Care Quality Commission

Bristol Community Health C.I.C.

1-296908348

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Whitchurch Health Centre	BS14 0SU
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Stockwood Medical Centre	BS14 8PT
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Brooklea Health Centre	BS4 4NH
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Air Balloon Health Centre	BS5 7PD
1-304870639	Bristol Community Health Headquarters	Single Point of Access service, Withywood Centre	BS13 8QA
1-304870639	Bristol Community Health Headquarters	Domiciliary Therapy and Podiatry service, Knowle Clinic	BS4 1UH
1-304870639	Bristol Community Health Headquarters	Bladder and Bowel service, The Medical Centre, Ridingleaze	BS11 0QE
1-304870639	Bristol Community Health Headquarters	Health Asessment Review team and Continuing Healthcare team, South Plaza	BS1 3NX
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Horfield House	BS7 9RR
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Southmead Health Centre	BS10 6DF
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Granby Clinic	BS3 3NU
1-304870639	Bristol Community Health Headquarters	Community Nursing team, William Budd Health Centre	BS4 1WH
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Fishponds Health Centre	BS16 3TD
1-304870639	Bristol Community Health Headquarters	MATS and Spinal service, Hampton House	BS6 6JU

Summary of findings

1-304870639	Bristol Community Health Headquarters	Rapid Response team, North Bristol Intermediate Care Centre	BS10 7EH
1-304870639	Bristol Community Health Headquarters	REACT In-Reach service and Community Discharge Coordination Centre, Southmead Hospital	BS10 5NB
1-304870639	Bristol Community Health Headquarters	Parkinson's Clinic, Fishponds Health Centre	BS16 3TD
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Shirehampton Medical Centre	BS11 9SB
1-304870639	Bristol Community Health Headquarters	Community Nursing team, Lawrence Hill Health Centre	BS2 0AN
1-304870639	Bristol Community Health Headquarters	Dermatology service, John Milton Clinic	BS10 7DP
1-304870639	Bristol Community Health Headquarters	Rapid Response team, East Bristol Intermediate Care Centre	BS5 8HX
1-304870639	Bristol Community Health Headquarters	Out-of-hours nursing team, Withywood Centre	BS13 8QB
1-304870639	Bristol Community Health Headquarters	The Haven, Montpellier Health Centre	BS6 5PT
1-304870639	Bristol Community Health Headquarters	Tuberculosis clinic, Bristol Royal Infirmary	BS2 8HW

This report describes our judgement of the quality of care provided within this core service by Bristol Community Health C.I.C. 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 Bristol Community Health C.I.C. and these are brought together to inform our overall judgement of Bristol Community Health C.I.C.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We rated community health services for adults as good because:

- There was a well-embedded culture of incident reporting and all staff spoken with were aware of their responsibilities to identify and report incidents.
- We observed good infection control practice through staff washing their hands, using personal protective equipment and following sterile techniques.
- Staff were up to date with their mandatory training and reported the training was of a good quality.
- The safeguarding team were visible and available for support, staff were confident in making safeguarding referrals.
- There were clear tools and templates that were used to help assess patient needs and respond to any risks.
- Policies, care plans, tools and templates were based on best practice guidelines.
- The organisation were aware of staffing pressures it faced and mitigated these to ensure safe staffing levels across community adult teams.
- We saw good examples of audits to monitor patient outcomes and the quality of the services.
- There was good integration of staff roles within teams to achieve multidisciplinary working, different teams linked together to deliver coordinated care and there were appropriate connections with external healthcare organisations.
- We observed good care and positive interactions provided by staff to patients. Patients were treated with compassion, kindness, dignity and respect.
- Shared decision-making was well embedded whereby staff involved patients in planning and making decisions about their care and treatment.
- Where practically possible the service was responsive and planned care to meet the needs and demographics of the local population.
- All staff spoken with were complimentary about the leadership within Bristol Community Health. Staff found local and executive management to be supportive, visible and approachable.

- There was an overwhelmingly positive culture amongst teams with a great sense of teamwork and camaraderie.
- The governance structure enabled information to be cascaded up through the organisation and back down.
- Identifying and managing risk was a high priority. Teams were monitored, and areas of risk were identified with actions to reduce risks and make improvements.

However:

- We did identify an inconsistent knowledge of the duty of candour amongst staff; the duty of candour requires openness and honesty to patients when things go wrong and an apology to be provided.
- The lack of mobile working affected negatively on the effectiveness of staff daily work, reducing access to information when working remotely and causing duplication in paperwork. However, the organisation was in the process of reintroducing mobile working.
- Improvements could be made to access for some services, for example podiatry and therapy teams, where referral to treatment times were below national indicators and therefore patients were waiting a long period of time for both urgent and non-urgent appointments. The organisation had identified their shortfalls in referral to treatment times and had implemented actions to improve these services.
- Staff safety was a risk area for staff lone working in the community. Teams were responsible for formulating their own lone working processes and therefore this was not supported by a detailed lone working policy. Speaking to staff, we found differences in the level of success teams had with their processes for ensuring staff safety.
- There was no oversight on the board for the services provided to people at the end of their life. The service had no specific risk register and there were no audits being undertaken.
- Not all staff supporting people at the end of their life had an understanding of the national guidance: 'five priorities of care for the dying adult'.

Summary of findings

Background to the service

Bristol Community Health provides community health care services making over 35,000 healthcare contacts with adult patients each month, and currently treating around a third of Bristol's over 65 population. The care and treatment was provided under the regulated activities: diagnostic and screening procedures and treatment of disease, disorder or injury.

The community adult teams provided care and treatment to people in their own homes, residential and nursing homes, local health centres, clinics and acute hospitals. Community nursing was provided 24 hours a day seven days a week.

We inspected a wide scope of community services provided to adults in Bristol. This included community nursing, urgent care, specialist services, continuing healthcare, musculoskeletal services and end of life care and pathways. We spoke to 178 staff across different job roles and seniority, 27 patients and 11 relatives/carers. We observed care in ten clinics running during the inspection and accompanied staff to 21 patient home visits. We reviewed 16 electronic and 13 paper patient records. We requested data and reviewed this as evidence. Additionally, we phoned and spoke with ten patients who provided feedback on the care they had received when using community adult services and six relatives/carers who provided feedback on the care received when a patient was end of life. We ran two focus groups during the inspection where in total 44 staff attended.

