North Somerset Community Partnership Community Interest Company

1-293935970

Community health services for adults

Quality Report

Castlewood, PO Box 237
Tickenham Road
Clevedon
North Somerset
BS21 6FW
Tel: 01275 546800
Website: www.nscphealth.co.uk

Date of inspection visit: 29 and 30 November, 1 and 2 December, 12 and 13 December 2016
Date of publication: 31/03/2017

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)
1-310911397	Clevedon Community Hospital		
1-310911016	Castlewood		

This report describes our judgement of the quality of care provided within this core service by North Somerset Community Partnership Community Interest Company. 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 North Somerset Community Partnership Community Interest Company and these are brought together to inform our overall judgement of North Somerset Community Partnership Community Interest Company.

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated adult community health services as good because;

- Staff reported incidents and there was evidence of thorough investigation leading to learning from incidents across the organisation.
- Staff were knowledgeable about safeguarding, mental capacity assessment and deprivation of liberties safeguards legislation and obtained consent for treatment and care interventions. This was embedded in the way staff worked.
- Staff had the right qualifications to carry out their jobs, there was a robust competence assessment framework and staff were encouraged and supported to enhance their qualifications.
- There was effective multidisciplinary working across the organisation and staff had good working relationships with GP across North Somerset.
- Staff had built positive relationships with patients and their relatives/carers and treated patients with dignity, respect and compassion.
- Staff involved patients and their carer in planning and making decisions about their care and treatment.
- There was an effective governance framework with evidence of learning from incidents across the service.
- Staff felt valued and team working was strong.

However:

- Staff compliance across the four localities and in the urgent and specialist care team with some mandatory training was low.
- There was a lack of auditing compliance with assessing risks to patients such as completion of Waterlow score, malnutrition universal screening tool and falls assessments. Waterlow score is an assessment that identifies the level of risk for a patient of developing pressure sore.
- There was not a consistent approach to obtaining patients' vital signs when patients were admitted to the caseload, which meant it was difficult to judge deterioration in a patient's condition.
- The infection control risk assessment for the leg club did not identify that the area for the preparation of the trolley should be cleaned before use.
- Staff did not consistently carry out assessment of pain using a recognised pain assessment tool.
- Staff did not always assess patients' nutritional risk assessment and take appropriate actions when a risk was identified.

Summary of findings

Background to the service

Information about the service

North Somerset Community Partnership (NSCP) was established in 2011 as an employee-owned enterprise. The organisation provides NHS community healthcare to North Somerset residents. NSCP cared for 49,242 patients in 2015/16, which demonstrates an increase in demand for services, in line with an increasing and ageing population.

The community adult's teams provide care and support people in their own homes, residential and nursing homes. They also held clinics in a local community hospital, GP surgeries and a local NHS hospital.

The organisation provides 26 community based specialist healthcare services. We inspected a range of clinics across North Somerset including: community outreach, community rapid response, Intravenous (IV) service (facilitating intravenous administration of antibiotics in the community), heart failure support, lymphoedema care, phlebotomy (urgent and routine blood tests for housebound patients in the community), podiatry, specialist older person's team, diabetes, tissue viability and a bladder and bowel support and advice service.

We visited three patient groups:

- Leg club (community based care for people with leg-related problems),
- Pulmonary rehabilitation
- Parkinson's group.

We spoke with staff from allied healthcare professions including physiotherapists, occupational therapists and speech and language therapists. We met with staff from the 'single point of access', the clinical hub and we spoke with administration staff across all localities.

We inspected community nurse teams covering four geographical localities: Rural (covering Nailsea and Wrington), Gordano Valley (covering Clevedon and Portishead), Weston and Worle. The community nursing teams worked from offices placed within GP surgeries across the four localities. We visited the outpatient services at Clevedon Hospital, the admission prevention team at Weston General Hospital.We also visited Weston Town Hall and Castlewood in Clevedon, where supportive services such as the clinical hub, single point of access, rapid response and the outreach team were based.

We attended five community nurse handovers and one multidisciplinary team meeting, held in a GP surgery.

We spoke with a range of people during the inspection. These included 92 staff across different disciplines, of different skill level including both nursing and allied healthcare professionals. We looked at 28 paper-based care records and five electronic patient records. We observed care in clinics, joined community nurses on home visits and we visited three patient groups. We spoke with 51 patients and eight relatives/carers.

Before and after the inspection we looked at audit results, minutes of meetings, organisational policies, incidents, complaints and positive feedback.

Our inspection team

Our inspection team was led by:

Chair: Graham Nice, Managing Director, independent healthcare management consultancy

Team Leader: Tracey Halladay, Care Quality Commission

The team included four CQC inspectors and a variety of specialists: an advanced nursing practitioner in community nursing, a community nurses and a physiotherapist.

Summary of findings

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

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 29, 30 November and 1, 2 December 2016. Before and during the visit we held focus groups with a range of staff who worked within the service, such as nurses, administrator and therapists. We talked with people who use services. We observed how people were being cared for and reviewed care or treatment records of people who use services. We joined nurses on home visits and observed clinics; we visited patient groups and observed nursing handovers and a multidisciplinary meeting We carried out an unannounced visit on 12 and 13 December 2016.

What people who use the provider say

During the inspection, we spoke to a number of patients who had used community services. They told us:

- "Everything is great, [I'm] always seen when I need to be, great staff", "Such kind, considerate service from reception, nurses and everyone. Really do feel well looked after",
- "Excellent, wonderful staff".
- "They [the staff] always listen to what you say and treat your comments with respect".
- "I was very impressed with the excellent treatment I receive".
- "The staff were very professional and respectful. I was treated very well and made to feel welcome".
- "Staff listened very well to concerns and responded to needs appropriately".
- "Usual excellent care and service".
- "Very professional and friendly staff",
- "Very happy with the service. I did not have to wait long to be seen" and "after an initial long wait for an appointment I am now happy with the service I get".
- "Can't fault the service"
- "Care and support from the nursing team is outstanding. They are caring and considerate and I would not have got through it all without the support and dedication of those who cared for me".

We left comment cards and boxes in various locations across the service prior to our inspection. We collected 68 completed comment cards. They covered the musculoskeletal MSK (34), physiotherapy (14), podiatry (6), lymphoedema (9) services and four about the organisation in general. All but one were positive about the service they received and the staff providing those services.

Outstanding practice

The community outreach team had adopted an effective approach to reach out to people and improve their access to health care. They set up ten weekly clinics in Weston-Super-Mare for 'hard to reach' groups such as

Summary of findings

people with substance misuse, homelessness and social isolation. The service provided interventions on a range of healthy lifestyle issues such as weight management, healthy eating, and reducing substance misuse including alcohol. Between October 2015 and January 2016 the service received 103 new referrals and assisted 11 people to find accommodation.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure risk assessments are timely and review processes to monitor compliance with these.
- Ensure compliance with all audits is monitored.
- Ensure staff are able to and complete electronic patient care records contemporaneously.
- Enhance compliance with mandatory training to ensure all staff receive training in line with the organisations targets.
- Review processes for documentation audits and identify effective measures when audits demonstrate an improvement is required.
- Ensure processes to monitor patient outcomes and evaluate the effectiveness of services are in place.

Action the provider SHOULD take to improve

- Review processes to flag up when compliance with mandatory training is low.
- Ensure compliance with infection control measures including cleaning of equipment and hand hygiene.
- Ensure premises used for care and intervention are clean.
- Ensure the date patients are admitted onto the caseload is clearly stated to ensure timely risk assessments are completed in line with the organisation's policies.
- Ensure patients' vital signs are assessed and recorded when admitted to the caseload and that compliance is audited regularly.
- Review staffing capacity and acuity of caseloads across the four localities to ensure these are equitable and manageable to enable delivery of safe care and treatment.
- Review how staff use dementia screening tools, refer patients for assessment and audit compliance with screening.
- Ensure nurses who have not undertaken a prescribing course only make recommendations to a GP to change a patient's medication.
- Review how locality risk registers are managed in a timely manner to reduce risks.

North Somerset Community Partnership Community Interest Company

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

By safe, we mean people are protected from abuse and avoidable harm.

We rated the safety of community adult services as requires improvement because:

- The organisation did not have an effective process for 'flagging' up when compliance with mandatory training was low. Only half of the required staff had completed training in some subjects.
- Staff did not always identify and responded appropriately to patient risks in a timely manner.
- Staff did not consistently submit audit results about assessing risks to patients.
- Staff did not consistently carry out baseline assessment of patients' vital sign when admitted to the caseloads. This made it difficult to judge deterioration in a patient's condition.
- Staff did not complete electronic patient records as they occurred due to issues with mobile devices. This meant that in emergencies, staff would not have access to up-to-date information about patients until they arrived at the patient's home. However, the provider was aware of this risk and had plans in place to overcome the challenges.
- The infection control risk assessment for the leg club did not identify that the area for the preparation of the trolley should be cleaned before use.
- The organisation did not make best use of staffing resources across the four localities.

However,

- There was a good incident reporting culture and evidence of thorough investigation leading to learning from incidents across the organisation.
- Staff were knowledgeable about safeguarding, mental capacity assessment and deprivation of liberties safeguards which was embedded into practice.
- Maintenance and use of equipment kept patients safe.

Requires improvement

Are services safe?

Detailed findings

Safety performance

- The organisation measured safety performance and harm free care. For example, the integrated quality and performance group reviewed the monitoring of safety measure such as incidents and pressure ulcers incidents (pressure ulcers acquired on the North Somerset Community Partnership's (NSCP) caseload). From April 2016 until end of September 2016, staff had reported 82 grade two pressure ulcers, five grade three, no grade four pressure ulcers and six 'Kennedy ulcers' (a rapid onset of tissue break down in patients towards the end of life).
- We reviewed the data collected for the safety thermometer across all wards, services and settings between November 2015 and November 2016. The data demonstrated that 89% to 94% of patients received harm free care. When care was not harm free, the harm was mostly attributable to pressure ulcers. However, less than 2% of pressure ulcers developed while patients were in the care of staff from the organisation, followed by falls and catheter-associated urinary tract infections. These were less than 2% out of 4035 patients audited. However, it was not specified how many of the patients were seen by community adult services.
- The organisation had six quality priorities for 2016/17, which came from a review of incident investigations and complaints. The quality priorities were a commitment to deliver value in health and care that reflect the needs of the local population. The six quality priorities included a reduction in pressure ulcers, end of life care, raise dementia awareness, 'sign up to safety' (a commitment to prevent avoidable harm), work with voluntary organisations to reduce health and social care inequalities in hard to reach groups and improve clinical assessment and care planning. The organisation had identified strategies to achieve each of the priorities and outline how to measure the effectiveness. We looked at five of these within the community adult services. We inspected and reported on end of life care separately.

Incident reporting, learning and improvement

- There was a good incident reporting culture. Staff understood their responsibilities to raise concerns, knew how to report an incident using the electronic incident reporting system and felt supported if they reported an incident. From November 2015 to November 2016, 1,600 incidents were reported across the four localities and urgent and specialist care services. Staff shared learning during nursing handovers. Team leads discussed real life incidents and questioned staff about these scenarios to create discussion and learning. For example, leads asked staff what they should do in the case of an unexplained death occurring in a patients home.
- Staff received feedback from incidents via team meetings and received minutes of these by email to ensure everyone had access to the feedback and shared learning. We reviewed minutes of meetings across the four localities and from urgent and specialist care teams and saw examples of learning shared across the organisation. For example, staff from specialist services discussed feedback from an incident that happened in the integrated community nursing services.
- From July 2015 to June 2016, staff reported 39 serious incidents. The majority of these incidents (87%) related to the development of grade three or four pressure ulcers that patients developed while under the care of the organisation. Learning events occurred after significant incidents. These learning events ran during lunch times in order to maximise attendance. The learning events were a safe environment for staff to ask questions and learn amongst their peers with the aim of avoiding reoccurrences of negative events.
- We reviewed three investigations into incidents relating to pressure ulcers. All three had an initial report and a more in-depth investigation report in order to identify root causes of the incidents. The investigations were thorough and identified recommendations for learning and change of practice. For example, it was identified that a Waterlow assessment (an assessment that identifies the level of risk for a patient of developing a pressure sore) and a plan of care, based on pressure ulcer standard operating procedures depending on the level of risk, was not always carried out at the first visit. They had introduced a new assessment template and audits to ensure nurses carried out sufficient assessment and care planning for three months. However, after three months, the organisation concluded they had not achieved compliance and therefore extended the auditing period to ensure the practice was incorporated. This was still ongoing at the time of our inspection.
- There had been a serious incident concerned with administration of insulin to a diabetic patient. The

organisation had investigated the incident and identified action/learning to ensure a similar incident would not happen again. The recommendations included a review of processes to ensure re-allocation of daily visits were communicated to staff as well as sharing the lessons learnt. Lessons learnt included missed opportunities to record a patient's vital signs/ completion of the national early warning score (NEWS) which may have highlighted the patient's deterioration earlier. Although the competence of the nurse involved was discussed, the investigation and wider learning did not include assurance that all applicable staff were up-to-date with mandatory diabetes training. We looked at the training records and found compliance with diabetes training was between 53 % to 92% and 50% to 86% for 'safe use of insulin training' across the four localities and the urgent and specialist care team. We asked team leaders and locality leads about the low training compliance, but they were not aware of the low compliance. Staff from the training department told us there were no processes to flag up when compliance was particularly low, or below a certain threshold, to alert managers.

