust policy required all staff to receive an annual appraisal and regular supervision. The trust integrated performance report for April 2014 showed a decrease in compliance with staff appraisals for the first time in six months. Staff and managers we spoke with in the community teams were able to demonstrate that appraisals were up to date, or that dates had been booked for staff to attend in order to complete the process.
- Clinical supervision was provided by professional leads for therapy and nursing staff. Evidence we were shown demonstrated supervision pathways were still being developed in some areas.
- Supervision and appraisal systems were embedded within the therapy teams and occurred regularly. Community nursing staff comments varied from area to area, with not all staff having experienced regular formal supervision with their line manager. Records showed their appraisals were up to date.
- New staff were provided with an induction training programme and were linked to a named mentor to support them in their new role. Newly qualified nurses were linked to a preceptorship programme to develop their skills and competencies.
- Trained community nurses provided mentoring to healthcare assistants to help them develop their skills and competencies.
- A programme of mandatory training was in place and staff completed training modules electronically or face to face. Training matrices were held electronically and showed staff were up to date with their training. Where gaps in training were identified, staff had been informed and managers were aware of the need to follow up the training.
- Staff reported that a lot of the face-to-face training was delivered at the acute hospital in Barnstaple, which made attendance problematic, due to the travelling distance for many teams. One example we were given was regarding Hospital at Home staff waiting for locally-based training for administering intravenous infusions.
- Concerns were raised regarding the reliance on e-learning in some areas. For example, healthcare assistants in the Rapid Response teams were required to provide care to patients with complex needs. It was voiced that the e-learning training did not prepare, or support, them to provide this high risk and complex care at times.
- We heard conflicting information from community nurses regarding tissue viability and wound-care training. Some teams were satisfied with the support and training they received, while in other areas the staff had not had access to such training.
- Community nurses at band 6 were able to apply for the community nurse training programme accredited with Plymouth University. Staff were positive about this training and confirmed they were encouraged to apply for it by their managers. One member of staff said they were well supported in their new band 6 role with the theory provided on the course.
- Dementia care training had been provided to all staff and also there was additional support within the community from the community matron specialising in dementia care.
- Nursing staff made positive comments about the patient handovers which took place each day. We were told these not only ensured a high standard of care was provided to individual patients, but provided learning and support for the staff.

Use of equipment and facilities

- Community nursing teams operated from offices at community hospitals and GP surgeries.
- The office allocated to the out-of-hours community nursing service at Exeter Community Hospital was small, had no natural light or ventilation. The office space provided desk space for two people and storage for notes and some equipment. We were told the team were allocated this office as a temporary measure in December 2013. On the day we visited, there were three members of staff on duty and the room was very hot. Other office space had been allocated to the team, but alterations had not been made to enable these offices to be used.

Good

Are Community Health Services for Adults effective?

- The community nursing team at Okehampton Community Hospital shared an office with administration and Hospice staff. This office was crowded and did not provide sufficient space for the members of the team to work in at any one time. There was no provision for confidential telephone calls or meetings. Temperatures in the room had been taken and deemed too high for staff to work in safely. Action was being taken by the trust to improve this, but the staff had not received clear feedback on how it would be resolved, or when.
- A second community nursing team were based at a nearby GP surgery in Okehampton. This team did not have their own dedicated office and, at times, were unable to meet. For example, for the safety handover, if the GP practice were using the room for other purposes. The team did not have a dedicated telephone number and all calls came through staff mobile telephones. Staff told us patients had complained they could not get hold of the service when they had needed to.

Telemedicine

- Telemedicine was not in use in the service.

Multi-disciplinary working and working with others

- In some community teams, the multidisciplinary team were co-located. In all of these areas, staff were positive about how well the multidisciplinary team worked together and how this benefited the patients. Where teams were not located in the same environment, staff reported there was a fragmentation of services and that it took time, which was sometimes not readily available, to contact other members of the multidisciplinary teams.
- Staff were positive in their comments about the out-of-hours community nursing team. However, several staff across the teams considered it would be beneficial for there to be a formal handover between the teams. The out-of-hours night staff finished their shift at 8am, but the day community nursing staff did not start until 8.30am. We were also informed that the evening out-of-hours staff finished work at 10.30pm, which was also the time the night staff started their shift. Messages could be left with Devon Doctors to be passed on to oncoming shifts, but staff would have appreciated a more formal handover with their colleagues.
- We observed multidisciplinary team meetings regarding a 'virtual ward' held by the complex care teams in four areas – Bideford, Tiverton, Okehampton and Ottery St Mary. These were attended by a combination of health and social care professionals, including a consultant geriatrician, community matrons, community nurses, community psychiatric nurses, therapy staff from complex care, rehabilitation and Rapid Response teams, social workers, hospice workers, voluntary sector workers and GPs. The meeting reviewed patients with complex care and support needs with a purpose of ensuring their care needs were met at home, on discharge from hospital or if they required a hospital admission.