Bristol Community Health provided a number of services for adults including:

- Twelve community-nursing teams who provided healthcare and support to housebound patients.
- Therapy teams who provided occupational therapy and physiotherapy at a person's place of residence or within the community setting. This included elderly and neurotherapy domiciliary therapy teams and clinics for musculoskeletal (MSK) outpatient service and musculoskeletal assessment and treatment service (MATS) and spinal service.

- Intermediate care included three rapid response teams and three community rehabilitation and re-ablement teams.
- Discharge coordination centre for a single point of exit for all hospital discharges in to community rehabilitation services.
- Three migrant health services to include haven, tuberculosis and healthlinks, which provided support to migrants, asylum seekers and refugees.
- Specialist services provided clinics across Bristol to support patients in their homes if required, and give support and advice to staff, including: bladder and bowel, respiratory, dermatology, heart failure, Parkinson's, falls, wound care and diabetes and nutrition.
- Macmillan rehabilitation and support team to help patients living with cancer to manage symptoms or issues in order to improve quality of life.
- Podiatry service held clinics across Bristol to provide comprehensive foot care.
- Two rapid emergency assessment care teams based in emergency departments support patients who have been in hospital for less than 48 hours to return home.
- A health assessment and review team and a continuing healthcare team assessed patient eligibility to access NHS continuing healthcare and funded nursing care.
- Single point of access team who received referrals, triaged the referral and transferred the case to the appropriate team.
- Palliative care, home support service providing personal care and emotional support for patients who wished to be at home, as they approached the end of their lives.

We visited or spoke with teams from the above services, with the exception of the community rehabilitation and re-ablement teams.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken, invited independent chair

Team Leader: Alison Giles, Care Quality Commission

The community adults team included CQC inspectors and a variety of specialists: a qualified nurse with a master's degree in clinical governance and an honours degree in community nursing, a qualified nurse who was a former matron of a nursing home and a current member of the health and adult care overview and scrutiny committee, and a qualified physiotherapist who has managed a number of community services. We were also supported by two experts by experience who talked with patients who had consented to talk with us by telephone about their views and opinions.

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 Bristol Community Health, 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 15, 16, 17 and 18 November 2016 and an unannounced visit on the 28 November and 1 December 2016. During the inspection, we held focus groups with a range of staff who worked within the service, to include community nurses and staff from other adult services. We observed how people were being cared for, talked with carers and/or family members, and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During the inspection, we spoke to 27 patients and 11 relatives/carers who were all overwhelmingly positive about the care and treatment they had received by Bristol Community Health services and staff. We phoned ten patients who used community adult services and six patients who used palliative care services, again all feedback was positive. Comments included:

"Absolutely brilliant, I can't praise the care enough."

"Care was fantastic and very respectful."

"Always smiling, professional and they treat me with respect."

"Marvellous. Could not fault the staff. Can access the service quickly."

"The quality of the service I have received here has been exceptional. The staff are wonderful. I have been treated with the utmost care, respect and dignity. I feel truly listened to."

"It has been superb. I could not ask for more care"

Are services safe?

"I am eternally grateful to everyone who came – the district nurses and the palliative care team. There was a follow up by the palliative care team, which went beyond the call of duty. Everything was well coordinated."

"Absolutely happy with all the care. It was brilliant – everything. Wonderful help and support."

Outstanding practice

- The organisation's approach to shared decision-making and inclusion of the patient was well embedded within their culture, we observed this in practice and evidenced in records.
- Specialist services were provided by Bristol Community Health to meet the needs of people; these services were flexible and innovative to make improvements to enable services to deliver care and treatment, which was accessible to the local population with no discrimination. For example migrant health services and the Macmillan rehabilitation support service.
- The Haven service recognised the additional support required for their staff to manage stories and images they were exposed to. Weekly access to a psychologist was made available for staff.
- We observed excellent multidisciplinary team working both across the organisation and with other healthcare organisations. In particular, staff worked hard to make sure all involved in the patients end of life care were up to date with their condition and their visits were all coordinated to prevent duplication.

- When patients were referred to fast track for end of life care, the whole palliative care team worked exceptionally hard to set up packages of care and to speed up discharges from hospital so they could spend their final days at home with their family and friends.
- The visibility of, and support provided by the safeguarding team had increased the quantity and quality of safeguarding referrals across the whole organisation.
- The multidisciplinary working undertaken by the rapid response team was helping to speed up patient discharges and prevent hospital re-admissions.
- The organisation had effective processes to review teams and identify areas of risk through their 'hot teams', this allowed issues and risks to be identified early and action plans to be developed and followed to reduce risks and make improvements.

Areas for improvement

Action the provider SHOULD take to improve

- Review staff understanding of the duty of candour in community adult teams and ensure it is consistently applied and evidenced.
- Continue to review staffing levels and pressures facing staff within the community adults' teams and follow action plans to increase staffing to enable services to be delivered safely and effectively. The tools used for escalation should be confirmed to be fit for purpose.
- Continue to monitor community adult service waiting times for patients and implement changes to improve access to patients.

- Review lone working arrangements across the community adult services to ensure robust processes for staff safety.
- Appoint a member of staff on the board to oversee end of life services.
- Devise an end of life strategy.
- Look at systems for monitoring and reviewing end of life care across the organisation.
- Devise a specific end of life risk register to monitor risks.
- Provide training for staff about the five priorities of care for the dying adult, which supersedes the Liverpool care pathway.

Are services safe?

Good ●

Are services safe?

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

Summary

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

- All staff had a responsibility to report incidents. Incidents were investigated, and as a result action was taken and learning was shared.
- We observed all staff following best practice for infection control to reduce the risk of infection.
- Equipment appeared fit for purpose and was well maintained.
- Records were complete, accurate, legible and up to date. On review of records, comprehensive assessments and risk assessments were completed for patients.
- The organisation reported good mandatory training compliance and staff told us the quality of their training was excellent. Staff spoken with had a good knowledge of training subject matter.
- The safeguarding team were available to support community adult teams. Staff were confident in when and how to make a safeguarding referral.
- There were a number of tools and templates available, which staff used, to assess patient risk and identify a deteriorating patient.
- The organisation was aware of the staffing pressures they faced and these were included on the operational risk register. Staffing was planned taking in to account patient risk and acuity, and bank staff and staff from other teams were used to ensure safe staffing levels.

However:

- There was an inconsistent knowledge of the duty of candour when talking to staff.
- The organisation faced challenges with staffing and teams were faced with pressures from the demand of case and workloads.

- The staffing tool used by the community nursing teams was not fit for purpose.