Duty of Candour

- Staff demonstrated awareness of Duty of Candour. Staff understood the principles of openness and knew when to apply Duty of Candour and what this involved. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This regulation requires the provider to notify the relevant person that an incident has occurred to provide reasonable support to the relevant person in relation to the incident and to offer an apology. This regulation requires staff to be open, transparent and candid with patients and relatives when things go wrong. Senior staff spoke of examples were Duty of Candour was applied. We reviewed three investigations into incidents such as the development of a grade three pressure ulcers and found it was clearly documented when the patient and/or relatives had been spoken to via the telephone and a 'Duty of Candour' letter was sent to the patient.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. The tissue viability service gave an example of when it had employed duty of candour following the deterioration of a patient. Whilst the service itself was not at fault, staff felt that different actions, had they been taken, could have resulted in a better outcome for the patient. The service wrote to the patient, and introduced new practices as a result.
- The organisation monitored compliance with application of duty of candour, when there had been a serious incident and avoidable harm was caused, in their monthly quality and performance meeting. This demonstrated a robust process to ensure duty of Candour was applied appropriately and consistently.

Safeguarding

- Systems were in place to safeguard adults from abuse. Staff understood their responsibilities and were knowledgeable about procedures for raising a safeguarding alert. We asked staff about procedures to follow, how to seek advice and found that safeguarding practices were embedded into daily practices.
- In 2015/16 community and specialist nurses raised 104 adult safeguarding concerns with the local authority. During the inspection, we observed staff in the heart failure service discuss and raise a safeguarding alert about an unsafe discharge of a patient to their home and a member of the discharge to assess (DtoA) team described how they had referred a vulnerable adult they were concerned about to social services. Community nurses discussed safeguarding issues at staff handovers and shared information. During one handover we observed concerns about the number of safeguarding alerts raised at a local care home.
- In 2015/16 there were 36 safeguarding concerns raised by staff in relation to pressure ulcers. The organisation's annual safeguarding report 2015/2016 discussed the difference between avoidable and unavoidable pressure ulcers. It stated staff were required to make a judgment, depending on the presenting history, whether neglect had been a prominent factor in the development of the pressure ulcer. If so staff should raise a safeguarding concern. However, staff were required to raise an incident using the electronic incident reporting system for all pressure ulcers. This meant there was a review of all pressure ulcers and that raising safeguarding alerts were not solely based on an individual's judgment.
- The organisation provided both children's and adult safeguarding training for all staff, which was mandatory, but at different levels depending on their role within the organisation. Staff attended a 'Think Family' training day when they commenced their employment. This training

involved training in safeguarding adults and children and was to be renewed every two years. Staff told us this training was of a high quality and supported staff in their roles and it was engaging as it was based around a family and included information about the mental capacity act (MCA) and deprivation of liberties (DOLs), safeguarding, child protection, female genital mutilation (FGM) and PREVENT (counter terrorism awareness). Adult safeguard training also included modern slavery, female genital mutilation, domestic abuse and self-neglect. Compliance with adult safeguarding training was 83% - 96% across the four localities and urgent and specialist care, against the organisation's target of 90%. Compliance with level two children's safeguarding training was 88% - 95% against a target of 90%. We enquired about compliance with level three children's safeguarding training for nurses working in the IV service as this service treated young people of the age of 16-17 years. However, the organisation informed us that since April 2016, the service no longer treat patients under the age of 18 years.

- Clinical staff told us that they regularly reported safeguarding concerns to the safeguarding lead who would inform the local authority. Staff were confident and felt supported to do so. The organisation had a safeguarding team who operated to support staff across various services. This included the opportunity for individual meetings with staff to offer advice, and debriefing as well as emotional support where needed. The service had a presence on the safeguarding adults board, which was a multi-agency board used to ensure that safeguarding arrangements across the local area were consistent and effective. Leads provided feedback from the meetings to staff via email. There was also a weekly newsletter sent from the organisation that the safeguarding leads used to advise staff of important safeguarding news. Staff commented that the safeguarding leads were approachable and visible. Staff received positive feedback from social care colleagues about the quality of the referrals they received from the service.
- There was up to date guidance on how to raise safeguarding concerns and details of support available to staff through the intranet. The safeguarding team also described a process of 'Professional Development Forum' and a 'Practice Based Learning Group', which were thematic sessions with real examples that staff could use to reflect on their knowledge and practice. The safeguarding team had also developed a neglect tool to help staff be confident when making decisions about the possibility of patient neglect. This was put into place due to feedback from staff who said they felt vulnerable in this area. Staff had access to laminated cards outlining pathways in relation to domestic abuse, self-neglect and the Mental Capacity Act. Staff also had access to University of Hull, Early Indicators of Concern in Residential and Nursing Homes (2012) to support them to be aware of organisational safeguarding as many nurses visit care homes within the area.
- The safeguarding adult's team were working to identify themes in safeguarding cases. The aim was to begin to understand the most common sources of referrals with the goal of working in a more proactive way in. The safeguarding team were developing its work with link roles. These staff provided safeguarding support within the teams in which they work with the support of the safeguarding teams. These staff met bi-monthly to network and share learning.
- Staff were knowledgeable about assessing safeguarding needs for every person in the household. For example, they would also consider the wellbeing of spouses or children when visiting patients in their home.
- The organisation worked with other agencies to provide advocacy services for patients and their carer's. These agencies included Age UK Somerset (a volunteer advocate for people over the age of 60) and AVoice (supporting victims of crime and antisocial behaviour).

Medicines

- The organisation had processes in place for managing medicines that protected people from avoidable harm. The adult community services reported four incidents related to medicines errors in the period from July 2015 to December 2015. This included a serious incident in relation to insulin management.
- Community nursing teams did not carry any medication apart from emergency medication in case a patient suffered an anaphylactic reaction. This is a severe and potential life-threatening allergic reaction that requires immediate emergency treatment intervention. Nursing staff carried anaphylactic kits and the expiry date was in range for all kits we viewed. Training in the use of these kits was expected to be renewed every year and we found that compliance was 84% to 95% against a target of 90% across the four localities and urgent and specialist care.

Requires improvement

Are services safe?

- During a tour of the outpatients department (OPD) at Clevedon Community Hospital, a drugs storage fridge was found to be unlocked. The OPD sister immediately ensured it was locked**.**
- The lymphoedema service had four independent prescribers. Nurse independent prescribers were nurses who have successfully completed an independent nurse prescribing course which allowed them to prescribe any medicine within their competency. The items they most often prescribed were lymphoedema garments and antibiotics to treat cellulitis. They used FP10 prescriptions that they gave directly to the patient. When not in use, they locked away the prescription pads. Each prescription, and its associated number was logged and scanned into the system to create an audit trail in the case of any issues or if any prescriptions could not be accounted for. The clinical and operational lead for the lymphoedema service was on the working party for the antimicrobial stewardship (a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics). The working group aimed to improve patient outcomes, reduce microbial resistance, and decrease the spread of infections caused by multidrug-resistant organisms policy which was due to be ratified just after our inspection.
- Medicine management arrangements were appropriate. We saw administration of medication records in patient's homes. These were completed comprehensively. We saw separate documentation kept for patients who received insulin. This was aimed at mitigating the risk of errors with this medication.
- We visited the heart failure service and found that nurses in the team initiated and titrated medicines based on their findings from obtaining a patient history, vital observations and electrocardiogram when needed. The organisation had a protocol, which clearly set out guidance on medicine doses and followed current evidence-based guidance.We did not see nurses prescribe outside of their remit. However there was a lack of clarity and awareness of when those nurses who had not undertaken the prescribing course could initiate and titrate patients medication. We raised this with the lead of the service who took immediate action to change practice so that nurses, who are not prescribers, would contact the patient's GP to put forward recommendations for changes in the patient's medication.
- The IV service, which administered intravenous antibiotics to patients in clinics or in patient's homes, obtained the medicines from the local acute NHS trust. If the GP referred a patient to the service, the community pharmacist would ensure the medicine was available. Nurses received training in how to deal with anaphylaxis (a severe and potential life threatening reaction) and carried emergency kits to give immediate treatment if a patient developed a severe allergic reaction. Training compliance across the four localities was 87%-95% but for the urgent and specialist care team, which provided the IV service, compliance was only 84% against a 90% target. However, we did not receive information about compliance for individual services.

Environment and equipment

- The design and use of facilities together with organisation polices and processes protected people free from avoidable harm. Clevedon Community Hospital outpatient department (OPD) was recently refurbished and was bright and visibly clean. There was a reception desk where a receptionist welcomed patients and showed them where to go for their appointments. The consulting rooms, for general outpatient use and those used by the musculoskeletal (MSK) service were all visibly clean and tidy and appropriately equipped. Consultations took place in privacy. Waiting rooms used for patients attending different clinics in GP surgeries were visibly clean, spacious and bright.
- At Clevedon Community Hospital OPD, (first floor) there was an emergency grab bag available at the reception desk along with a small oxygen cylinder. These were checked regularly to ensure they were ready for use. There was access to a full emergency trolley from the minor injury unit (MIU) on the ground floor. The room used for podiatry services at Clevedon Community Hospital was well organised, clean and tidy. However, space was limited when a wheelchair user was in the room and staff were concerned about how effectively they could evacuate the area in an emergency. The issue had been raised with managers and was detailed on the risk register.

Requires improvement

Are services safe?

- At the Marina Health Centre (DN's, lymphoedema, discharge to assess) there was an emergency grab bag available at the reception on the second floor. In an emergency, a full resuscitation trolley and medical staff from within the building were available.
- The premises used for the community nurses as their bases were large rooms fully equipped with computers and telephones. In one location, a work desk station had been adapted to the needs of an employee due to their medical needs.
- We looked at storerooms in different localities; staff were aware of stock rotation and we did not find anything that was out of date apart from at Worle Health Centre where we found ultrasound gel which was out of date. We saw some staff had allocated responsibilities for ordering stock. We found some storerooms were untidy, although there were clear signs asking for storerooms to be kept tidy. In the Rural's locality at Nailsea, staff collected out of date (but intact) dressings and similar for medical charities working in hostile or war affected countries.
- The maintenance and use of equipment kept people free from avoidable harm. Equipment was maintained and available to keep people safe. The equipment we saw was serviced and tested as required and stickers on the equipment showed the completion date. Staff checked equipment regularly. For example, blood glucose monitors were calibrated regularly in line with policy. Staff told us that if equipment was broken, it could quickly be replaced.
- 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. Staff described that equipment was easy to order and that in most instances there was a same day delivery for standard stock items.
- Staff carried dressings, dressing packs and similar in the boot of their car. While some staff had a bag specifically for the task with pockets and zips to ensure the dressing and other small equipment was kept tidy and protected from accidental contamination, other staff stored the dressings and other equipment loose in plastic carrier bags or bags not designed for the purpose. Consequently, dressings and other equipment were not protected when the car was used for private purpose and could easily fall out of the bag during transit. Staff told us that they only carried small amounts of dressings and we did not find any that was out of date. Staff were not aware of any policies or other requirements regarding how they carried the dressings or other equipment. Some nurses mentioned that a new 'car boot' audit was coming.
- We visited different locations where the organisation hosted different patient group activities or clinics. We visited the pulmonary rehabilitation group at the Hand Stadium in Clevedon, the Parkinson's group in a community centre in Portishead, the leg club in Nailsea and different clinics held in GP surgeries or the local NHS trust across the North Somerset area. Some of these locations were not purpose built, but patients liked the groups being held in their local community and not having to travel far to attend the groups or clinics.
- Staff were able to order specialist equipment such as hoists and beds which was delivered quickly and often on the same day. Allied healthcare professionals visited patients and their carers to provide training in the safe use of such specialist equipment on the day of delivery.
- There were systems and processes to ensure the safe management of waste. Staff were aware of safe segregation of clinical waste and arranged for the local council to collect clinical and infectious waste following their policy. Staff told us it was easy and quick to arrange. Staff carried clinical waste bags in their car boot to enable safe segregation of waste, but did not transport waste in their cars. When staff obtained samples such as blood tests from patients, these were transported in plastic boxes with a lid to the GP surgery where they would be sent off for testing.

Quality of records

- Patients' individual care records were not always written and managed in a manner that kept people safe. The organisation was in the process of introducing electronic care records, but was challenged to ensure continuous connectivity of mobile devices. This was on the corporate risk register and there were plans in place with actions to help overcome these challenges. However, this meant the majority of patient records were paper-based and stored in the patient's home. Some staff had laptops, but did not have access to 'mobile working'. Electronic patient records completed by community nurses, were concise and often referred to the paper-based records held in patient homes for more details. Specialist services completed patient records using the electronic system, whereas clinical

leads documented care interventions in the paper-based care records and a more comprehensive documentation was logged on the electronic patient record.