Co-ordinated integrated care pathways

- Staff demonstrated a good understanding of the referral procedures and pathways for both internal and external health professionals.
- Multidisciplinary teams worked well together, particularly where they were co-located and we were told this was beneficial for expediency, allowing patients to receive services from other professionals as quickly as possible.
- The electronic system in use in the community enabled staff to review the support being provided to the patient and liaise with the appropriate professional regarding their care.
- Community nurses raised concerns regarding poor referrals from other providers of healthcare. For example, when patients were discharged from hospital. On some occasions, this had led to patients not receiving prompt treatment. Staff raised these issues through the trust electronic reporting system and were aware that their managers had followed the concerns up to improve working practices in the future.

Good

Are Community Health Services for Adults caring?

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

Summary

We found the care delivered by staff was kind and caring. We observed that all staff treated patients with dignity and respect. Staff demonstrated an empathy and understanding of their patients.

Patients were included in the planning and delivery of their care and told us they were able to ask questions and always received information about their care and treatment needs.

Patients made positive comments about their care, with many saying they could not think of any way in which the service they received could improve.

Compassionate care

- Staff were committed to providing a high quality service to patients and demonstrated, through our discussions and observations, that the patients were at the forefront of each visit and service.
- We spent time with nursing and therapy staff visiting patients in their own homes and observing the care provided to them when attending clinics in local hospitals. We saw that staff consistently treated people with kindness and compassion and showed empathy and understanding to them.
- Feedback we had from patients was positive and all said they received a caring and good service. Specific comments made included: “They are wonderful and very friendly,” and, “The care I receive is excellent, I cannot fault it and [they] are so supportive to me,” as well as, “They do more than expected. I ran out of equipment last week and they were insistent that they would drop off more for me, which they did.”
- Patients we spoke with were all positive about the service provided to them. Comments made included, “They always take time to talk to me, and give as much time as I need,” and, “If I am unwell, I can contact them and they will always come and help.”

Dignity and respect

- Training was provided by the trust for staff on providing patients with dignity and respect. Therapy staff we spoke with confirmed they had attended this training.
- We spent time with nursing and therapy staff visiting patients in their own home and observing the care provided to them when attending clinics in local hospitals. We saw staff consistently treated people with respect and promoted their dignity at all times.
- The trust had taken part in a national bereavement survey. This had been conducted by the Department of Health and assessed the quality of care delivered in the last three months of patients’ lives. The results from the combined 2011 and 2012 survey showed the trust was in the middle 60% of local area teams for always showing respect and dignity to patients.

Patient understanding and involvement

- Care plan documentation identified that patients and/or their families had been involved in the planning of their care.
- Therapy and nursing staff and patients we spoke with confirmed patients were involved in their care planning and were enabled to make informed choices.
- During our visits with staff to patients in their own homes, we saw the staff discussed the planned care and treatment with patients and information given to ensure their understanding.
- Education regarding their condition, impact and treatment was provided to patients in therapy-led outpatient clinics.
- When it was the wish of the patient, relatives and representatives were involved in the planning and delivery of their care. We observed a community nurse explaining fully to a patient’s relative the wound care being provided. We saw therapy staff demonstrating to a relative the support they would need to give with the planned exercise programme, when at home.

Emotional support

- During our visits to patients in their own home, we observed staff discussed wellbeing issues with patients and their relatives.
- Referrals to external organisations were made when necessary. For example, to the Age UK befriending service. Staff were observed to follow-up such referrals and ensure the patient had been satisfied with the service.

Good

Are Community Health Services for Adults caring?

- We observed that staff took the time to listen to patients and provided advice and support during visits. If they were unable to provide help regarding a specific issue, advice was given as to who they would contact.
- Patients told us the community nurses who visited them provided emotional support to them and to their families. Specific comments included: "The care I receive is excellent, very caring and understanding. They care about my wife too and always ask how we are coping and support her as my main carer," and, "They always look at all of my needs and have helped with different things while they have been coming."