Detailed findings

Safety performance

- Safety performance and harm free care was measured using the safety thermometer. The safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care and involves a monthly snapshot audit. This includes information on pressure ulcers, falls, urinary tract infections (UTI), catheters and venous thromboembolism (VTE). We reviewed data between April and September 2016 and found data to be consistent each month. In summary, the data reported 97% of harm free care provided across the organisation; this is good compared to other similar services. Each team was provided with a breakdown of their individual safety performance data and this was shared with staff at team meetings.
- In October 2016, the organisation reported in their monthly quality report to the board the overall harm free care as 98%, which was above the national benchmark of 94% and community benchmark of 94%. They identified falls had decreased from 1.3% to 0.5% which remained below the national benchmark of 0.6% and community benchmark of 0.7%.
- The organisation had seen a rise in serious incidents for pressure ulcers. However, this was attributed to the increased numbers of patients unwell and at the end of life on caseloads. We were told complex case review meetings took place quarterly to discuss incidents, the number of pressure ulcers and common trends.
- Harm free care meetings took place at which root cause analysis (RCA) of incidents were reviewed.

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Following review, common trends were identified and patient safety messages were sent out by email to the whole organisation to address issues for change and improvement.

Incident reporting, learning and improvement

- There was a well-embedded culture of incident reporting among all community adult teams we visited. Staff understood their responsibilities to raise concerns, record and report safety incidents, concerns and near misses. Learning from incidents and improvements could be demonstrated.

- Staff spoken with said the electronic incident reporting system was easy to use, they were confident in recording incidents and were encouraged to report the same day. Staff said the person reviewing an incident, for example managers, provided them with feedback via email or at team meetings. Particular examples of feedback were with regard to outcomes of safeguarding incidents reported. Staff also said learning from incidents was disseminated to all teams.

- A monthly newsletter named 'close encounters timeline' was sent out to staff summarising incidents and learning. We reviewed the newsletter for August and September 2016, which included incidents involving medication, equipment/device failure and needle stick injury.

- The organisation reported 49 serious incidents requiring investigation (SIRI) for the community adults' service between 3 July 2015 and 4 July 2016. Of these 49 SIRIs, 40 were reported by community nursing teams, two from both wound care services and intermediate care/rehabilitation, and one each from rapid response, physiotherapy, translation services, continuing healthcare assessment team and podiatry. The majority of the SIRIs, 39 in total, were described as grade three or four pressure ulcers developed under Bristol Community Health care. Two SIRIs of the wrong dose of insulin were reported.

- All SIRI's were subject to a root cause analysis (RCA). Staff responsible for completing the RCA received specific RCA training. One example of a SIRI and completed RCA was where a patient had been delivered the wrong pressure-relieving mattress; as a result, the patient developed a pressure ulcer. The RCA and complex case review identified the wrong mattress had been delivered by an external organisation. Following this incident, learning had

been identified and changes had been made to clinical practice improving the checking process by staff of the equipment. We saw evidence of the patient safety alert disseminated to staff titled 'trying to identify the type of pressure relieving mattress', this provided a background to the incident and the checks staff must follow.

- The palliative care home support service told us about an incident where learning had been shared. The incident had shown the correct documentation was not in the patient's house, for example, 'do not attempt cardiopulmonary resuscitation' form. Following this, a checklist was devised and now when the palliative care home support service visit a patient for the first time they must ensure correct documentation was being used, otherwise they must report to the community nurse.

- One community nurse team demonstrated how they had made changes because of increased insulin incidents with missed doses. The team has since implemented a coordinator role and an associated checklist. The coordinator was responsible for caseload allocations and checking patients requiring insulin have been visited. The increased level of medicine incidents, particularly missed doses for insulin, had been identified in board reports. The board identified how work was continuing in training staff and reviewing processes. An insulin task and finish group was set up and were providing training for all staff administering medication; this commenced in April 2016.

- We were told by senior staff there had been an issue with the podiatry staff not routinely reporting incidents involving pressure ulcers. Following a review of this all staff within the team received skin bundle training, after which reporting of pressure ulcers increased. Staff told us this had increased the number of pressure ulcers identified and as a result, more patients were receiving treatment for their pressure ulcers sooner.

- Senior managers and clinical staff held regular complex case review meetings, where all relevant staff involved in the case were invited. This included clinical managers and staff relevant to the investigation, safeguarding lead, learning disabilities staff and various managers including quality and safety, clinical leads, operations and governance. We attended a meeting, and heard staff present incidents and accept

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challenges and questions from the rest of the meeting attendees. We also saw discussions around learning from the incidents, which included the use of organisation wide electronic patient safety messages, and discussions around buying specialist equipment to help prevent similar incidents happening again.

- There were effective arrangements to respond to relevant safety alerts. One example was an alert for methotrexate overdosing that was disseminated to teams; we saw this information displayed on safety alert boards. A second example was an alert identified by the organisation; some patients experienced undesirable side effects from interactions between their existing medication and heart failure medication. The medicines manager informed the clinical commissioning group and sent out a safety alert to GP practices. The medicines manager also performed a retrospective audit of all patients on this medicine to identify patients who were at risk of having unwanted side effects.

Duty of Candour

- There was an inconsistent knowledge and understanding of the duty of candour by staff. Some staff told us they had received formal training on the subject but others had not. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.

- Staff who had an understanding of the duty of candour were aware of the principles of openness and transparency, which were encompassed by the duty of candour, and the requirement to provide an apology to the patient and/or relatives/carers. Examples of when the duty of candour were applied included patients with pressure ulcers attributable to the organisation. Patients were offered an apology regardless of whether the pressure sore was avoidable and an investigation was carried out, after which the outcome was provided to the patient. Although staff said they followed the duty of candour, they acknowledged this was not clearly recorded within the patient records or the incident report to evidence the duty of candour.

- The organisation told us they had identified a gap in the application of duty of candour when reviewing complaints and root cause analysis; as a result, the complaints lead delivered additional duty of candour training to staff. However, during our inspection we still identified a gap in the understanding of duty of candour among staff.

- We reviewed two complex case reviews, which included whether the duty of candour had been met. In one complex case review, it said the patient had been spoken to and apologised in line with duty of candour, however a duty of candour letter had not yet been sent to the patient. This showed a delay in duty of candour communication as it was documented the duty of candour was carried out in February 2016 and the complex case review was completed two months later in April 2016. We were told letters do not go out until after the complex case review meeting has taken place. This meeting considers the investigation and determines whether or not harm has occurred as a result of Bristol Community Health and what organisation learning there is following the investigation, which can be shared.