- Staff completed contemporaneous paper-based records in the patient's home; they were legible and staff signed and dated entries. However, staff completed electronic patient records when they returned to the office or the next day as when visiting patients later in the day, meant that they did not have time to return to the office to complete records. This was not compliant with the organisation's clinical documentation policy, which stated staff should complete documentation after each patient contact. This meant we were not assured that all electronic patient records were contemporaneous and up-to-date, which could be a risk to the management of patient care. If nurses were called out in the evening or overnight, the nurses would not have access to up-to-date electronic records of patient visits until they arrived at the patient's home. When services used agency nurses there was a system to allow agency nurses to log into the electronic patient records, but the detailed records were kept in patient's homes.
- When staff discharged patients from the service, staff collected the paper-based records and stored these securely in the locality offices in locked filing cabinets. If a patient was re-referred for a further or repeat care episode, staff used the same paper-based records. We reviewed 23 patient records and found that there was no clear date for the start of the care episode. It was difficult to ascertain if patient risk assessment was completed at the first visit as the organisational documentation policy prescribes
- While we saw patient records that were organised, legible, up-to-date and contained all necessary information, we also saw patient records where not all assessments were reviewed at regular intervals. For example, one patient had had a frailty risk assessment completed in February 2016. This was not reassessed during the remainder of their care, despite deterioration in their general health. Another set of records that we looked at, showed that a 91-year old patient had not had their frailty assessed using the approved assessment tool. The same patient did not have a 'National Early Warning Score' (NEWS) set of observations recorded as a baseline in the notes.
- We found an example where there was no wound management plan in place although wound care was the main reason for the visit. However, the nurse rectified this immediately with an appropriately completed care plan.
- We reviewed three patient records with a treatment escalation plan (TEP) form in place, where two of the three were not completed. Although information regarding decisions about advanced treatment was recorded in patient's notes, the boxes were not completed. The forms were stored at the front of the patient held paper records, and would help to form decisions about treatment in an emergency.
- Staff were aware of confidentiality and the need to keep documents safe. When on visits, staff were aware of minimising the amount of information taken outside the office and only carried the essential information with them. They kept this within a blue non-see through folder. However, we noticed that some nurses left their computers in their locking the screen, which meant patient information was visible on the screen for others.
- The organisation undertook documentation audits once a quarter. We reviewed the audit results for the last 12 months and found that five services had not participated at all and none of the other services or integrated care teams had submitted audit results for all four quarters. The compliant scores were between 56% and100%, which suggests significant gaps in some documentation records. Documentation was not a standard agenda item for all team meetings. It was unclear whether any actions were identified because of the audits and implemented to enhance compliance.

Cleanliness, infection control and hygiene

- The organisation had systems in place to prevent and protect people from healthcare associated infections, however, staff did not always follow procedure. The organisation's cleaning policy set out procedures to ensure clean clinical environments, but there was little reference to outpatient clinics held in GP surgeries and how it was assured that premises were clean and well maintained. We visited a clinic held in a GP surgery at New Court surgery where we noticed on a chart that the equipment was last cleaned on 16 November 2016. We observed staff using equipment without cleaning it before use and we did not observe staff clean the equipment and couch after use; this was not compliant with the organisation's policy.

Requires improvement

Are services safe?

- At a leg club (community-based treatment and advice for patients who experienced leg related health problems) staff used a disabled toilet as a preparation area for leg baths. Staff told us they did not clean the toilet area prior to preparing leg baths, although staff stated it was cleaned after use. When the premises were not being used by the leg club, it was open to the public for various other functions. Therefore the service could not be assured the facility was clean enough before using it. There was an infection control risk assessment for the leg club that included the cleaning regime. However, it did not specifically refer to the toilet area. There was no documentation to demonstrate the toilet area was cleaned prior to use. Therefore we could not be assured the facility was clean enough before using it.
- The infection prevention and control policy and procedures stated that compliance was audited through the annual infection control and prevention (ICP) audit programme. We reviewed the infection control audit dashboard 2016/2017 and found that many services did not complete ICP audits regularly. For example out of 22 localities or services, only eight had completed the audit for hand hygiene technique. At the time of our inspection, the organisation had recognised that there was not a sufficient robust audit programme in place to provide assurance that staff were compliant with infection control and prevention standards and policy.
- The organisation had a policy for infection control and prevention but not all staff followed this with regards to hand hygiene when visiting patients in their homes. We observed staff washing their hands before and after care interventions but in some cases, staff used the patients' own soap or in one incident, staff used the patient's shower gel. This was not compliant with the organisations hand hygiene policy which stated staff should use their 'own' soap. Some patients put out a clean towel for the nurse and we saw staff use kitchen paper to dry their hands.
- We looked at the hand hygiene audits from September to December 2016. The community nurses teams were on average 100% compliant except from the Gordano Valley team, which were 86% compliant. These were monthly audits but all localities had only submitted one audit result except Gordano Valley who had submitted for two out of the four months. For urgent and specialist care services compliance for submitting audits were a little better 17 services had submitted one or two audits out of four but there were three services who had not submitted any audits for the four months. This meant that there was not a robust system in place for auditing compliance with hand hygiene across the adult services.
- We observed staff use personal protective equipment such as gloves and aprons for care interventions that involved a risk of spillage or a potential infection risk. Gloves and apron were discarded in the dressings waste bag and then placed in the patient's domestic waste bin. The leg club had purchased clinical waste bins that allowed clinical waste to be transported safely, away from the venue and disposed of in clinical waste collection points. We asked staff about disposal of infectious waste and found that staff were knowledgeable about how to arrange collection with the local council.
- We observed staff adhering to aseptic techniques when carrying out dressings in patient's homes, despite the challenges the environment could pose.
- Staff adhered to the bare below elbows policy and wore clean uniforms both in clinics and when visiting patients in their homes. Staff tied their hair back and did not wear jewellery apart from smooth wedding bands.
- Storerooms were small with large amounts of equipment. Boxes were stored on the floor, which is not in line with best practice for storing materials, and meant efficient cleaning could be compromised. We did not see a display of dates when the storerooms were cleaned in all localities. In one GP surgery, where the organisation held a leg clinic, we found that dressings and other materials were stored in plastic boxes with a lid. The boxes were stored on the floor, in a small corridor leading to staff toilets, together with kneeling cushions and a stand for a doppler machine (used to assess blood flow) when this was in use. Although the room appeared clean, there was no visible record of when it had last been cleaned.
- The organisation had an infection prevention and control forum, which met quarterly. There were representatives from all localities and from the urgent and specialist care team. There was a set agenda and evidence of effective processes to identify areas of risks, learning and good practice. Where improvements were required, actions were assigned to named people and an action log stated a completion date for actions as well as a requirement that it was updated each month until actions were resolved.

Requires improvement

Are services safe?

Mandatory training

- The organisation provided training in safety systems, processes and practices. Training included basic life support, anaphylaxis, conflict resolution, dementia awareness, diabetes training, safe use of insulin, equality and diversity, fire safety, frailty, health and safety, information governance, safeguarding, mental capacity and deprivation of liberty, pain, sepsis and vital signs, infection control, and manual handling. Pressure ulcer awareness and management were also part of mandatory training for staff in line with their training matrix. Some mandatory training was carried out face-to-face while other training could be accessed via the managed learning environment (MLE). The average compliance rate across all four localities, including urgent and specialist care, was between 50% (safe use of insulin) and 95% (frailty).
- The organisation provided statutory training in infection control. We reviewed staff compliance with training which varied across the adult community services: the 'Rurals' team 94%, Gordano Valley 89%, Worle 89%, urgent and specialist care 84% and Weston integrated care team 81%. The training compliance target was 90%, which meant that five out of six teams were below the target in September 2016. However, we reviewed the annual report 2015/2016, which set out a work plan for 2016/17 recommending a statutory training compliance target of 95%. In other words, a consistent training compliance matrix was not in use.
- Staff attended manual handling training as part of the mandatory training programme provided by the organisation. The compliance was 83% to 100% and for the advanced manual handling it was 76% to 93% across for the four localities and urgent and specialist care. This was against an organisational target of 90%.
- Information governance formed part of the mandatory training and compliance was below the target of 90% with 73% to 88% of staff across the four localities and urgent and specialist care were up-to-date with training.
- We reviewed a summary of compliance for quarter two (30 September 2016) which listed all mandatory training requirements. The summary stated the organisation's target compliance for 34 different subjects. Compliance was below target for 21 subjects. Staff were given protected time to complete mandatory training and we saw two rotas that showed staff allocated to mandatory training. Compliance was discussed at appraisals and linked to annual incremental pay rise, so it is not clear why compliance varied and at times was very low.

Assessing and responding to patient risk

- Staff did not always identify and responded appropriately to patient risks. We saw records of care where not all of the required assessments such as Waterlow score (a risk assessment tool to assess a patient's risk of developing pressure ulcers), malnutrition universal screening tool (MUST a tool used to assess patient's risks of malnutrition) and frailty assessment, had been recorded. It would therefore pose a risk to those patients' care as potential risks had been missed, or not recorded. In one locality we looked at five sets of paper records and found only one of them had had all necessary assessments of patient needs and risks completed. We reviewed five electronic records and found that risk assessments were not always transferred or documented.
- We also found, that although risk assessments were completed, staff did not always document actions to mitigate the risks of pressure ulcers or malnutrition or it was not documented why the actions had not been followed through. We looked at 31 patient records (paper based and electronic) and found risk assessments were not up-to-date in 11 out of the 31 patient records.
- Community nurses in each of the four localities held a daily handover/safety briefing, which were scheduled at set times that was outside of breaks. They were timed to maximise attendance and allowed for changes in planned visits to be taken account of. Information passed over at handover was relevant and current. Risks were also discussed for both patients and staff for example, One patient that we visited had been identified as requiring two staff to complete the leg dressings. This was because the dressings took a long time and a strain on staff's backs. In order to minimise the strain and time spend bending down, it had been risk assessed as less strenuous and safer for staff to attend in pairs. At the end of the handover meeting, staff reviewed outstanding visits and new visits which had been added by the 'single point of access,' to ensure the afternoon caseload was manageable for nurses and patients had safe care interventions.

- When the late shift transferred to the night shift, we saw effective processes for handover. This allowed information to flow through the day and into the out of hours service. There was a half an hour overlap between the late and the night staff which was enough time for information to be passed shared. There were arrangements in place for night staff to pass information to day staff. This took the form of a spreadsheet containing information regarding patients seen, together with information about whether patients needed further visits. In addition, the night service left voicemails on phones in team bases with the same information. This was a safeguard to ensure information was handed over.
- The organisation introduced a training programme to recognise sepsis using a recognised early warning score. Sepsis is a highly time sensitive condition which in severe cases can be life threating. Staff from the 'rapid response' team spoke of examples of how the introduction of the national early warning scores (NEWS) had helped identify patients with sepsis and arrange for urgent admission to hospital for treatment. In 2015/ 2016, there was a national drive set by the Commissioning for Quality and Innovation (CQUIN) to train 75% of clinical staff in the community to receive training in sepsis screening. We reviewed training compliance for sepsis and reviewed audits the organisation had carried out to ensure community teams were using the sepsis tool. Compliance with sepsis training exceeded the target and was from 86% to 95% for the four localities and urgent and specialist care services. The community rapid response team used the NEWS tool in the assessment of all patients they were called out to see. However, compliance with obtaining baseline set of observations was not embedded in practice within the community nursing teams. Audits to evaluate compliance demonstrated, the NEWS chart was not completed at first visit for 34 % of new patients but compliance with taking appropriate action following NEWS calculation was 100%.
- In the Worle locality nurses used a 'trigger tool', which was a green front sheet, kept in patient's notes as a visual aide memoir to ensure timely care interventions. For example, the trigger tool reminded nurses about when next catheter change was due.
- The organisation had a pressure ulcer prevention and management policy, which outlined standards for assessing risk to patients for developing a pressure ulcer. We joined a community nurse carrying out a regular weekly visit to check the skin integrity of a patient with reduced mobility. The nurse used a visual check of all skin areas at risk of breakdown and recorded her findings on the care plan. The nurse also checked that the air mattress was working and ensured the patient was aware of who to contact if there was any changes, including problems with equipment.
- Staff were focused on improving the quality of care. The falls service had implemented a falls risk assessment tool that all staff should use to assess the risk of a patient falling. However, staff members did not always complete this form and the service did not have a system in place to monitor if this was completed. Staff from the service recognised the need to upskill all staff in the reduction of falls. The service hoped to train staff in falls reduction techniques from January 2017. The falls service provided education to local care homes in relation to falls prevention as well as advice for individual patients they visited there.
- We visited the pulmonary rehabilitation patient group and asked about emergency procedures in the event of a patient suffering a severe reaction to exercise such as a cardiac arrest. Staff brought an automated defibrillator and oxygen with mask to all sessions. The equipment was maintained and there was evidence it was checked regularly. Staff supporting the patient group had designated responsibilities in the event of a medical emergency and all staff were aware of their role.

Staffing levels and caseload

- Staff provided care and treatment to patients despite staff shortages due to vacancies and maternity leave. There were difficulties with recruitment of suitable staff, in particular to senior nurse positions. The organisation reported a sickness rate of 4.47%, which meant they were within their target of less than 4.5% of their workforce being off sick. There were also a number of nurses on maternity leave, which added to vacancy numbers for example, in the Worle locality there were four nurses on maternity leave. This had been risk assessed and escalated to senior management as it could have a potential negative impact on patient care because temporary staff may not have extended competencies for example to set up syringe drivers for patients receiving end of life care.
- The organisation reported a turnover rate of 14% in the period from August 2015 to July 2016, which meant 100

members of staff had left the organisation during this period. There were vacancies within administration, healthcare assistants and registered nurses roles and also in the night time rapid response team however, in other localities, there were staffing levels above the stated requirements. For example, in the Worle integrated care team the nurses were over-established by 20.5% in order to manage skill mix staffing pressured due to absences. In the Weston integrated care team was 25% under the required staffing levels (October 2016). We asked if staff in Weston and Worle were moved depending on demand. Staff told us it rarely happened, although nurses from the rapid response team often helped if their workload allowed. This meant that the organisation did not always make best use of their resources to optimise staffing levels in all localities; however, we were told that there were plans to review this in 2017.