Promotion of self-care

- The Exeter Community Nursing Centre had recently been set up in and was located in the Exeter Community Hospital. This was staffed by community nurses who had been seconded to the role for a period of time. Patients who had previously been seen at home by the community nurses attended the clinic. This enabled them to book an appointment at a time convenient to them and reduced the need for them to wait for a visit from the community nurses. Patients we spoke with at the clinic expressed their satisfaction with this service. Comments made included: "I like an early appointment and can then get on with my day," and, "Wonderful staff and doing an excellent job with my leg."
- We observed community staff visiting patients in their own homes. We consistently saw staff encourage patients to be part of their care and to carry out aspects of the care themselves. This was achieved in a caring and encouraging manner.
- The Rapid Response and reablement teams had an ethos of encouraging patients and promoting independence. This ethos was discussed at supervisions and team meetings, as evidenced in minutes from those meetings.

Good

Are Community Health Services for Adults responsive to people's needs?

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

Summary

Community services were responsive and flexible in order to meet the assessed care needs of individuals. The care delivered was person-centred, holistic and carried out in convenient locations for patients, whenever possible.

Patients who required the support of other healthcare professionals were referred by the community staff. Some delays were reported for some specialist services. An example given was for continence services. Other specialist nurses visited patients in their own homes or community clinics promptly. For example, the tissue-viability nurses.

Rapid intervention teams across the county responded to referrals for patients who experienced a health or social care need, but did not require hospital admission, or for whom rapid care and treatment could prevent a hospital admission.

Service planning and delivery to meet the needs of different people

- Community leads advised that there were specialist services working within the community, providing access to services across area. Specialist services included sexual health and sexual assault services – located in an industrial estate Exeter, to be inconspicuous to patients who required this service. There were also specialist services for bladder and bowel care and podiatry.
- Information gathered from the trust board meetings identified the staffing skills mix and establishment of specialist areas fell short of guidelines for the rehabilitation stroke services within community settings. This was considered to be partially because of the enhanced roles of Allied Healthcare professionals in these services, which were not included within the nursing skills mix and establishment.
- The Rowan Unit Day Centre, for people who required dementia care and support, had been developed in Ottery St Mary, which provided an outstanding service to patients and a support network for their carers.

Access to care as close to home as possible

- Outpatient clinics were run in community hospitals across the area and patients were able to choose where they attended for their appointment. Patients told us the system for booking appointments was flexible and they had received an appointment that was suitable for them.
- Some specialist services, such as continence services, were not provided locally and this caused problems for patients when it came to accessing this treatment, due to the logistics.
- The complex care teams provided care and treatment to patients in their own homes to prevent further admissions to community or acute hospitals.
- The complex care teams supported patients to be discharged back into the community at the earliest opportunity from acute hospitals.
- A national NHS Leadership Recognition Award had been presented to the Assistant Director of Health and Social Care, following work carried out with the community teams in developing projects to help people get the health and social care they needed closer to their homes.

Access to the right care at the right time

- Community staff reported delays in referrals to some specialist services, such as for continence problems.
- A single point of access was available for patients who experienced a health or social care need, but who did not require hospital admission, or for whom rapid care and treatment could prevent a hospital admission. The rapid intervention team assessed the complexity of new referrals and triaged the patient to the appropriate staffing team.
- Therapy staff raised concerns regarding the move towards patients staying in their own homes, as opposed to being in hospital and their ability to rehabilitate people in their own homes effectively. This had been raised with the trust by staff within a written document and was being reviewed by the cluster manager and senior therapy staff. There were some areas of concern regarding the remit of the Rapid Response teams, which were being looked at by the cluster manager.

Good

Are Community Health Services for Adults responsive to people's needs?

Flexible community services

- Awareness of pressure ulcer prevention had been heightened following previous incidents and the trust had developed the community nurses role to provide guidance and training to care homes.
- Community nurses worked within teams. We received mixed views on how the teams worked together, with some staff commenting that the teams supported each other. In other areas, there appeared to be less flexibility regarding cross-team working.
- Patients who attended the Exeter Community Nursing Centre were able to request a visit from the community nurses if they were unwell and not able to attend the clinic. This ensured they received their treatment at the correct time.

Meeting the needs of individuals

- Support from tissue-viability specialist nurses was available to all community teams through the acute trust. Referrals were made to the tissue-viability nurses and supporting information provided electronically, such as photographs of patients' wounds, to enable the tissue-viability specialists to triage effectively.
- A community dementia care matron was in post and provided care to people with dementia living in their own homes. Staff were able to refer patients to the matron and also received support and guidance from her when necessary. All staff had attended dementia training, which was delivered by an external provider over half a day.
- Outpatient 'balance' clinics were seen as being very successful in reducing falls for patients who had been assessed as being at risk from falling.
- Patients told us they did not always know when the community nurses were coming to see them, but could arrange a specific time if needed. For example, if they had an appointment to keep. Patients did not raise the visit times as a concern and we were told they usually knew if their visit was to be in the morning or the afternoon. If the staff were going to be late they often rang to inform the patient.
- Patients were provided with a leaflet regarding the code of conduct for staff and patients. This set out clearly the relationships and behaviours expected when they were visited in their own homes.
- A detailed information pack was given to patients who were cared for by the community rehabilitation team in South Molton.