Safeguarding

- There were clear safeguarding processes to safeguard both adults and children from abuse. Staff were aware of their responsibilities to report safeguarding concerns and adhered to safeguarding policies and procedures.

- Teams spoken to were confident in completing safeguarding referrals and gave examples of the types of concerns they would report. Staff told us they received feedback from safeguarding concerns and referrals they raised. This was cascaded from the organisation's safeguarding team to frontline staff through their line managers. A flag was added to the electronic patient record system when a safeguarding referral had been made; this effectively informed other staff who had contact with the patient.

- The safeguarding adults' policy reflected current legislation and guidance. The policy was easily available to staff in hard copy and on the intranet, and included the contact details for the relevant local authorities. A flow chart could be followed by staff when making a referral and staff had a responsibility to report any safeguarding concerns the same day. The policy also included information on female genital

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mutilation and prevent. Prevent is training for the government counter terrorist strategy so people have the due regard to the need to prevent people from being drawn into terrorism, identifying people who may be vulnerable to radicalisation and referring and supporting these individuals.

- An enhanced safeguarding process was used by the Haven service (migrant health service) to provide staff with a greater understanding of what would be deemed a cultural belief or accepted practice in a patient's country of origin.

- Staff completed safeguarding level two training for adults and children, delivered via an e-learning package. Safeguarding training for the community adults service in October 2016 reported 98% compliance safeguarding adults level one, 92% compliance safeguarding adults level two, 98% compliance safeguarding children level one, 92% compliance safeguarding children level two, and 88% safeguarding children level three. Training required three yearly updates. The safeguarding children lead was required to have safeguarding children level four and this was updated each year.

- The safeguarding manager was assured staff understood their responsibilities to follow the safeguarding policies and procedures because the number of safeguarding referrals had increased. The annual safeguarding report produced by Bristol Community Health showed between April 2015 and March 2016, the number of safeguarding referrals made by staff increased by 77%. Between April 2015 and March 2016, the number of missed safeguarding referrals had decreased overall.

- Link safeguarding staff were based within different clinical teams and helped deliver key messages and updates to the wider teams. Training to the link staff was delivered in quarterly meetings using key messages, updates, discussions and case studies. Link safeguarding staff attended a minimum of two meetings a year. We were shown minutes of one of these meetings.

- Staff could name the safeguarding and dementia lead and provided examples of how they had contacted them for advice and guidance. The safeguarding team provided advice to staff and kept a log of all calls. A monthly analysis of the calls was completed to identify any themes or teams where additional training was needed. For example, they would target teams who

were not calling in for advice, and offer refresher face-to-face training, especially teams who may not need to make many safeguarding referrals due to the nature of their work. In the annual safeguarding report for 2015/16, 24 teams had been identified for additional safeguarding training; teams were identified through a combination of call logging and complex case review meetings, and had received further face-to-face training from the safeguarding team.

- Complex case reviews were attended by the safeguarding team, these meetings helped identify complex individual cases where safeguarding alerts should have been raised. Learning from these meetings was shared with the wider team through the link safeguarding staff and electronic patient safety messages.

- There was an escalation policy for Bristol Community Health staff to use, which had been agreed by all members of the Safeguarding Adults Board. This policy was for staff to use when they had not been able to reach agreement on decisions made by local authorities. When this had happened, the safeguarding team took the case to the strategic safeguarding manager at the local authority to resolve. The safeguarding team had completed work to raise staff awareness of the policy, monitoring the use of this policy had shown an increase in the numbers of cases being referred.

- The safeguarding team told us clinical staff were good at assessing the needs of their patients and since the introduction of a new category of self-neglect in the Care Act 2014, they had seen an increase in safeguarding referrals using this category. Staff told us this was because some of the most vulnerable patients were well known to the clinical staff, so they were able to quickly identify whether there had been a decline in the patient's condition, which may require a safeguarding concern to be raised.

Medicines

- Arrangements for managing medicines were observed to be safe within community adults' teams. Staff adhered to the organisation's policy on medicines management; ensuring patients were kept safe and well advised. Medicines were stored safely and

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securely at all bases and temperatures of rooms where medicines were kept were monitored. Stock takes were completed weekly to ensure there was sufficient stock and medicines were in date.

- There was no delivery service of medicines for the musculoskeletal assessment and treatment and spinal service and musculoskeletal service. The services and the organisation, prior to our inspection, had already recognised a delivery service would be better practice and discussions were being held to implement this. The ordering and collection process for the services had therefore been risk assessed, we saw copies of the risk assessments and we found it to be appropriate.

- The system for prescribing medicines was paper based, and medicine was delivered directly to patient homes. Prescribing templates had been developed for use on the patient electronic record system; this was hoped to become mobile so staff could prescribe while out in the community. Medicines were also obtained by a GP prescription by the patient, their family/carers or delivered to the patient by the chemist. The medications were held at the patient's home for community nurses to administer when visiting the patients.

- The community nursing teams carried adrenaline for allergic emergencies. Nurses carried adrenaline, which required being drawn up in to a syringe, and health care assistants carried devices with fixed doses of adrenaline. We checked a random sample of these and confirmed all were in date.

- We observed nurses safely administering patient medicine and maintaining a record in the patient notes. One nurse administered a controlled drug for pain relief, this was signed out in the controlled drug record and a record of the use of medicine, where placed (method of administration), batch number, expiry, time, date and dose was made. Patient records observed included a community nursing prescribed medicine authorisation chart, signed by the GP, and an accompanying record of medicine administered, which was clearly completed.

- During home visits, community nurses were observed asking patients about their medicines, checking any side effects, if there had been any changes to their prescription, and ensuring they had appropriate medicine available. Should further medicine need to be prescribed or discussed the nurse would request from the GP.

- We observed good practice by a health care assistant who checked the expiry date of a patient's own skin cream before applying. The health care assistant noticed the cream had expired, they informed the patient they were unable to use this cream and the patient should dispose of the cream and a new one would be ordered.

- Community nurses were using syringe drivers for some patients receiving end of life care. Syringe drivers are a device used to deliver medicines just beneath the skin and used for pain relief and/or symptom control. We saw these were prescribed by the patient's GP on a prescription chart and the community nurses signed and dated these when they had changed the syringe driver. Where syringe drivers were in use all doses were written up and signed off.