- We spoke with clinical leads who expressed concerns about the vacancies for clinical leads across North Somerset and the difficulty with recruitment of clinical leads with sufficient experience. The staffing plans for each locality included two clinical leads and at the time of our inspection, there were two vacancies.
- There was no nationally recognised tool to help managers ensure the caseload of community nurses was manageable. In the Weston locality, one manager had developed a template to help plan daily caseloads based on the estimated time an activity would take a nurse to carry out safely. For example, it was estimated that the safe administration of insulin for a diabetic patient would need a 15 minutes visit by the nurse, whereas a complex leg dressing may require an hour to carry this out safely. We looked at data about the number of patients for each locality team per month and found that the number of patients seen by each of the four integrated care teams varied from 237 patients in Worle to 579 in the Weston integrated care team (October 2016). This was reflected in the funded full-time equivalent staffing levels. We also found that the actual patient-to-nurse ratio varied significantly across North Somerset. In the Worle locality, the ratio was one nurse to every 18 patients, whereas in the Weston locality the ratio was one nurse to every 30 patients. The data did not specifically identify if the nurse was an assistant practitioner, a community nurse or a clinical lead, nor did the data take into account the acuity of the patient or distances to travel between visits. Staff were not regularly moved across to other localities to ensure efficient use of staff resources to deliver safe care and treatment.
- The nurse-in charge on the previous day planned the visits for each nurse. The nurse-in-charge also looked at the planned visits for the next day and considered the priority of the visit and the location of the patients' home to come up with an efficient plan for each nurse. The organisation had a 'delegation of duty' policy, which set out responsibilities in relation to delegation of tasks for each group of healthcare professionals within the community nursing team. We witnessed one assistant practitioner who highlighted a task she was not competent to carry out; this was immediately addressed, with visit being reallocated to a registered nurse. This demonstrated that staff were aware of safe delegation.
- The organisation monitored the appropriateness of referrals to the community nursing services, as there was increasing demand on capacity. Community nursing teams were encouraged to use a sensitive, but common sense approach to discharge patients from home visits if patients were not housebound. The organisation also monitored the number of community nurses visits to patients' homes who were not at home, these patient were referred back to their GP practice for continuing care and treatment.
- There was effective communication between team leaders and the 'single point of access' (SPA) when there were high caseloads and/or sickness amongst staff. This meant that the SPA reviewed the urgency by which new referrals needed a visit or enlist the help of the rapid response team if they had capacity to help the integrated care teams.
- The localities used bank staff to cover for vacancies or sickness. Some bank staff worked regularly two to three days a week and received same mandatory training and appraisals as staff on permanent contracts. Some localities also used agency staff and these were sometimes 'block booked', which meant the same agency nurse would work in the team regularly for a fixed period. Team leaders told us that using agency staff were used as a last resort to cover staff shortages because of the cost and also to ensure continuity of care for patients.
- In the Weston locality, there was a high caseload of patients with diabetes requiring daily visits for insulin

administration. The organisation had funded a specialist diabetic nurse to oversee an 'insulin project', which reviewed the insulin requirements of patients in partnership with the patient and the patient's GP. This ensured optimal treatment and to reduce the number of visits from community nurses. The project also included working with the local NHS trust about safe discharge of patients with diabetes and working with staff in care homes to train them to administer insulin safely. The clinical governance meeting minutes in May 2016 reported the project had seen a significant drop in 'insulin visits' from 50 a week to just four. The adult diabetic specialist nurses ran training programmes for practice nurses to enable them to manage diabetic patients effectively at their local surgeries, as they did not have to capacity to see all diabetic patients regularly. This was due to an increase in the number of patients with diabetes year on year. We recognised this as a good use of resources however, at the time of our inspection there was still a concern amongst community nurses and team leaders about managing the daily visits for insulin administration.

- The physiotherapy outpatient service felt they had been understaffed and as a result, their waiting list had been as high as 22 weeks. This had recently been reduced to 18 weeks as two new staff had started in the department to fill vacancies.
- The podiatry team was losing one specialist podiatrist and were concerned about the impact this would have on their ability to offer nail surgery to all their patients in the short term. They had other specialist podiatrists, but they specialised in biomechanics (looking at the way people walk) and one who specialised in diabetes. In order to meet the demand for podiatry services, patients had to meet a strict criteria, such as a high risk diabetic.
- The discharge to assess (DtoA) service had enough staff to ensure they met the pathway criteria for the timescales to visit new patients. However, the team were concerned about how this would continue once the inpatient beds at Clevedon Community Hospital were re-opened and some staff redeployed back to the inpatient ward.
- The night service was busy for the majority of the night. The shift started at 9.30pm and finished at 7.30am. It was staffed by two teams of two nurses, with some of the staff coming from Clevedon hospital; whilst it was being refurbished and were due to go back when the work was complete. Staff were worried about the effect on the night service when this happened. This had been highlighted, but staff were not aware of any contingency plans to manage this situation at the time of our visit.
- We spoke with a consultant geriatrician who was one of four doctors employed by the organisation. The consultant geriatrician had annual appraisal at which they had to show evidence of ongoing revalidation and received clinical supervision from an external organisation to ensure they had appropriate ongoing support.

Managing anticipated risks

- Managers and team leaders responded appropriately when there were changes to the services or staffing levels. For example, in one locality, when unplanned sickness for a member of staff occurred, management took efficient measures to review the nurses' planned visits for the day to allocate patients and prioritising patients with diabetes who needed their insulin before breakfast.
- Occupational therapists visited patients on the day of delivery of additional aids and equipment to ensure patients and carers received training in how to use the equipment.
- The organisation had a 'personal safety and lone worker policy' to support staff visiting patients in their homes and staff were knowledgeable about this. Staff were required to phone a designated member of staff each morning, at the end of the shift and following a visit to a difficult patient or family. There were processes in place to ensure contact with staff if they had not phoned. Electronic recording systems showed alerts, for example the need for two nurses to visit, if there were any safeguarding incidents, dogs at a property or there was a key safe. There were processes in place if a member of staff needed immediate assistance and the service worked with 'Care link' for monitoring of staff's safety for those working evenings or overnight.
- Staff in the community outreach team met with patients in the local soup kitchen and had an agreement with staff and volunteers to ensure nobody was alone with patients. Staff also carried personal alarms, worked with street wardens and used CCTV monitoring as security if meeting with patients outside of the soup kitchen. Staff felt safe and stated they had built up a lot of trust with the patients and patients knew they were there to help them.

Requires improvement

Are services safe?

- The organisation also had a winter plan to ensure ongoing services in adverse conditions. The plan included a priority rating of visits to patients and the use of a 4X4 vehicle to help staff get through adverse weather conditions. The plan was available to all staff on the intranet; locality leads who also acted as duty managers, were knowledgeable about the escalation plan.

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents. The organisation had a business continuity plan with a list of yellow and red triggers to activate an escalation plan to maintain business as usual as far as possible. This was available on the intranet and staff knew how to access it if required.
- The clinical and operational lead for the lymphoedema service told us, they had recently had a fire drill where they had to evacuate patients. It was noted that staff took the patients down the stairs and not to the refuge area, at the end of a corridor, where they would have been safe for 30 mins. There had been shared learning across the team from this incident. Further discussion within the team led to ordering of long sleeve gowns for patients who would find it hard to dress quickly in the event of an emergency. This meant they could leave the building more quickly and with dignity.

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

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

We rated the effectiveness of the community adults services as good because:

- Staff followed care and treatment guidelines and pathways based on current best evidence.
- Staff had the right qualifications to carry out their roles. There was a robust competence assessment framework and staff were encouraged and supported to enhance their qualifications.
- There was effective multidisciplinary working across the organisation and staff had good working relationships with GPs across North Somerset.
- There were systems to ensure appropriate referrals were made and when clinical support was needed.
- Staff were knowledgeable about mental capacity assessment, deprivation of liberty legislation and obtaining consent for treatment and care interventions. These were embedded in the way staff worked.

However,

- Staff did not consistently carry out assessment of pain using a recognised pain assessment tool.
- Staff did not always assess patients' nutritional risk assessment and take appropriate actions when a risk was identified.
- Services did not consistently collect data to measure patient outcomes and they did not participate in national audits to benchmark their treatment and care.

Detailed findings

Evidence based care and treatment

- The organisation used relevant and up-to-date guidelines to ensure best evidence-based care was followed. The organisation was at the start of a process to ensure clinical guidance for staff was based on National Institute for Clinical Excellence (NICE). This was part of an audit programme. There was a clear plan to enable these changes, however it was felt it would take approximately 12-18 months before the process was completed. There was only one 'Lead Nurse and Professional Advisor for Managed Care' leading this process. Using the system of link nurses, it was their task to implement the move to NICE based practices.
- We saw many examples of care based on guidance by the national institute for clinical excellence (NICE). For example, the specialist diabetes nurse used an approach from the diabetes national standards framework to promote a self-care model for patients with diabetes patients in the community, to help reduce the case load of daily visits to patients for insulin injections. The diabetic specialist nurses used NICE guidance that included Type 1 diabetes in adults: diagnosis and management (NG 17; Updated July 2016), Type 2 diabetes in adults: management (NG28; Updated July 2016) and Diabetes in adults (QS 6; Updated August 2016).
- The Discharge to assess (DtoA) service used pathway 1 (home-based rehabilitation) with patients discharged from three local acute trusts. They used pathway 2 (bed-based rehabilitation) to accept patients into a number of care home beds purchased by the clinical commissioning group (CCG). Pathway 1 patients were seen within two hours of arrival at home. Pathway 2 patients were seen, where possible, on the day they were discharged to the care home bed. These pathways were accepted ways of working taken from NICE best practice guidance.
- The specialist diabetes nurse used an approach from the diabetes national standards framework to promote a self-care model for patients with diabetes patients in the community, to help reduce the case load of daily visits to patients for insulin injections. The diabetic specialist nurses used NICE guidance that included: Type 1 diabetes in adults: diagnosis and management (NG 17; Updated July 2016), Type 2 diabetes in adults: management (NG28; Updated July 2016) and Diabetes in adults (QS 6; Updated August 2016).
- Pulmonary rehab service facilitated a pulmonary rehabilitation group for patients with chronic lung diseases such as chronic obstructive pulmonary disease

(COPD). This service, which began in 2005, met with NICE guidelines: Quality Statement 5: Pulmonary rehabilitation after an acute exacerbation (2016). The service recognised that pulmonary rehabilitation did not meet all standards, as it was not possible to ensure all patients could attend within four weeks of discharge from hospital. The service had trialled a rolling programme where patients could join at any time but when evaluating patients' feedback, it was decided to run a whole programme for a set group and enrol new patients on the next available group.

- The lymphoedema service was a member of the British Lymphoedema Society from where they got the most up to date guidance and information in order to inform their practice.
- The podiatry team used Diabetes UK competencies for managing diabetics and NICE Guidance:Diabetic foot problems: prevention and management (NG19; Updated January 2016).
- The Tissue viability service encouraged teams to use a 'PURPOSE T' assessment tool. This tool uses a number of methods to identify the risk to a patient of developing a pressure ulcer. This is a nationally devised tool, based on research, which aims to minimise the chances of a patient developing a pressure ulcer. This hands off assessment had been implemented electronically for use in outpatient departments to identify at an early stage ambulatory patients who may at a later stage be at risk of developing a pressure ulcer.
- The leg club, care was set up following guidance based upon the Ellie Lindsay Leg Club Foundation's model. The leg club model aimed to motivate and empower patients to take ownership of their care, alleviate their suffering and reduce stigma attached to their condition. Nurses working within the service had received training around these methods, with Ellie Lindsay herself having visited and offered training. In addition, the service had formed positive relationships with manufacturers of dressings who also provided extra training. Competencies, based on approved practices, were assessed by the lead for the service.

Pain relief

- The bladder and bowel team used the 'bothersome score' to help determine the level of pain when assessing a patient's symptoms. We did not see staff use any other recognised pain assessment tool consistently when talking to patients about their pain. We observed staff asking patients about pain, but it did not seem to form part of embedded assessment of patients.
- Nursing, therapy and podiatry staff asked patients about their pain levels during assessments and ongoing visits to peoples own homes and in clinic settings. However, we did not see recognised pain scoring scales in used consistently but staff documented details in patient's evaluation notes.

Nutrition and hydration

- Patient's care plans did not always include an appropriate nutrition and hydration assessment and management plan. The organisation had a 'nutrition and hydration' policy, which outlined processes to ensure staff screened all patient for malnutrition using the malnutrition universal screening tool (MUST) on admission to case load and on each new episode of care. It also included standard operating procedures to follow depending on the outcome of the screening and encourages staff to implement a plan of care, setting treatment goals with the patient and evidence that these were reviewed. We reviewed care records and found it was not clear when patients were admitted to the caseload, or a new care episode started. This meant it was difficult to ascertain if MUST assessments were carried out as per policy.
- In one care record we reviewed, staff assessed the patient to be at high risk of malnutrition, but the recommended actions were not implemented. We asked the member of staff why this was and were told that the weight was 'normal for the patient' and that there was no real concern about the patient being malnourished. However, this was not documented and a review of the patient's present appetite and diet had not been assessed and/or documented.
- We reviewed minutes of meetings from the nutrition link nurse meeting (19 October 2016) where it was highlighted there was low compliance with MUST score being entered on the electronic patient records and there was no evidence that compliance with MUST screening for patients new to the caseload or a repeat care episode was monitored.
- We observed that patients with a category 3 or 4 pressure ulcers were referred to a dietician as per the organisation's policy.