Moving between services

- We found patient referrals between community services were managed in a timely way, with good communication between the staff involved. In one area, we observed a joint visit with an occupational therapist and a physiotherapist that saved the patient having to repeat information.
- Staff discussed patients with other members of the multidisciplinary team prior to visiting them to ensure they were fully aware of the patients' conditions and situations.
- Previously in the trust, patients had experienced lengthy waiting time targets for diagnostic tests, for example, ultrasound scan procedures. However, since February 2014, targets had been met. Data showed the number of patients whose transfer of care had been delayed was higher than that of other local trusts.

Complaints handling (for this service) and learning from feedback

- There was a policy and procedure in place to ensure staff were aware of the processes in place to inform patients who wished to complain.
- Complaints leaflets were provided to patients and detailed the action they should take if they needed to complain.
- Complaints were referred to the managers of services and investigated appropriately. We saw records relating to complaint investigations and written responses that had been provided to patients.

The community nursing teams had received a small number of complaints and evidence was provided to show the action taken and response that had been made to the complainant.

Good

Are Community Health Services for Adults well-led?

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

Summary

Services were well-led by team leaders, team managers and area (cluster) managers. The trust vision and values were present throughout the community services, although some staff were not clear about these when asked.

Risk registers were held at trust-level and managers were aware of the risks identified in their teams and the action being taken to address the issues.

Vision and strategy for this service

- Staff awareness of the trust vision and strategy was mixed, but many staff commented they believed that the trust put patients first and at the centre of all care.
- Information was provided to staff on the Health and Social Care division's values in a newsletter and was also displayed in staff offices.

Guidance, risk management and quality measurement

- The trust provided a quality account for the period 2013/2014, which identified priority areas for community services. We saw, throughout our inspection, community staff and services were aware of these areas and action was being taken to address the issues. For example, to reduce the number of pressure sores and to improve services for patients who required dementia care and treatment.
- The trust maintained and managed an intelligence matrix, which highlighted issues and concerns. We saw that issues noted on a safety walk-round within teams had been raised, and action taken, to reduce the risk.
- Risks and concerns had been identified regarding IT connectivity issues. These were being reviewed and action was ongoing to improve the service.
- New services commissioned by the trust, for example, the Community Nursing Centre, were detailed in standard operating procedures (SOP), which provided detailed and clear guidance on how the service was to function. This ensured services operated to a high quality, within trust policy and procedure and negated potential risks to patients.

Leadership of this service

- Staff were generally positive about the local management support to them. They said their managers were approachable and felt able to raise concerns or issues directly to them. However, staff did raise concerns regarding the job roles of their immediate line manager and felt there was insufficient time allocated to them for management, as they also had clinical responsibilities.
- It was not as clear to staff who the trust board members were, or how they were able to raise issues with them. Some staff were aware that there had been visits to their areas from board members, while others were not. Positive comments were made from staff who had been present at a recent visit to their office from a board member who had carried out a 'patient safety check' on their team. This had been a positive experience with immediate verbal feedback given to the staff.
- A business plan had been submitted to the board, which identified the need for senior community nurses to work at the weekends as currently there was no senior nurse on duty to support staff and patients when required. This proposal had not been approved at the time of our inspection.
- In some areas, staff reported to a manager who was at the same band-level as themselves. They felt this could be difficult on occasion and gave examples of when they had raised issues with a senior manager as opposed to their line manager.
- Staff informed us of changes in the delivery of services and operational policies, which had taken place. For instance, we were told the policy regarding sickness absence had been changed and now staff felt under pressure, under the new policy, to attend work when they were not fit to do so. One community team had raised issues to their line manager, but the team appeared to feel powerless and said their morale was low.

Good

Are Community Health Services for Adults well-led?