- There was a standard end of life prescription chart used across Bristol Community Health. Symptom management guidelines were included for staff to refer to for advice. Patients who were identified as requiring end of life care were prescribed anticipatory medicines. These 'just in case' medicines were prescribed in advance in order to promptly manage any changes or deterioration in patients' pain or symptoms. The prescription chart gave qualified nurses the flexibility to meet patient's needs by including a treatment range, with the ability to administer from a starting dose to a maximum dose and anywhere in-between. This enabled medicine doses to be increased or decreased as required in response to changeable symptoms with minimum delay to the patient.

- We saw medicines were stored safely in patients' homes for end of life care. We observed a qualified nurse administer 'just in case' medicine to two patients whose symptoms had deteriorated. They followed the prescription chart and checked the medicine carefully against this. They then recorded the batch number and how much medicine was given in the patients notes, signed, and dated the patient's prescription chart. Any medicine left over was disposed of as per their policy.

- The heart failure service introduced sick day rules, where patients were provided with a clear plan of action to take regarding their medicines and which medicines they should stop if feeling unwell. This was done to avoid renal deterioration. Patients were prompted to seek medical advice.

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- The rapid response team carried out a medicines review for every patient on first visit, which ensured they were taking the correct medicines and the patient knew why they were taking this medicine.
- Bristol Community Health was working to meet two Commissioning for Quality and Innovation (CQUIN) targets set by the clinical commissioning group. The two targets for 2016/17 were to reduce the numbers of medicine incidents, focusing on missed doses of medicine and controlled drugs related incidents, and to maintain the reduction in use of broad-spectrum antibiotics. The rate had already reduced from 19% to 11% under a previous CQUIN.
- There had been an increase in the number of near misses in relation to documentation surrounding the administration of insulin. The medicines manager had identified staff in the community were using an established manual system to record when next doses of insulin were due to be given, and investigations showed staff were not using the system consistently because there was not a standard operating procedure. This was rectified, and we saw the numbers of missed doses of medication had decreased, and was being continually monitored by the medicines manager.
- The medicines manager told us work had been undertaken to help staff understand the need to pause and check before administering medicines in the community, in particular insulin. Staff told us working in patient's homes could be distracting, and staff had received additional training to help them explain to patients and their families about the importance of having time to concentrate on some of their tasks in relation to the administration of medicines.
- Controlled drugs were monitored closely following a serious incident where a quarterly report on controlled drug prescriptions had shown some anomalies for one member of staff. The investigation was handed over to the police. As a result, prescription data reports were changed from quarterly to monthly reports and all data was shared with line managers of the community teams. Bristol Community Health also had a policy, which meant no more than one-week stock of a controlled drug could be prescribed by a nurse prescriber, unless they had special scope of practice arrangements such as in the pain management or palliative care teams.

- Staff we spoke with in the out of hours service told us missed medicine doses were often an issue as carers did not consistently ensure patients were taking their medicine or documenting when they did. On one visit, we saw nurses check a medicine chart to ensure it contained the same medicines as the pre-dispensed dosette box in the patient's home, where all tablet medicines were ready sorted into doses for each time of the day it needed to be taken. The nurses found the chart and the box did not match up and proceeded to review and update the whole patient medicine chart. One of the nurses told us they would discuss the incident with their manager as they felt it should be reported as a near miss. The nurses identified another Bristol Community Health nursing team had written the original incorrect chart, and gave details to the manager to pass on to the other team.
- The out of hours team told us it was sometimes difficult to obtain prescriptions for new medicines overnight, and they were reliant on the out of hours GP service to sign prescriptions, which staff said took time away from visiting patients.

Environment and equipment

- Equipment was observed to be fit for purpose and was used to support safe care and treatment. All teams told us they had all the equipment they needed to complete their job and equipment was in good working order.
- Bags containing equipment, for example protective gloves and aprons, dressings, and for qualified nurses, needles and syringes, were available to all staff visiting patients at home.
- Equipment available to and used by staff was serviced annually. We performed random checks of equipment; all were observed to be in date and labelled clearly with the date of the next service. Should equipment be faulty or need a repair there were processes to report and replace in a timely manner.
- An external equipment provider was used to order equipment required for patients, staff told us equipment could be ordered the same day and out of hours if urgent. There were no problems with equipment availability.
- There were arrangements to ensure specialist equipment was available to patients who were receiving care and treatment in their own home. There were 1,500 staff who were qualified equipment

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prescribers, who wrote requests for equipment based on the patients' requirements. The prescriptions were submitted by the equipment co-ordination team who checked each prescription against the patients' needs. If the order for a single piece of equipment exceeded the budget, a specialist panel were required to grant authorisation. Staff would ensure they had researched equipment and presented a case to the specialist panel for approval, which explained in detail all the reasons why the patient required a piece of equipment and how it would benefit them.

- The domiciliary therapy team told us if specialist equipment were delivered, the clinician would receive training on how to use the equipment by a company representative supplying the equipment. The clinician was then responsible to train the patient and/or their relatives/carers on how to use the equipment safely.

- Equipment safety issues were reported as incidents on the electronic incident reporting system and reported to the external provider who supplied the equipment. There were stickers on the equipment with the contact details of who to contact in the event there was a breakage or fault. Patients were also advised to contact their therapist if there was an issue with the equipment, which would then be escalated to the equipment providers. Once a patient no longer needed to use equipment, it was deep cleaned and made safe for use by other patients.

- Equipment was held at bases in locked stock cupboards. We observed equipment was well organised and on a random check equipment was in date. There were processes for checking and ordering stock. The community nursing teams said the wound care team reviewed stock for dressings six monthly to ensure current and appropriate dressings were in use.

- Waste was managed safely. We observed community nurses placing waste in a bag, which was then disposed of by the patient. Staff told us there were systems to arrange for environmental health to deliver yellow clinical waste bags to the patient if large amounts of clinical waste were produced. Community nurses also took a labelled sharps bin to patient homes, to dispose of sharps safely and correctly used the safety closure mechanism. The premises we visited where community clinics were held had procedures to be followed for the management, storage and disposal of clinical waste.

- There were processes for community nurses to sign the syringe driver boxes in and out. Community nurses told us they stored between three and five syringe drivers at their bases but at times had to borrow some if they needed more. However, they felt this had never delayed them from being used. Each syringe driver was stored in a box that contained all the required equipment for its use. For example, water for injection, needles, soft set infusion line and batteries. Community nurses told us these were serviced and maintained, we saw stickers indicating equipment was serviced and in date.

- Staff were confident in safe manual handling practice and had received training. Equipment could be ordered to safely move patients in their homes. We were told community nurses would complete a risk assessment for patients and visit in pairs to ensure safe manual handling practice.