- At Clevedon Community Hospital patients had access to cold drinks and there was a small café outside the main entrance where patients and their relatives or carers could buy cakes/snack and hot drinks.

Technology and telemedicine

- Telehealth was used to enhance the delivery of effective care and treatment. We spoke with staff in the clinical hub that was in charge of reviewing data and taking appropriate action. The organisation had the facility to monitor 30-35 patients remotely every day. The patient was supplied with a Bluetooth enabled box, which prompted them to check their vital signs (blood pressure, pulse rate and oxygen saturation levels) at intervals determined by their condition. The information was transmitted to the clinical hub where clinical staff reviewed data and took appropriate actions. The actions included a telephone call to the patient, referring the patient to the rapid response team for urgent assessment or they could arrange a paramedic ambulance to assist the patient. Staff in the clinical hub had escalated the need to review the effectiveness of how the telemehealth technology was used.
- Community nurses were able to photograph wounds to assess the progress or deterioration of wound healing. The photographs were uploaded to the electronic patient record which enabled staff to discuss treatment options with colleagues at handovers and refer patients to the tissue viability service.
- The falls service made use of telecare equipment, such as falls detectors and bed occupancy sensors. Staff felt these were effective and helped to reduce risk of falls effectively.
- The Speech and Language Therapy (SALT) service used technology to assist with communication. NHS England had cut funding for the Bristol Communication Aids Service (BCAS) run by a nearby NHS trust. This service previously provided communication aids to patients with varying levels of need. Only patients with the most complex needs could now access equipment. The SALT service had developed the use of free applications on electronic devices to assist individuals with those levels of need where BCAS no longer provide equipment.

Patient outcomes

- The organisation had a clinical audit programme which ensured clinical audits were carried out across different services benchmarking practice against national guidelines (NICE), CQUINs and as requested by the clinical commissioning group. Audit results were discussed in the monthly 'quality and performance' meeting. We reviewed the minutes of the meeting held in September 2016 and found that the community heart failure team reached 100% compliance with all aspects of the NICE guidance applicable to the service. This excluded cardiac rehabilitation as the service was not commissioned to provide cardiac rehabilitation.
- The organisation had an "outcome" based contract with commissioners. This meant that funding depended on a set of agreed outcomes being achieved. In order to be able to measure these outcomes, the organisation was introducing processes and systems that were better able to collect such information.
- The audit programme demonstrated how the organisation took part in some national audits such as infection control and safe and appropriate use of antimicrobials. However, the adult community services did not take part in the national intermediate care audit. Some services collected a range of outcome information including progress towards patients' individual goals.
- In December 2015, the tissue viability specialist nurses team carried out a thematic review of pressure ulcers to identify measures to reduce pressure ulcers. For example, the introduction of a 24/48 hour mobility tool and extending education opportunities to nursing homes, care homes and practice nurses within North Somerset. Reducing the incidents of pressure ulcers was one of six quality priorities for delivering safe care and preventing avoidable harm. The aim was to reduce the incidents of grade three pressure ulcers by 30% and grade four pressure ulcers by 50% by March 2017. The overall incidents of pressure ulcers reduced by 52% for grade three and by 63% of grade four pressure ulcers for the year 2015/2016, when compared to the number of pressure ulcers from the previous year. This meant the organisation was on track to improve pressure ulcer prevention and care.
- Some services collected a range of outcome information including progress towards patients' individual goals.
- Discharge to assess (DtoA) service recorded outcomes from their short-term service. For example, in October 2016 there were 41 discharges from the service. Three patients were discharged with an ongoing funded package of care (POC), 28 were discharged without a POC, one was discharged with a private POC, three discharged to the community therapy team and there

were six emergency transfers to an acute hospital. This meant the majority of patients were managing independently at home after being assessed with support from the team.

- For patient experiencing a fall each patient was reviewed six months following their discharge from the service. There had been a 50% in reduction in falls during this time. This compared favourably with the national target of 30%. The falls service now plan to review patients after one month to gain further data.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Registered health care professionals had the qualifications required for their role and were supported to obtain further qualifications at a nearby university to ensure continuous professional development. Clinical leads and many specialist nurses had completed the nursing prescribing course. We met with nurses who had completed a course in physical assessment and clinical reasoning or other courses of specific interest to them and particular to their role. All nurses told us they felt supported by the organisation and were given time off to study and help to cover the course fees.
- The organisation operated a system whereby appraisals occurred during a three month window at the beginning of the financial year. Staff had monthly one-to-one meetings and received appraisals and supervision from their line managers. At the time of our inspection, staff in the Weston locality, were 85% compliant with appraisal whereas in the other three localities and for the urgent and specialist services, compliance was above the target of 95% as set by the organisation. This meant that the majority of staff within the community adult services had had an appraisal within the last 12 months.
- Staff we spoke with told us that they received appraisals. The goals set in these appraisals were positive with an emphasis on development and discussed at regular supervisions throughout the year. Staff said they benefitted from regular formal supervisions. They also had the opportunity to discuss particular concerns at any point without having to wait for supervision.
- Staff received a corporate induction when they started working for the provider; one occupational therapist (OT), who had just completed their induction, said it was the best induction they had ever had. Staff had opportunities for professional development. Registered nurses had support to complete requirements for their revalidation. One member of staff was supported to complete a Master's degree while a healthcare assistant had just completed the foundation degree and had been offered a job as an assistant practitioner within the organisation.Student nurses felt the organisation offered a good placement with plenty of scope for learning and development.
- We spoke with assistant practitioners who had been supported to obtain the foundation degree and secured a job within the organisation. They were supported through supervision in order to obtain the extended skills needed for their role. Designated people who were qualified to assess competence assessed and signed off staff's competence.
- Health care assistants were supported to complete a national vocational qualification in health care and to gain the skills that were required to undertake the tasks asked of them. The organisation had introduced a care certificate for unregistered staff to ensure they had the required skills and competencies.
- Specialist podiatrists and general podiatrists were engaged in ongoing training to ensure their competence. One podiatrist was completing a master's degree in tissue viability and wound healing. This was part funded by the organisation and they were able to take study leave to attend face-to-face training.
- There was monthly 'in-service' training for qualified therapy staff. There were plans in place to provide 'in-service' training for rehabilitation staff as their needs were different to qualified therapy staff.
- The organisation employed four doctors. All had an annual employee appraisal at which they had to show evidence of ongoing revalidation. The consultant geriatrician had clinical supervision from an external organisation to ensure they had appropriate on-going support.

Multi-disciplinary working and coordinated care pathways

- All necessary staff were involved in assessing, planning and delivering care and treatment. Allied healthcare professionals were not part of the locality nursing teams in all four localities, but staff told us it was easy to access their input and expertise via the single point of access.

Some specialist services, such as the pulmonary rehabilitation, consisted of a lead nurse, a physiotherapist and an assistant practitioner who all worked together.

- We observed staff in specialist clinics adopting a holistic approach to assessment and make referrals to other healthcare professional for support and advice. For example, staff in the 'bladder and bowel' service referred a patient to occupational therapist and physiotherapist for assessment as the patient had had recent falls in her home.
- Nurses and allied healthcare professionals attended monthly multidisciplinary team meetings with GPs, and hospice nurses, held at GP surgeries.
- Allied healthcare professionals such as occupational therapist, physiotherapist and speech and language therapists received referrals from Care Link and from specialist nurses and community nurses working in the four localities. The allied healthcare professionals also liaised and referred patients from their caseloads to the community nurses if they were concerned; these concerns could for example include the prevalence of pressure ulcers.
- Staff in the Weston locality explained that they operated a link nurse system in local residential and nursing homes they could contact for advice and support. The link nurse would also make contact with residential and nursing homes regularly to ask about concerns or updates on patient's well-being. The residential home support service also worked closely with residential and nursing homes to upskill staff and the 'bladder and bowel' service supported staff in residential and nursing homes to manage patients with incontinence.
- Staff from the lymphoedema service described their good working relations with the Macmillan services to whom they were affiliated. This meant they could attend Macmillan study days, ask for leaflets relevant to lymphoedema and its management and have these translated into other languages and formats as required.
- The discharge to assess (DtoA) service spoke about good multi-disciplinary working to ensure the best care and outcome for patients. The DtoA service had a full MDT meeting every Wednesday to plan for all patients they were going to accept for the following week.
- The specialist older people's team (SOPT) described successful multidisciplinary working with internal and external services such as the falls team, discharge to assess, local GP's, mental health consultants, Age UK and the Alzheimer's Society.

Referral, transfer, discharge and transition

- There were clear and effective processes for staff to communicate between teams and when referring patients to other teams or services including GPs. Staff worked together to assess and plan ongoing care when patient needs.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when patients were referred. Community nursing teams and allied health professionals received referrals via the 'single point of access' (SPA) or the 'clinic hub'. The SPA processed referrals for managed care whereas the clinical hub managed urgent and emergency referrals from GPs, the ambulance service, clinical leads, or community nurses who needed additional advice and support. Staff at the clinical hub triaged calls and delegated visits to the rapid response teams. They also managed the overview of available safe haven beds; these were five beds in local nursing homes that staff could admit patient to for enhance nursing care and daily visits by the rapid response team to assess their ongoing health needs. Referrals made via the SPA were also triaged by clinical staff who allocated visits to the appropriate community nursing team or allied health professionals. The triage included an assessment of the urgency of the visit to help ensure caseloads for community nursing staff and allied health professionals were manageable. The main source of referrals via the SPA came from 'Care Link', which was a social services point of access where referrals or self-referrals were managed.
- Additionally specialist services such as the heart failure service, the 'bladder and bowel' service also received referrals via the organisation's joint clinic booking service (JCB) who dealt with first clinical appointments for some specialist services
- We visited the 'admission avoidance' team working with staff in a local NHS trust. Staff assessed patients who did not need admitting to hospital and helped arrange additional short-term support to enable the patient to stay at home or admit the patient to safe haven bed.

The intravenous service (IV) service could also treat patients with intravenous antibiotics in the 'safe haven' beds or in their own home to avoid admission to hospital.

- The adult community service worked with the local acute NHS trust to ensure appropriate plans were in place when patients were discharged from hospital into the care of the community services. For example, the diabetic service had worked closely with staff at the local NHS trust to ensure all diabetic patients were discharged from hospital after a review by a nurse specialist or consultant. This was to optimise treatment and if possible, reduce the need for multiple visits by community nurses each day to administer insulin.
- The DtoA service enabled patients discharged from hospital to receive assessment of their needs in their home. The team visited the patient within two hours of discharge and put in place additional aids and arranged for up to three daily visits, these were reviewed regularly to reduce the visits as the patient regained their independence.
- The specialist services we looked at had clear referral pathways. This included the DtoA, podiatry and lymphoedema services. Services and community nurses discharged patients from their caseload when patients were admitted to hospital and then re-admitted patients again once they were discharged from hospital. The nurses explained this was to identify who were responsible for care. For example, if a patient was discharged from hospital with a pressure ulcer, a nurse would identify this on the first visit and it could therefore be documented that the pressure ulcer had not developed while the patient was on the community nurses caseloads.
- All staff spoke about the close working relationship with patients' GPs. This helped to ensure patient's health, safety and well-being when returning to their home or if patients needed to be admitted to the local NHS hospital.

Access to information

- There were clear and effective processes for staff to communicate between teams and when referring patients to other teams or services including GPs. The electronic patient records allowed staff to share information about patients with GPs. It also allowed staff to access information about medication and blood test results, which meant that they were able to explain these to patients if required.
- Information was not always available to all staff to deliver effective care and treatment. There were challenges around connectivity for mobile working which meant that electronic patient records were not always up-to-date. This meant that in the event of an unexpected referral to the rapid response team out of hours, staff could not access accurate and up-to-date information about patients before attending the call out. Risk assessments were not always completed in a timely manner and it was not easy to see when the dates of when patients were admitted into the community services or a new care episode started.
- The organisations policies and procedures were all available on the intranet system and staff knew how to access the information they needed, to deliver effective care and treatment.
- There was information displayed on noticeboards in the different community nurses bases and included information about link nurse roles, management of blocked catheters and who to contact to support practice. In addition, there was information about line management structure, and contact numbers for the same.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff consistently demonstrated an understanding of the importance of gaining consent and processes to follow where patients did not have the capacity to consent to their treatment. All staff were provided with training for Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS) and highly regarded for its quality. Training compliance for MCA and DOLS was below the organisation's target of 90% across all localities and urgent and specialist services except the Weston integrated care team which exceeded the target with 94% of their staff having completed the training (September 2016).
- We spoke with staff who gave us examples of joint visits with senior members of staff or allied health care professionals when they were concerned about a patient's capacity to make decisions about their care.
- We heard a community nurse asking a patient for their consent to discuss their current situation at a

multidisciplinary team meeting planned for the following day. We also witnessed nurses ask for patient's permission or consent before discussing their care and treatment with other healthcare professionals such as the patient's GP or specialist services delivered by nearby NHS hospitals.