- The community areas were separated into clusters, with a cluster manager responsible for three areas. Positive comments were made regarding the current cluster managers and staff commented they received more support now than in previous months.
- Information sharing from the trust board took place across areas in a variety of ways. Staff received electronic newsletters and emails and information was seen displayed on notice boards. Emails contained information from specialist nurses and managers regarding changes in practice or treatment.
- Team meetings were regularly held by team leaders and managers. The minutes of these meetings were available and showed that consideration had been given to trust-wide issues and changes, in addition to localised information. For example, the training needs of the team.
- The trust had recently joined the national Community Nursing Network and staff were part of the south-west community nursing network.
- Community staff we spoke with raised concerns to us regarding the payment for their mileage while on duty. In line with the national agenda, a change had recently been made to the system of payment in that after 3,500 business miles the amount paid per mile was to be considerably decreased. This caused concern amongst staff, particularly those working in rural areas where they were liable to exceed the mileage limit. Staff were concerned this would have financial implications for them and that people would leave their jobs. The perception of the staff was that the implications from this had not been considered fully.
- The 2013 staff survey identified that the trust scored higher than the national average for the support staff received from their immediate line managers. However, the trust scored lower than the national average on the percentage of staff reporting good communication between senior management and the staff.

Culture within this service

- Staff we spoke with told us they were able to raise issues or concerns to their immediate line managers, when necessary.
- Team meetings were held in all areas and we were provided with minutes from various team meetings, which showed staff were able to raise issues and that these were discussed and action taken to address the issue.
- Concerns had been raised to senior managers by community therapy staff who were based at Okehampton Community Hospital several months before our inspection, regarding the care that had been provided to some patients in their own homes. Staff were anxious that they had not received feedback from the written report they had submitted. The newly-appointed cluster manager was made aware of this situation during our inspection and took immediate steps to address the issues and feedback was given to both staff and the CQC.
- A positive culture was encouraged within the trust, with celebration events held to promote and highlight working practices of a number of staff. Information available showed that community staff had been recommended for awards for projects and work they had completed.

Public and staff engagement

- The trust was experiencing commissioning changes with the prospects of some areas of community services being provided by another health trust. Information had been provided to staff and the public regarding these changes by Northern Devon Healthcare NHS Trust. Patient experience surveys were conducted within the community teams and the information collated and fed back to participants and staff. The results showed a high level of satisfaction with services received by patients in April 2014.

Innovation, improvement and sustainability

- Two district nurses from the trust had been named as winners in the annual Guardian Public Services Awards initiative. This had been regarding a project that provided training and support to care homes within the Ifracombe, Braunton, Lynton and Lynmouth, Barnstaple and South Molton areas, which had helped prevent admission into community or acute hospital beds. We spoke with a community matron who had been working closely with general practitioners to enable some senior staff to have access to the electronic system GPs use for holding patients' records. This would provide continuity of treatment and care for patients.
- Since the cessation of the formal district nurse training, the trust had been proactive working in partnership with Plymouth University to provide accredited module training for community nurses. Staff were on a second

Good

Are Community Health Services for Adults well-led?

cohort, completing two accredited modules. Positive comments were made by staff regarding this training, including how this had improved their practice and competencies.

- The Hospital at Home team in Exmouth had been accepted to participate in a National Institute for Health research admission avoidance trial.
- A community nursing team had been involved in a review of pressure damage experienced by patients. This had led to a presentation for other teams and changes in practice to reduce the number of patients affected by pressure damage. Auditing of the teams' caseloads had evidenced that there had been no grade 3 or 4 pressure ulcers since November 2013.
- An initiative had been introduced by the trust to encourage staff to complete their mandatory training by linking this to their incremental pay increases. This had commenced in May 2014 and staff had been informed at team meetings and within the trust newsletter. As this was new in its inception, there were no outcomes available for review.
- Money, known as 'Section 256 funding' had been made available for community-based services provided by Northern Devon Healthcare NHS Trust and Devon County Council. The main criteria for funded schemes was that they were focused on preventing admissions to hospital, or expediting discharges for patients. The ideas for the schemes were developed and led by cluster managers and their teams by identifying the needs for their own areas. A detailed report was available regarding all the schemes and new staff teams that had been developed under Section 256 and the outcomes for patients. Examples of these, which we saw in operation during our inspection, were:
- The acute care team at Exeter.
- The community nurse-led clinic at Exeter.
- Hospital at Home services.
- Single point of access services.
- Rapid assessment at home.
- The red phone scheme.
- Home-based intensive rehabilitation and reablement teams.
- Education and support to care and nursing homes in North Devon.
- The onward care team.
- Patients and staff made positive comments regarding the success of these services. Some staff expressed uncertainty regarding the longevity of teams as they had been set up as pilot schemes.
- A new service had been developed in Exeter, led by the community rehabilitation team, which provided a multidisciplinary assessment clinic for adults with mainly neurological conditions. This reduced the number of appointments patients had to attend for their care and treatment, which was provided in a more focused and holistic way.