- The environment in the community clinics was appropriate to deliver care and treatment. Some clinic premises were old and tired through use. However, regular maintenance was carried out.

Quality of records

- Individual patient records were written in detail for each patient visit; records were kept at the patient home and inputted on the electronic patient record system. Electronic records ensured records were kept secure and maintained patient confidentiality.

- Staff working in the community were not able to access the electronic patient record system remotely and therefore would complete electronic records when they returned to their base. Patient records were also held at the patient home and these would be completed at the end of a visit. Staff visiting patients were required to input their notes on the electronic patient records within 24 hours of seeing the patient. Staff told us this was not always done as caseloads or training days could prevent them adhering to this target.

- We reviewed 13 hand written records in patient homes and 16 electronic records. Records were accurate, complete, legible and up to date. Handwritten notes were signed by the person completing. Paper records, which were not held at the patient home, were stored securely under lock at the bases.

- There were numerous templates available for staff to use, both hard copy and electronic, which staff said

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had improved the quality of their records due to the prompts available, which ensured all appropriate information had been recorded, making the process more efficient. We reviewed examples of set templates, for example the integrated community healthcare team template on the electronic system which clearly outlined relevant detail for example; consent, personal care plans, risk assessments and shared decision making.

- A form was used for community nurses to complete when they were using a syringe driver. This was completed at each change of the syringe driver and included where it was sited on the patient's body, rate it was set and volume in the syringe. It was also signed by the qualified nurse, dated and time recorded.

- The clinical lead for the end of life team had recently devised a new care-planning format for the palliative care home support team to use. This covered eight areas, for example, symptom control and personal care. Each area provided a standardised plan that was individualised for patients by the qualified nurse who assessed them. These were updated and amended as required. These were left in patient homes. The information from these was added into the organisation's computer system for care planning along with risk assessments, for example, Waterlow pressure ulcer assessment.

- The quality of patients' care records was regularly audited. We saw evidence of annual documentation audits completed across different teams and services; these audits identified areas for improvement and the actions taken as a result. Main trends for improvement, which were apparent throughout the different teams and service audits, included the use of unexplained abbreviations, recording of consent and allergies.

Cleanliness, infection control and hygiene

- Infection control practice was observed to be in line with best practice and good standards of cleanliness and hygiene were maintained. We observed staff were bare below the elbow, washed their hands before and after patient contact in line with best practice hand hygiene techniques, used hand gel, wore personal protective equipment to include gloves and aprons and followed sterile techniques when caring for and treating patients. Medical wipes were used to clean equipment after use.

- An infection prevention and control team provided advice on the prevention and control of healthcare associated infections to both staff and people who use the service. Organisation-wide policies were also available for infection control and hand hygiene, which were seen to be in date at the time of the inspection. Staff showed us how they accessed organisation policies from the intranet and hard copies were available.

- Infection prevention control leads in each team were available to provide advice to staff. The leads attended infection prevention control meetings after which they disseminated any changes, learning, training to staff at departmental, and team meetings.

- Some clinic premises were old and tired but they were found to be visibly clean and records indicated regular maintenance was carried out. We observed staff cleaning equipment, couches and keyboards, after patient use, using disinfectant wipes. There were hand disinfectants available and accessible to all staff, patients and visitors on entering and exiting the clinics we visited. There were hand washing reminders on walls and hand washing instructions in bathrooms at location bases.

- Monthly hand hygiene audits were completed by each team where staff were observed washing their hands and confirmed to have correct hand washing practice and technique. We saw examples of completed hand hygiene audits. The monthly quality report for adult services in October 2016 demonstrated 98% compliance was achieved, based on 248 audit sheets.

- We saw examples of good infection control practice to include the outbreak of diarrhoea and vomiting in a care home reported using an infection control information sheet. This was displayed on the caseload board of a community nursing team, to inform staff so visits to the care home were restricted to urgent patients only. We were told if staff had children at home with illness, for example diarrhoea and vomiting, their caseloads would be reviewed and they would not visit any vulnerable patients. The rapid response team told us they would visit patients with diarrhoea and vomiting at the end of the day.

- The monthly quality assurance report for October 2016 for infection prevention control training reported 95% compliance for clinical staff and 92% compliance for admin staff, which exceeded the organisation's 90% target.

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Mandatory training

- Staff completed mandatory training, which allowed the delivery of training in safety systems, processes and practices. Staff spoken with said the training was of good quality and comprehensive. Staff were alerted of training due to expire and teams had visual training boards to make staff aware of any training requirements and updates.
- Mandatory training was delivered through a combination of face-to-face sessions and e learning. Staff mandatory training included; basic life support, clinical governance, conflict resolution, dementia awareness, equality and diversity, fire safety, fraud awareness, health and safety risk management, infection prevention and control, information governance, mental capacity act, moving and handling, safeguarding adults level one and two and safeguarding children level one and two.
- We were provided with a report of community adults' compliance with training for all teams, dated at the end of October 2016. There were very few gaps identified in the report. The organisation's monthly wellbeing assurance report presented to the board for October 2016 identified current compliance for adult services mandatory training met the organisation's 90% target with the exception of safeguarding level three training, which was at 88% compliance, additional training was available in November and December 2016 to improve compliance.

Assessing and responding to patient risk

- Comprehensive risk assessments were used to assess and respond positively to patient risk. Risk assessments were developed and delivered in line with national guidance. The organisation aimed to keep patients safe at home, however assessing risk allowed staff to mitigate risks identified or identify early if a patient was deteriorating and required additional medical support or admission to hospital.
- The risk assessments we reviewed were complete and noted whether any actions were required to reduce risks. This ensured patients were clearly assessed and a response was taken to any apparent risks. Risk assessments were used for screening an unwell patient, which included early warning score, sepsis and delirium screening tools. This allowed staff to assess whether people needed urgent medical