- Staff obtained consent before any clinical and care interactions and documented this in patient records. There was a policy for procedures to obtain consent when taking photographs of wounds.
- The organisation had a corporate policy to support staff with issues relating to deprivation of liberties (DOLS).Staff understood what DOLS meant and that they needed to be aware of this when visiting patients in care homes. Staff stated they would seek advice from managers if they needed to consider or had any concerns about a DOLS application.
- The tissue viability team had developed a 'non-concordance protocol' for patients who were not following recommendations provided by staff in managing their skin care. The protocol identified the need for staff to ensure assessment of the patient's mental capacity and that individuals were supported to make informed choices.

Good

Are services caring?

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

Summary

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

We rated caring as good because:

- Staff treated patients with dignity, respect and compassion. Staff built positive relationships with patients and their relatives/carers.
- The adult community services received positive feedback from patients and their relatives/carers.
- Staff involved patients and their carer's in planning and making decisions about their care and treatment.
- Staff communicated effectively with patients and took time to answer questions.

Detailed findings

Compassionate care

- Staff treated patients with kindness, dignity, respect and compassion when they received care and treatment. We accompanied nurses visiting patients in their homes and observed staff treating patients with compassion, dignity and respect. Patients called nurses by their first names and nurses formed appropriate relationships with patients, based on compassion and care.
- Staff took their time to interact with patients and their relatives or carers. Staff were focussed on the purpose of the visit and managed care well, whilst also offering kindness. For some patients, the visit by staff may be their only social interaction. We observed, staff adopting a holistic approach to the patients. For example, one member of staff closed a birdcage before providing wound care but remembered to open it again afterwards, as this meant a lot for the patient.
- Staff demonstrated encouraging, sensitive and supportive attitudes towards patients. Patients said they enjoyed visiting the leg club; that it enabled them to meet other patients with similar needs. During this social situation, nurses still provided individualised care in a dignified way. Patients had the option of having their legs dressed away from other people, although none of the people we saw chose this option.
- Nurses openly discussed complex needs of patients. For example, during a community nurse handover, nurses discussed a patient for whom additional considerations needed to be taken into account. There had been previous discontent from the patient and the nurses discussed ways of minimising the patients concerns with their ongoing treatment.
- Staff spoke kindly and fondly of patients they visited and had built positive relationships with the patients they were treating. This enabled them to deliver person centred care and respond to the needs of the patient quickly. For example, a team of two nurses supported a patient who experienced pain during dressing changes. This enabled the nurses to complete the process more efficiently and smoothly by working together. One nurse discussed pain relief and offered emotional support whilst the other was able to focus on the dressings. The patient said that they felt very well looked after by the team of nurses and looked forward to them visiting.
- We joined nurses and allied healthcare professionals on visits to patient homes. Staff rang doorbells before entering the homes of those patients they knew were unable to answer the door or used key safe codes to access the patient's home. Staff introduced themselves to patients they had not met before and explained their reason for visiting.
- Staff were aware of the importance of continuity. Staff were aware of the importance of good communication and explained how they would contact individuals if they were delayed in order to apologise. Staff identified this as being crucial to managing expectations and being open with patients.
- During one visit, a nurse had remembered a patient's daughter was away and offered to make a hot drink and prepare food. During another visit, a staff member checked that it was acceptable to speak in front of a family member to ensure privacy was maintained.
- Staff respected patient's privacy and dignity at all times. We observed one clinic where the patient was required to partly undress for an examination. This was carried out by a nurse of the same gender, but the nurse did not offer the presence of a chaperone for the duration of the examination. However, the patient's dignity was upheld by curtains being drawn and the nurse asked for permission before entering the curtained off area.

Good

Are services caring?

- We observed a nurse carrying out an assessment of a patient in their home. the nurse ensured privacy and dignity was upheld by asking for consent and drawing the curtains to ensure people walking past could not see what was happening. The organisation had a chaperone policy however, we did not see any leaflets to explain about chaperones in the outpatient departments, or in clinics that involved intimate examinations. Staff told us that they would arrange for a chaperone to be present or re-arrange an appointment if this was not possible.
- Staff respected confidentiality when caring for patients. They did this by ensuring doors were closed during treatment, when in patient's homes. When in more communal areas, such as the leg club, treatment areas were well spaced and nurses spoke in volumes that could not be overheard.
- Staff maintained patient confidentiality by not bringing any information from their base with personal
- Staff took the time to introduce themselves, their role and the service they worked for to new patients. They asked what the patient would like to be called and explained the reason for taking notes and about the need for gaining consent before they did anything with or to the patient.
- The services encouraged patients and their carer to complete the friends and family test as a marker of how likely they were to recommend the services to family and friends. In March 2016, the organisation had 611 responses from patients who used community services, of which 604 (99%) stated they would recommend the service. In the same survey, the specialist services received 2318 responses, of which, 2287 (99%) would recommend specialist services to friends and family. The four localities received 321 compliments in the period from April to September 2016 and the urgent and specialist service received 532 compliments for the same period.
- We received 68 comment cards back from patients prior to our inspection. Feedback was very positive with patients giving examples of how kind staff had been, how they had explained what they were doing and in a lot of cases how much better they felt following their consultation/treatment.
- We saw feedback cards from people who had received services from the falls team. All were positive and one person had written in November 2016,staff were 'most helpful and I was treated with dignity'. We also saw two feedback cards from patients discharged from the heart failure service – both of these contained very positive feedback about the service.
- Staff also considered the wellbeing of pets and staff told us of one example where a patient could no longer care for their cats; the community nursing team arranged for re-homing of the cats. Staff explained that patients cared about their pets and they were often a source of comfort for patients who were housebound.

Understanding and involvement of patients and those close to them

- Patients and their carer's were routinely involved in planning and making decisions about their care and treatment. On a home visit, we observed a nurse applying a holistic approach to the assessment of patients' condition, symptoms and needs, which meant they looked at both health and social care needs. For example, we observed a nurse advising a patient's next of kin about their entitlement to claim carer's benefit as they were the main carer for the patient. The patient's next of kin was present and was encouraged to join in the conservation when appropriate and with the patient's permission. During another home visit, a nurse explained the results of blood pressure readings to both a patient and their relative in a way they could understand. The nurse confirmed what this meant and agreed a plan of action with the patient. Another patient told us how staff had taught them and their family how to self-manage their condition, which meant less visits to the clinic.
- Staff communicated with patients and their carers in a manner that ensured they understood their care, treatment and condition. Staff offered opportunities to ask questions and took time to explain when clarification was required. Staff referred to the front sheet in the care records held in patient's homes, to remind patients and their carers how to access help if required. A patient told us, they were happy their relatives had been invited to be involved in discussions about their care. The patient felt this had enabled a more open and meaningful relationship with the nurses who visited. The involvement of relatives enabled them to support the patient when their condition was exacerbated, which in turn enabled the nursing staff to have a clearer understanding of the individual's experiences.

Good

Are services caring?

- During a home visit, we observed a patient who had not wanted a certain type of dressing on their leg ulcer. The nurse had assessed that the individual had the capacity to make choices in this situation and used a different type of dressing which suited the patient. Staff spoke with confidence about individual's goals and their right to make choices about their care. One staff member commented that they would do everything in their power to 'reach the goals of the patient'.
- During one visit, a nurse became aware that a relative was finding it difficult to sleep at night due to their caring role and was in need of additional support. The nurse responded to both the patient and their relative in a sensitive and supportive manner and gave advice and guidance about where to find further information and who to contact.
- During the inspection, we observed several specialist clinic appointments. We observed strong professional/patient relationships that were supportive of the patient's needs. Patients told us they were able to ask questions about their care/condition and staff supported them to learn more about how to manage their illnesses/condition.

Emotional support

- Patients and their relatives received the support they needed to cope emotionally with their care, treatment and condition. Staff recognised the broader emotional wellbeing of patients. Staff discussed at handovers, the emotional wellbeing of their patients and had a genuine motivation to support this, as well as the physical health of their patients.
- Nurses were concerned and reviewed the welfare of patient's main carers. We observed a consultation in a specialist clinic where the nurse asked about the well-being of the patient's husband due to a recent diagnosis of dementia. The nurse discussed different options for additional support and signposted the patient to a patient group forum where additional advice was available, as well as offering a social network with others in similar situations.
- Staff from the outreach team told us of an incident where they had escorted a patient to hospital for a procedure to offer emotional support. The patient had capacity and consented to the procedure but had nobody that could accompany them to hospital and offer emotional support. The patient was very nervous about being in the hospital environment and had appreciated that staff had taken time to go with them. Staff from the community outreach team explained that offering emotional support whilst also providing health education and advice was the way they gained the trust of the people on their caseload. Sometimes offering emotional support and listening was the only way they could help patients.

Good

Are services responsive to people's needs?

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

Summary

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

We rated responsive for community adult services as good because:

- The organisation worked with the clinical commissioning group to ensure the services met the needs of the local population as far as possible.
- Clinics were scheduled to meet the needs of individuals as far as possible and many patients benefitted from clinics in locations close to their homes.
- The service provided patient group activities, which enabled patients to gain social interaction as well as access to advice, education and support.
- The service provided care and treatment in a non-judgemental manner and accepted patient's individual choices.
- The service responded to and handled complaints in a timely manner.

However,

- Staff did not routinely screen patients for dementia or refer patients for further assessment.

Detailed findings

Planning and delivering services which meet people's needs

- Information about the needs of the local population was a base to plan for future challenges to the services in the local area. This included, classifying areas into zones to minimise travel time for nursing staff. In addition, the service had a clear understanding of the local area demographics, in terms of age and economic status and the large number of care homes in the area. The service was looking at ways to work more closely with these homes in order to provide more efficient and effective care for these patients. Services routinely collected data in order to feed back to commissioners about caseload numbers and care provided.
- Different services within the adult community services division spoke about the commissioning of services to meet the needs of the people in the community. Staff spoke with passion and enthusiasm for services that they had been instrumental in developing, with the support of the clinical commissioning groups (CCG) for North Somerset.
- A locality lead had identified local challenges within the area services were provided and showed us an action plan and team report, which took account of challenges both within and outside of the service. These documents were communicated to the executive team and the clinical team. The report allowed the service, to quantify changes and challenges and was also used to inform commissioners.
- The organisation worked to enhance the care provided to elderly and frail people to improve independence, quality of life, mobility and decrease confusion. The specialist older peoples team (SOPT) consisted of a geriatric consultant, a consultant nurse and a specialist pharmacist. The team ran two clinics a week, and visited people in their own homes. The team carried out comprehensive assessments including a review of medication and referred patients to ensure they receive the correct support. SOPT implemented the Edmonton Frail Scale as a reliable tool to enable staff to assess how frail a patient may be. The team facilitated a training programme to support staff within the organisation and other agencies including mental health and palliative care agencies.
- The organisation worked to increase the number of clinic based treatments to enable more people to access the right treatment in the right place and to reduce waiting times. This included additional weekly clinics set up in Weston-Super-Mare, for community physiotherapy. The falls service extended the number of clinics run in communities, which, as well as encouraging people to get out of their homes, also increase the efficiency of managing caseloads.
- The organisation was commissioned to implement a 'discharge to assess' (DtoA) pilot service, to enable patients to return to their home once medically fit for discharge following a stay in hospital. The service aimed to accelerate discharge from hospital, for those with rehabilitation needs, without the limitations of accessing care packages prior their discharge from hospital.The DtoA team visited patients within two hours

of discharge from hospital, assessed their needs and facilitated the delivery of specialist equipment. Community nurses or allied healthcare professionals carried out daily visits, until the patient had regained their independence or a package of care was arranged with social services. Patients remained on the DtoA service caseload for an average of 20 to 35 days after discharge from hospital.

- Specialist therapists and nurses, supported by administrators, facilitated patient group activities to meet the needs of people in the community with specific healthcare needs. We visited an exercise group for 15 people with Parkinson's disease. The group met once a week to exercise to music to enhance movement and promote wellbeing. The exercise programme was based upon an Australian exercise programme and the physiotherapist was a qualified instructor. The programme ran for ten weeks and had been so successful, that the patients had decided to carry on meeting once a week to exercise together.
- We visited a pulmonary rehabilitation group, which included education and support from staff about different aspects of living with a chronic pulmonary (lung) disease. The group was led by a physiotherapist, with extended qualifications in treating patients with chronic lung disease, a respiratory specialist nurse and an assistant therapist. The programme ran over 6 weeks and introduced patients to exercise in a safe environment under supervision. There were extensive risks assessments with identified actions to take in case of medical emergencies. These included staff bringing emergency equipment, such as an automated defibrillator, to the group session each week. Patients were complementary about the group and pleased with the progress they had made towards their own individually set goals.
- We attended a 'Leg Club', which was a joint venture with a volunteering committee. The leg club provided both a social and clinical opportunity for patients to attend. The club, which was run by volunteers, offered hot drinks and social opportunities for patients to sit, talk and socialise. It also had facilities, and clinical staff, to offer leg and foot dressings to four patients. In addition, on alternative weeks, the group offered a Doppler test, a diagnostic test of circulation in the lower limbs. Patients told us, it was a good opportunity to meet other people with similar conditions and that it got them out of the house. On average, the leg club would treat 20 patients in a three hour session. Patients were not discharged once their ulcers had healed and were free to come back to discuss concerns and therefore had access to professional staff even when they did not have active ulcers. Patients told us this was reassuring and they found the club to be an invaluable resource.
- We met with the 'residential home support service team', which was a project, due to finish in March 2017. The aim of the team was to upskill and train carers in residential homes to help with 'admission to hospital' avoidance. The team concentrated training around the four most common causes of hospital admission for people in residential homes (falls, pressure ulcers, end of life care and because of infections,) but also included diabetes, dementia, delirium and constipation.
- The organisation ran a 'bladder and bowel' service which had a caseload of 374 adults. The bladder and bowel team also contributed to the support of people living in residential and nursing homes by providing assessment and support in the management of incontinence and constipation. The bladder and bowel service had one member of staff dedicated to this role. They carried a caseload of approximately 500 people living in residential homes and 900 people living in nursing homes across North Somerset. However, they stated this was manageable as they could see many patients in one day or ask for updates from staff in residential and nursing homes.
- The musculoskeletal (MSK) interface service (a service for patients with hip, knee or shoulder conditions) provided an average of 600-800 appointments per month and MSK physiotherapy services provided about 1,000 appointments per month at either Clevedon community hospital or Nailsea. The waiting time for an appointment with the MSK interface service was seven and a half weeks at the time of our inspection. For MSK biomechanical podiatry (a service for patients with musculoskeletal problems with their feet or lower limbs) the waiting time was approximately three weeks. However, for the waiting time for MSK physiotherapy was approximately 18 weeks at Clevedon and Portishead and 19 weeks for patients attending assessment at Nailsea.
- The adult diabetic specialist nurses held advice sessions in a variety of settings in the local community to try to encourage people with diabetes or those who think they may have diabetes to attend. For example, meetings took place in local schools, community centres and

even a local pub. Specialist services often held clinics in the evenings and at weekends as people who attended may still be of working age and found it easier to attend 'out of hours'.