attention. Tools were available both electronically and in paper form. We observed staff completing these tools during our visits. One nurse told us they carry more equipment now to allow them to monitor patients using the early warning score and be aware if patients are becoming acutely unwell. The clinical frailty scale one to nine was combined with the early warning score to give objective information.
- Further risk assessments were in place, for example, patient mobility assessment and multi factorial falls' risk assessment. There was a dedicated falls team to educate and train all specialist community teams in falls assessment. Following a patient fall, an audit would be completed; the audit checked patients were assessed correctly and provided with the appropriate information. Patients at risk of falls were offered a staying steady leaflet and specific advice on falls reduction.
- The organisation aimed to establish a culture where all staff considered pressure ulcer risk in every interaction with patients. The dedicated wound care service, led by a tissue viability specialist nurse, was available to support staff in the community by providing training and advice. Skin champions were present in teams to provide a link and support function. Patients with wounds that had difficulty healing were referred to the wound care service to ensure the situation did not deteriorate and to avoid hospital admission.
- We observed staff were very aware of the risk of pressure ulcers and this was regularly monitored and discussed. Staff used the Waterlow pressure ulcer risk assessment and the SSKIN (skin inspection, surface, keep moving, incontinence, nutrition) bundle. Staff told us there were clear patient pathways relating to pressure ulcers and protocols for pressure ulcer prevention and wound management.
- During home visits patients at risk had their skin observed; we witnessed one patient being informed of the risk of pressure sores due to their low body mass index and they were advised how to use a cream which would be prescribed.
- On review of electronic patient records, we saw an example of a pressure ulcer, which was photographed to allow the wound to be monitored for either improvement or worsening. Photographs were regularly sent to the skin champion or the wound care service for review and advice.

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- Patients who were assessed as being at high risk of developing pressure ulcers were provided with pressure relieving equipment for their chair and bed. Patients were also provided with information leaflets on how to reduce their risks of developing pressure ulcers. A lower limb/Doppler wound care snapshot audit tool for community nursing teams was completed and returned to the wound care service. This tool assessed the number of patients being treated for a lower leg wound, the status and the care they were receiving to ensure the care was appropriate.
- To improve management of pressure ulcers at home the community nursing teams and wound care service provided education and training to carers, with an aim to reduce pressure ulcers and improve outcomes.
- A new palliative care pressure ulcer prevention protocol, for patients in the last three months of their life, had been devised and was due to be implemented. This would direct staff to assess pain, nutrition and their risk of developing pressure ulcers using their recognised templates.
- Within podiatry, diabetes risk assessments were carried out which gave a risk rating of red, amber or green. The result was recorded on the patient electronic record system and acted as an alert for staff. There were protocols to follow for each risk rating which staff followed by taking the appropriate actions. In addition to taking the appropriate actions, patients at risk of diabetes were given a contact number for a dedicated risk line, which could be accessed for advice on diabetes and ongoing care.
- At the time of our inspection, the rapid response service was piloting the use of equipment for blood tests at patient bedsides, to aid in the identification and diagnosis of sepsis. As part of the process, data was being collected on whether the machine was improving their identification rates to see if it was cost effective to roll the equipment out permanently. The pilot was still ongoing so no definitive conclusion could be drawn.
- Community nurses told us if an end of life patient's symptoms deteriorated or changed they would contact the GP or the local hospice for advice and support. A 24-hour telephone advice line was available which was run by the local hospice.

- The single point of access team had developed clear triage flowcharts and the use of key words to trigger escalation of cases to qualified staff such as pain relief for patients at end of life.
- The out of hours' team prioritised patients based on their clinical need, using the early warning score. The single point of access case manager established a period within which a patient would be visited, which allowed room to accommodate any urgent referrals.
- People with long-term conditions were triaged and assessed accurately so safe treatment and care was provided to guard against risks associated with their complex condition. There were specialist nurses leading cardiac services, respiratory services, smoking cessation and clinics within community teams.
- Community staff received basic life support and anaphylaxis training should they need to respond to an emergency.
- Teams completed handovers and/or safety briefings to ensure patients were discussed and risks were assessed.
- Community nursing team handovers were supported by a standard operating procedure on handover and coordination of care. Community nursing teams used handovers to discuss complex patients, risk areas, safeguarding, new pressure ulcers and any concerns. Handover templates were completed and included actions; we observed completed handover records, which identified key issues.
- The community long-term condition teams completed a safety briefing every morning. We observed two safety briefings; both were thorough and discussed individual patients and their care plans in detail using their electronic record and their patient card. The teams appeared to be very knowledgeable and had a good understanding of patients and their needs to ensure patient safety.
- The palliative care home support team completed a handover at the start of each shift to ensure staff were up to date with patients' needs.
- The React team held a safety briefing at 10am every day to review any complex patients, check skill mix, any infection outbreaks, equipment issues and any safety issues, for example, patients with the same name.

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- Bristol Community Health had systems to assess and respond to patient risk, patients and their families were also advised to contact their GP or to attend the emergency department if they became unwell or their condition suddenly deteriorated.

Staffing levels and caseload

- Staffing levels, skill mix and caseloads were planned and reviewed taking into account patient risk and acuity. At the time of inspection, staffing levels were as planned. However, the specialist services had small teams, which decreased the resilience and had a potential risk of difficulties to recruit in to specialist roles.
- The organisation was aware of the demand, capacity and workload pressures facing staff and the teams where this had greater implications. This was evident on their operational risk register, where we saw risks being mitigated. Bank staff and staff from other teams were used to ensure staffing levels were safe across the community adult teams. In the June 2016 staff survey only 33% of staff agreed there were enough staff at Bristol Community Health to do their job properly and only 44% of staff said they had enough time to do their job effectively. This supports the demand and workload pressures staff were facing.
- There were staff vacancies in some teams; however, the organisation were advertising and trying to promote recruitment for roles where there were difficulties in recruiting. For example holding open days to attract more applicants.
- The board report outlined the safe staffing plans intended for 2016/17. Whereby each service co-developed a bespoke 'safe standard', setting out what is required to deliver high quality care, taking into account demand and capacity of the service, acuity and complexity of patients, skills and experience of staff and staff mix. We were not provided with assurance this had been implemented in full across the community adult services.
- The organisation recognised nationally there were no community tools for staffing and therefore was trying to combine tools and intelligence to understand their staffing. An integrated nursing capacity tool and escalation process was used for the community nursing teams; however, we found this was not fit for purpose. Staffing levels were indicated for each community nurse team for planned and actual and the

capacity was then RAG (red, amber, green) rated. We reviewed this tool for community nursing teams and saw examples where teams were inappropriately rated as red or amber. In line with the tool this would initiate an escalation process, however the escalation process was not followed, which was correct, because staffing was appropriate to meet the demands of the service and the caseloads. The tool was therefore not being used correctly.