- Teams who carried out home visits said they tried to book appointments, which were most convenient for the patient. For example, nurses arranged to see patients later in the day if the patient was a late riser. The podiatry and lymphoedema services offered clinics in a number of areas in North Somerset, to allow patients to access the service nearer to home.
- We visited outpatient clinics and patient groups in different locations across North Somerset. For example, the Marina Health Centre hosted a number of North Somerset Community Partnership (NSCP) services on the first and second floors. The building was modern and purpose built with lift and stair access to all floors. There was a receptionist available to show patients where to go for their appointments and to book future appointments. However, when village halls were used for patients to meet, it was not always equipped to allow patients to call for help in emergencies when for example using toilets.

Equality and diversity

- Services took account of the needs of individual patients and spoke about the importance of not being judgemental in the way they cared for patients. Staff spoke of respecting people's choices as to their way of living. In the community night service, we saw visits were prioritised to take account of the patient's social situation, including the needs of their relatives and carers.
- Where the organisation used other locations for example for the leg clubs, the Parkinson's group and the pulmonary rehabilitation group, the premises had disabled access and parking. The organisation paid a local company to pick up patients in the Weston area so that they could attend a leg clinic.
- The lymphoedema service told us about a patient who was deaf and used lip reading as a means of communication. The person was always given a double appointment so the staff and patient were not rushed. The team also told us they often emailed information to deaf patients who were not able to communicate via the telephone.
- The integrated care services in Weston and Worle localities, had looked closely at the methods by which working with care homes was organised. The aim was to provide greater consistency and foster positive relationships. With this in mind, the same nursing staff visited care homes to ensure consistency. This enabled nurses to get to know the service users and the care home staff. Consequently, nurses understood the challenges faced by the homes, together with the people who lived there.
- Some patients chose not to comply with their treatment. The tissue viability service had developed a non-concordance protocol, which described the processes staff should follow if patients chose not to comply with their recommended treatment plans. This gave nurses a structure on which to base their decisions and clear guidance, but also allowed staff to feel safe to respect the decisions of their patients. We did not see this protocol in use in other areas of the service, although the document could lend itself to universal use. The outreach team provided care to 'hard to reach' groups using a non-judgemental manner and focussed on giving the patients the knowledge and opportunities to manage their own care as far as possible.

Meeting the needs of people in vulnerable circumstances

- The service took account of the needs of different people, including those in vulnerable circumstances. This included projects which encouraged patients to attend clinics for social interaction with others in similar circumstances. The organisation funded a bus to collect patients for a weekly leg clinic in Weston and patients told us they looked forward to going to the groups and that it helped them in feeling less lonely and isolated.
- We observed a number of appointments in variety of specialist clinics. The appointments were longer if patients had specific needs such mobility or cognitive issues. Staff took the time to get to know the patients and could therefore tailor their appointments and time needed to meet their individual needs.
- The Community outreach team set up ten weekly clinics in Weston-Super-Mare for 'hard to reach' groups such as people with substance misuse, homelessness and social isolation The service reached out to groups of people in the local community that were not registered with a GP, but had healthcare needs that were not met. The care the service provided included wound care, safe injection technique, sexual health advice and signposting to GP

services or to a regional mental health care trust for treatment. Between October 2015 and January 2016 the service received 103 new referrals and assisted 11 people to find accommodation.

- The organisation had made it a quality priority to become a dementia friendly organisation; the organisation had employed a dementia specialist nurse and provided dementia training of all staff. At the time of our inspection dementia training compliance exceeded the organisation's target of 85% with more than 97% of staffin community adult nursing teams and urgent and specialist care teams having completed the training. In addition, the organisation's residential home support team facilitated teaching in the home to support people with late stage dementia and end of life. However, dementia screening was not embedded and we did not see any care records where patients had been referred for dementia assessment although staff were aware of signs and symptoms.
- We saw the discharge to assess team discussing a patient who was living with dementia and became upset when their door alarm sounded. The team discussed ways to overcome this for the patient whilst still keeping them safe.
- When appropriate, staff used an assessment tool, named the PHQ9. This is a patient health questionnaire' with a particular focus on a patient's mental health. The outcome of this assessment allowed staff to identify if there were any additional mental health needs of the patient. Nurses then referred to appropriate services when necessary.
- We did not observed any incidents were additional help with communication was required such as interpreters but staff were knowledgeable about how to access these services if required. There was policy and guidance available on the intranet or staff would contact their manager, clinical hub or the single point of access if they needed assistance when visiting patients. There was a facility on the electronic patient record system to flag up additional requirements.
- Staff described examples of where reasonable adjustments were made in order to help people with disabilities or learning difficulties. For example, space was made available for those patients who required a carer to remain with them during treatment in outpatient clinics. Disabled parking spaces were available at all main entrances of the sites we visited. GP surgeries, used for patients to attend clinics, had lift access to the floors where services were provided and there were disabled toilets in all of the areas we visited. In the recently refurbished outpatient department at Clevedon Hospital, there were doorframes painted in bright colours to help people living with dementia negotiate the environment.
- Patients were supported to manage their illness/ condition whenever possible. For example, patients with lymphoedema, once trained, could visit the 'pump' clinic and use the equipment independently to help relieve their symptoms. Staff were on hand to help and advise if necessary, but otherwise patients arrived at reception, were shown to their room and advised reception when they were leaving. In podiatry, specialist podiatrists could advise and supply inserts for shoes to help patients walk better thereby reducing pain and helping to maintain skin integrity. This took a level of commitment from the patient and/or their family. The benefits of using the inserts and making sure they fitted exactly right were discussed with the patient on an ongoing basis.
- We visited two patient groups were staff facilitated exercise to enhance their independence and promote wellbeing. We visited the Parkinson's group in Portishead where a physiotherapist had developed an exercise programme to help patients maintain their mobility. Patients, in the pulmonary rehabilitation group, set their own goals and were empowered to exercise, despite suffering from a chronic lung disease. This helped to promote wellbeing and built resilience. Patients from both groups told us that attending the groups had had a positive impact on their day-to-day living and stated that they enjoyed the social aspects of the group and sharing their experiences of living with a chronic disease.

Access to the right care at the right time

- Patients had timely access to initial assessment and treatment in most services. Where possible, staff accommodated individual's preference for time and place when booking appointments for clinics. Senior staff from the four localities dialled into a teleconference each morning with senior managers located at Castlewood. In this conference, staffing levels, caseloads and safe haven beds were discussed in order to reach an overview and assessment of operational pressures. The senior management team from Castlewood also

dialled into a regional teleconference to gain a picture of operational pressures across different services (including local NHS trusts and ambulance services) across North Somerset.

- The organisation funded five 'safe haven' beds in nursing homes across North Somerset; these beds were for patients who were at high risk of being admitted to hospital. The patient stayed for up to seven days and received nursing care from the local staff and extended care and treatment from the rapid response nursing team, specialist nurses and allied healthcare staff.
- The musculoskeletal team reported an average waiting time from referral to treatment time of 5.4 weeks. The physiotherapy outpatient waiting list was around 18 weeks at the time of our inspection but waiting times for first assessment had at times been up to 23 weeks. However, the service had recently filled vacancies employing two new physiotherapists and hoped this would help reduce the waiting time.
- There were a team of occupational therapists (OT) who worked alongside community nurses and supported the 'discharge to assess' service. The OTs received referrals via the single point of access team and at the time of our inspection, there was a waiting list of three to four weeks for assessment for non-urgent assessments. All referrals were triaged by an OT, which ensured timely assessment and intervention. For example, the OT team had a referral from a nursing home where there was no hoist in place to help when transferring a new patient in and out of bed; the OTs were able to assess and request appropriate aids (hoist) which was in place by then end of the same day. OTs would visit patients referred for non-urgent assessment, within three to four weeks.
- Discharge to assess service triaged referrals onto two different pathways; one for patients suitable for home based and another for patients admitted to local nursing or residential homes for rehabilitation. In October 2016, the service received 53 referrals for patients discharged for home-based rehabilitation, of which 47 patients were accepted onto the pathway. The team saw all patients within two hours of discharge for assessment and the service was available Monday to Friday.The average length of stay with the service was 20-35 days. From April 2016 to end of October 2016 the majority of patients were discharged from the service (average of 68%) with no further care needed, some were discharged from the service with a package of care (average 11 %) while 15 % (48 patients) were emergency transfer back to the acute hospital.
- Patients were able to access treatment at a place convenient for them. The falls service would see people in their own homes or within a number of clinics throughout the local area. People were able to move between these clinics as appropriate to their needs at the time. Clinics were available Monday to Friday and generally ran on time and patients we spoke with said they did not have to wait long on the day of their appointment. If community nurses, specialist nurses or allied healthcare professionals had to cancel home visits, they phoned the patient to explain the reason, re-arrange the visit and to ensure the patients wellbeing.
- Community nurses explained how they aimed see patients at times in the day or evening that suited the patient's best. However, due to the nature of unplanned visits this was not always possible. We observed nurses contacting patients to discuss when they would arrive and this system worked well. Patients we spoke to said they were generally happy with the times that nurses arrived. The visits that we observed did not feel rushed and patients told us that they did not feel their visits were rushed. Nurses worked in a three shift pattern covering from 8am to 5pm on an early shift; 2pm to 10pm for a late shift before the night shift started their shift at 10pm and worked to 8am in the morning.
- Where possible services told us they arranged for cover during periods of sickness. However, this was not always possible and in these circumstances, nurses often worked overtime or visits were rescheduled for the following day. The service prioritised care for patients most at need. When we visited the overnight service, we witnessed the planning of the shift to get to a patient that had fallen, followed by triage of other patients based on their needs. If visits to patients were cancelled, nurses always called the patient to explain why the visit was cancelled, arrange a new time for nurses to visit and to ensure the wellbeing of the patient.
- The rapid response service provided care to patients in urgent circumstances for examples if they had fallen - this operated 24 hours a day, seven days a week When referrals arrived, they were triaged and allocated to staff with the correct skills. In addition, where capacity allowed, the rapid response team were able to support community-nursing teams when they were busy.

Good

Are services responsive to people's needs?

Learning from complaints and concerns

- People's concerns and complaints were listened and responded to in a timely manner and learning from these were used to improve quality of care. The provider had a policy for managing concerns and complaints which was available on their website. The policy set out steps, for timely response to complaints about the organisation. The policy stated that a complaint should be acknowledged within three days and a mutually agreed timeframe for dealing with the complaint should be agreed. The steps included advising the complainant of outcomes of investigation and actions taken. The final step was to ensure that any learning was reported monthly.
- The service had received 23 complaints in the period from August 2015 to August 2016 from across all localities. Eight complaints (35%) were upheld; these were related to six complaints about communication, one complaint about clinical treatment and one complaint about the premises. Most of the complaints were about communication issues. We reviewed two complaints and found the organisation had responded in a timely manner. Complaints were discussed in different meetings at different levels from board meeting to team meetings; this meant that staff across the organisation was aware of people's complaints and any changes that was made as a result of patient's complaints. For example, the development of the tissue viability service demonstrated where the organisation had learned from complaints. Poor patient outcomes attributed to other services, highlighted where actions could have been taken differently.
- There had been four complaints about the MSK service between August 2015 and May 2016. Two of these had been upheld. The upheld complaints were due to long waiting times from the initial referral to the first appointment. An increase in staff numbers meant the waiting times for patients was reduced. There were no trends identified as part of the complaints investigations.
- Staff told us complaints or concerns about their service were shared with them and any learning from them discussed at team meetings. It was unclear if there was a system to monitor, if any new practice put into place following a complaint, was embedded in practice.
- Patients were provided with information about how to make a complaint or raise a concern. Contact details were available and located on the front page of the patient care record, kept within patient's homes. All paper-based patient record folders viewed contained these details and we heard staff remind patients of the contact details if they had any concerns. Where clinics were held in GP practices, we did not see clear information about how patients could make a complaint about the care and treatment they received from staff from the organisation. However, we observed staff hand out feedback cards to patients when they were discharged from the services.

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

By well-led, we mean 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.

We rated well-led for community adult services as good because:

- The organisation had a vision and strategy and a set of values, which some staff had been involved with when the values were agreed.
- There was an effective governance framework with evidence of learning from incidents across the service.
- There was a corporate risk register but risks about service viability were not always entered on the risk register.
- Staff felt supported by their managers and team leaders and felt positive about the new executive managers in place, which they hoped would create stability, and support innovation.
- Staff felt valued and were supported to develop.
- Staff felt informed, engaged and team working was strong.

However,

- Managers did not consistently identify actions to manage risks.

Detailed findings

Leadership of this service

- Some staff were line managed by managers from social services although employed by North Somerset Community Partnership (NSCP) and some NSCP managers provided line managed responsibilities for staff employed by the council. This meant that staff working in the same team had different policies to adhere to but although staff commented that it was unusual it did not present any difficulties in the day-to-day work. Staff we spoke with were all positive about their local line management arrangements.
- Managers and leaders of services had the skills and knowledge to carry out their role. Many of them had worked within, or at similar services at a lower level and so had a working knowledge of the practices of staff. One of the lead nurses had worked as a district nurse, a lecturer and was a nurse prescriber, and at the time of the inspection was an advisor to the managed care team – offering support, and guidance
- Staff in community adult services felt well supported by their team leaders and locality leads. Staff received support when required and it was easy to access team leaders when staff had questions about care. Team leaders felt supported by locality leads who were often in the offices and therefore accessible for ad hoc advice and support; if they were not in the offices they were always available via telephone.

Service vision and strategy

- Staff were aware of the values of the organisation and some staff we met with had been involved with project work, where the values were developed. Staff demonstrated these values when caring for patients.
- The new executive team was in the process of introducing a new model of care, which focussed on a whole system approach. Staff in leadership roles were aware of the new model of care. However, the majority of staff 'just carried on doing their job' and did not feel that it had an impact on the way they were working. Many specialist services already supported the new model of care such as the patient groups for Parkinson's, the pulmonary rehabilitation group and the leg club. Individual services had visions of how to develop services to include more patients while at the same time help to manage capacity effectively. However, some senior nurses and specialist nurses felt there had been a period where it was difficult to enhance services in line with their vision. This was because there had been many executive managers in temporary posts who did not make decisions about new services. Staff told us they were pleased to have a new executive team, with only a couple of key appointments

outstanding. Staff felt this would create stability, but also the opportunity for development as it was largely a completely new executive team who was keen to improve services.

- The organisation had clear quality improvements priorities and staff engagement to achieve this was clear. For example, the work of the tissue viability service to reduce the prevalence of pressure ulcers and the innovative ways of working by the outreach team to reach out to 'hard to reach' groups in the local area.

Governance, risk management and quality measurement

- There was a governance framework to support the delivery of the strategy and good quality care. There had been recent changes to the logistical ways of working which meant that teams were now working in localities. This meant the organisation was in the process of appointing registered managers for each of the localities. This work was ongoing and included work about the responsibilities of registered managers and support available to fulfil responsibilities.
- One of the highest risks on the corporate risk register was low staffing levels, including difficulties with recruitment of staff, and the effect this may have on existing staff. Locality leads, team coordinators and clinical leads repeatedly stated staffing and capacity was something they worried about. Staff also raised this in focus groups we held with staff before and during the inspection. Other risks involving adult community services included a lack of multidisciplinary team working for patients with diabetic foot ulcers, harm from pressure ulcers acquired, capacity within the musculoskeletal team to meet demands and access to data and documentation of care. Each locality and the urgent and specialist care team had separate risk registers where locality leads or managers added current risks to services. However, there were no identified actions and the risk register had risks from 2014 with no actions or closure documented. This meant we were not assured about the effectiveness of how risks were managed within the localities.
- We visited two services at risk due to staffing; the lead nurse in the pulmonary rehabilitation service was due to retire in March 2017, the assistant therapist was going on maternity leave and there was already a vacancy within the service. The heart failure specialist team lead was leaving the week after our inspection and although a new lead had been appointed, there was an unfilled vacancy in the service; the heart failure service had started a waiting list to manage caseloads. Although, both services told us managers were aware and there were plans in place to recruit new staff. The risks to the delivery of the services were not on the corporate risk register and therefore it was not clear how this was managed.
- There were not always plans to ensure risks were mitigated effectively. For example, the night service had two nurse vacancies, which they were struggling to fill. Staff who usually worked at the hospital were covering these gaps, and the night service was running close to capacity. Staff expressed concerns about what would happen when the hospital reopened in the New Year and had been raised with managers.
- We visited three patient groups across North Somerset. One of the groups had decided to carry on meeting weekly and exercise together when the programme came to an end. However, the allied health professional was no longer going to be present and there was a lack of risk assessments about who would be responsible and liable in case of medical emergencies with patients whilst participating in the group exercise.
- There was a clear process for the reporting of, feeding back and learning from adverse incidents. We spoke to staff with varying levels of responsibility within this process. It was clear that the system was embedded and staff were confident in its use. We saw evidence that learning was discussed and shared at board level. We also reviewed minutes of meetings and found that patients' experiences – both good and bad – were discussed and evidence that the outcomes were shared with members of teams. We reviewed minutes of staff meetings in relevant services and we were able to corroborate the evidence and we were assured that learning from patient experience was shared at all levels and across the organisation.
- We reviewed minutes of meeting from the different localities and the urgent specialist care team. These demonstrated there were set agendas, but the agenda items were not consistent. This did not provide assurances that key messages were always shared effectively across the organisation. For example, in September 2016, minutes from the Gordano Valley locality meeting highlighted the need for all clinical staff to complete antimicrobial stewardship e-learning, however this was not included on Weston and Worle.

Good

Are services well-led?

We reviewed minutes of meetings from 'link nurse meetings'; for example the minutes of the tissue viability link nurse meeting. These minutes were not from a set agenda, but more a list of updates or issues discussed. There was little evidence that these meetings were used to discuss incidents and share learning from investigations into for example the development of pressure ulcers.

- Compliance with mandatory training was below the organisation's target in 21 out of 34 modules. Staff in the training department sent out training compliance reports monthly to locality leads and emails to staff that were not compliant with their mandatory training. There was no process for flagging up when compliance with training was much lower than the target. For example, we reviewed training compliance for diabetes training and 'safe use of insulin' and found varied compliance across the localities from 53% and 50% in Gordano Valley to 92% and 86% in the Rurals locality; the target compliance rate was 80%. We raised this with locality leaders and team leaders who were not aware of the low compliance rates this meant that managers did not have a clear overview of mandatory training compliance and effective actions were not taken to ensure staff compliance.
- Corporate policies held required information and guidance and reviewed regularly with updates as required. However, we found an example where the review was overdue.
- We did not see a consistent approach to auditing of assessment of risks compliance. We reviewed the MUST clinical audit November 2016, which stated 38 audits were returned but we unsure how many should have been returned. It was identified the recording of MUST assessments on the electronic patient records was a weakness with gaps and only 68% compliance.

Culture within this service

- Staff felt valued and respected. Staff also felt empowered to contribute towards changes in the way they work to care for patients. New ideas were listened to and staff were enthusiastic and passionate about what they did. The organisation encouraged candour, openness and honesty and there was a 'no blame' culture when incidents happened. Staff stated they were proud to be working for the organisation and that they looked after each other. They felt working for a small organisation was helpful as it meant that staff 'knew' each other, which encouraged efficient team working.
- Locality and team leaders were proud of the dedication of their teams and felt they provided a 'high quality of care'. A member of staff commented that they were 'really proud of the team and the wealth of knowledge' that it contained.
- Staff felt well supported by their team leaders who 'would fight their corner' and provide support when required. However, staff also told us that they do not log extra hours they worked.
- There was an emphasis on promoting the safety and well-being of staff. The service had embedded 'lone working' practices supported by the organisation's 'lone worker policy'. Staff said they felt safe and if they had concerns about visits, these concerns would be listened to and would be actions taken to ensure their ongoing safety.
- The organisation promoted well-being amongst staff. Staff had access to 'positive steps' (a partnership service with staff employed by healthcare organisations) which offered different kind of support, such as counselling, to staff free of charge. Staff also told us of a recent project, were staff across the organisation signed teams up to a step challenge. Participants were given a pedometer and encouraged to log daily 'step counts', league tables encouraged uptake and friendly competition between teams.

Public engagement

- Different services worked with voluntary sectors based in North Somerset for example, the admission avoidance team worked with Red Cross who could take people home and help them settle back into their home. The residential home support team worked with Age Concern and the Alzheimer's Society and the outreach team worked with volunteers helping to run the 'soup kitchens' which was a safe place for the team to meet with people needing the help, advice and support from the outreach team.
- Patients were able to feed back their views on the services provided via the NHS friends and family test to say if they would recommend the service. Staff told us they were told about the outcomes of this survey.
- Some services submitted information about public events and the actions taken as a result of feedback

from an organisational audit about patient and public involvement. For example, the little café run by the league of friends were the product of engagement between Clevedon Community Hospital and the public. The bladder and bowel service, the diabetes serves and the pulmonary rehabilitation service also logged public events such as talks, which included positive feedback about the services.

Staff engagement

- We looked at the results of the staff survey 2015, published in May 2016. It was not clear how many members of staff from each service had responded but the response rate had declined in comparison to the previous year with just 37% which meant that just over one third (226 employees) of the total staff had completed the survey. The staff survey highlighted that staff felt they worked well in teams and staff told us that team work was one of the reasons they enjoyed their work. Staff were generally positive about working for the organisation and all staff spoke positive relationships with patients and colleagues.
- The organisation had a staff council whose aim was to represent the views of staff in a forum that could be heard by the executive team. Staff were aware of the council and told us the council was in the process of being reinvigorated after having suffered a lull in recent times. There was also a drive to be more open at board level with it being available for staff to attend and ask questions.
- The organisation awarded individuals and teams for exceptional commitment, care, compassion, competence, courage and communications. The community outreach team won the 'partnership and patient and public involvement award' and the lead intravenous nurse won the clinical excellence award for receiving the most nominations from patients. The deteriorating patient's group' won the patient safety award for implementing an early warning score tool across the organisation to support staff in early assessment and treatment of patients at risk of clinical deterioration.
- The organisation distributed weekly bulletin to all staff via email. Staff felt that this kept them informed of NSCP activity across the patch. The lymphoedema team distributed a team bulletin on alternate weeks to keep all staff informed of team issues and any other developments. This was said the be useful as members of the team did not meet very often as they ran clinics in different areas on different days
- We spoke with several teams who had been visited by members of the executive team; staff told us the executive team members had spent time with them, observing them carrying out their jobs and felt this had given the executive team a good insight into the job and the challenges within the job.

Innovation, improvement and sustainability

- The organisation had introduced a new model of care, which involved a whole system approach to care. There was an awareness of this amongst senior staff and in particular specialist services. Some of the recently introduced pilot projects supported this care model. For example, the Parkinson's group felt empowered to carry on meeting and felt connected with and supported by others in similar circumstances. The pulmonary rehabilitation group encouraged patients to change their behaviour to include more exercise and worked to their own goals; they too benefitted from meeting with others with similar conditions.
- A consultant nurse led a project aimed at leading innovation and quality improvement in care for older people and sought to develop a wider approach to diagnosing and managing frailty in specific area within the community.
- A specialist nurse was involved with a research project to detect hyperglycaemia (high blood sugar) in cancer patients receiving a specific medicine (Dexamethasone).
- The tissue viability service was trialling a new dressing system, which was an alternative to compression dressings. The device enabled nurses apply a more consistent approach to treatment, and had proved effective at healing leg ulcers. Although the device had a larger outlay at the start of treatment, the service had estimated savings at £17,000 on dressings per team where this device could be used. It also estimated a cost saving of £6000 in nurse's time per team.
- The Speech and Language Therapy (SALT) service intended to carry out a training programme in 2017 within care homes. The service recognised that staff frequently changes within care home settings so this training was to be delivered three times a year.
- Diabetes UK initiatives were followed by the tissue viability service in relation to identifying the need for

Good

Are services well-led?

foot care for people with diabetes. The team requested all staff use the 'check, protect and report' method as well using stickers in care records to highlight the need to check patient's feet. We observed nursing teams using this system during home visits.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: **12 – (2) (a) Assessing the risks to the health and safety of service users of receiving the care or treatment:** Staff did not always identify and responded appropriately to patient risks. We saw records of care where not all of the required assessments such as Waterlow score (a risk assessment tool to assess a patient's risk of developing pressure ulcers), malnutrition universal screening tool (MUST a tool used to assess patient's risks of malnutrition) and frailty assessment, had been recorded.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: 17 – (2) (b) Assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity: There was a lack of auditing compliance with assessing risks to patients such as the completion of Waterlow score, MUST assessments and falls assessments. Compliance with audits such as infection control and documentation were not consistently submitted, which meant there was a lack of corporate overview. **17 – (2) (c) Maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and**

This section is primarily information for the provider

Requirement notices

of decisions taken in relation to the care and treatment provided:

How the regulation was not being met:

Electronic patient records were not completed contemporaneously in community adult services to enable all healthcare professionals to view up-to-date care and treatment for patients.