- Bank and agency staff were used across community adult teams to bring staffing to planned levels. For the three months June, July and August 2016 bank usage in the adults' services included 190 additional clinical shifts, 249 admin and clerical, 50 allied health professionals and 661 nurses. The use of agency staff was much lower, for the three months June, July and August 2016; agency usage in adults' services included 13 admin and clerical, 169 allied health professionals and 20 nurses. Agency were not used for short term cover and were only used for block booking for weeks or months at a time, all short term temporary staffing cover was covered by the bank. A community nurse team manager said the community nursing teams had seen an increase in bank staff at the weekend due to increase of patients requiring insulin.
- Community nursing teams completed rotas one or two months in advance. Caseloads were allocated daily and continually reviewed in line with capacity and patient risk. The teams used a t-card board, whereby cards were filled out with essential information for each patient, and allocated to different members of the nursing teams. Caseloads were triaged and prioritised ensuring urgent patients were seen as soon as possible, for example palliative care patients and blocked catheters. The community nurse team managers huddled weekly to ensure weekends were covered and any gaps in staffing were addressed and covered by the wider team.
- The domiciliary therapy team recognised their referral rate was high and placing a high demand on the service. To address this, they introduced a stricter triage process for referrals to ensure only patients who really required domiciliary visits were added to their caseload and all other patients were offered outpatient clinic appointments. Therapy assistants

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were also in post to address increasing caseloads. Staff told us caseloads were large but reviews were carried out to determine whether they were manageable and if not, changes were made to help with capacity.

- Managers recognised times of the year that were more difficult to staff, for example holiday periods and weekends. An example was provided in the summer where capacity was an issue with community nurse teams so teams worked together to provide support, the rapid response team had a decrease in referrals so could also provide additional support.

- The south community nursing teams were piloting a 5-7pm shift to bridge the gap between the day and night team. This included a buddy system to contact other staff on shift.

- The rapid response team provided cover to the community nursing teams in the mornings between 7:30am and 8:30am, and on the weekends, between the end of the community nurses day shift, and the start of the night staff's shift. Staff said this put extra demands on the rapid response service, as they could not always complete all of their administrative work.

- The palliative care team had an electronic white board, which had details of all patients on their caseload, new referrals to the service, and patients who had died. This also showed where staff would be for each visit. Two staff visited patients when carrying out personal care; however, qualified nurses could visit patients alone when completing their assessment of care needs. The palliative care home support service would visit the same day to offer support and care if a patient was discharged home on fast track or had been referred from other health care professionals if their condition had deteriorated at home.

Managing anticipated risks

- Managers had an awareness of anticipated risks and how these were taken in to account when planning the services.

- Daily situation reports were completed for key services to include community-nursing teams, rapid response

services, out of hours' service, urgent care centre, palliative care home support, community respiratory service, REACT in-reach service, safe haven beds and community beds and intravenous patients supported in the community. The services were RAG (red, amber, and green) rated each day to determine if there was appropriate capacity and anticipate where support from other services may be required. Green represented business as usual with potential support available for other services, amber represented proportion of disruption to service with limited capacity available to support other services and red represented severe service disruption with no capacity available to support other services. Infection control and staffing issues were also recorded. We saw evidence of three completed reports for the duration of our inspection.

- The organisation provided us with a draft winter plan for 2016/17, dated 31 October 2016. This plan covered the winter period October to March where pressures placed on the service increase due to incidence of illness rising and a demand for the community service. The winter plan was not final at the start of the winter period. The plan outlined the leadership and senior decision maker, escalation arrangements and arrangements for additional capacity to support the acute hospitals.

- The risk of adverse weather would be reviewed in line with the weather forecast. Managers and team leaders would ensure there were appropriate arrangements and prioritise patients to ensure people continued to receive safe care. In adverse weather, staff were expected, if possible, to walk to their closest base. Staff were able to access four by four vehicles, available through a charitable organisation.

Major incident awareness and training

- There was a business continuity plan was which would be followed in the event of an emergency or major incident. All on call managers had received emergency training.

Are services effective?

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

Summary

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

- Care and treatment was provided effectively in line with evidence-based guidance. The organisation based policies, templates, tools and care plans on this evidence basis.
- Audit programmes were in place to capture information about patient outcomes. Learning was identified from audits and changes made as a result to make improvements to services.
- Competency workbooks were used to ensure staff were working at a satisfactory level. Staff were supported in their own personal development and additional training was available.
- Staff received regular supervision and were up to date with appraisals.
- We witnessed excellent multidisciplinary team working, within teams, across teams and services, and with external healthcare organisations.
- There were clear processes to receive referrals and transfer patients between services within the organisation.
- The electronic patient record system allowed different teams to access patient information to allow for coordinated and integrated care, the system also interfaced with the GP system, improving communication with the patient's GP.
- Staff spoken with had knowledge of the mental capacity act and deprivation of liberty safeguards; they were able to make best interest decisions in patient's homes in line with current best practice guidance.

However:

- It was not always clear who had overall responsibility for each individual patient's care.
- There was no mobile working. This restricted access to information while staff were working remotely, and caused duplication of records.
- There was an inconsistent knowledge among staff of the five priorities of care of a dying patient.

- Patient outcome information about end of life care was not being routinely collected or monitored.

Detailed findings

Evidence based care and treatment

- Services, care and treatment were based on relevant and current evidence-based guidance, standards, best practice and legislation. The organisation based policies, templates, tools and care plans on this evidence basis.
- Patients had their needs assessed and care goals managed in line with evidence based guidance, standards and best practice. For example, the diabetes and nutrition service promoted diabetes support and education in line with National Institute of Health and Care Excellence (NICE) guidelines.
- Staff told us discrimination, including on the grounds of age or disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation, was avoided when making care and treatment decisions.
- Changes to NICE quality standards were disseminated to teams via email and updates provided through team meetings. Policies and guidance were amended in line with changes.
- There were link staff across clinical teams for example skin champions, continence and catheter, diabetes, infection control and safeguarding. Link staff attended regular meetings and were updated on current guidance and legislation for them to feedback to their teams.
- Community nursing team bases displayed on boards evidence based guidance to ensure staff awareness and knowledge, for example sepsis six, national early warning score, pathways for acutely unwell patients and acute kidney injury.
- Leaflets were available for patients to inform them of best practice. For example preventing pressure sores and pressure sore hot spots, which informed patients about the SSKIN bundle (skin, surface, keep moving, incontinence, nutrition, and hydration).

Are services effective?

- Staff within the wound care service told us they followed NICE guidance (CG179) on pressure ulcer prevention and management. All staff followed national guidance whereby skin damage from grade one to grade four was reported as an incident. All grade three and four pressure ulcers required further investigation.
- Staff in the neurology domiciliary therapy team specifically told us they were following the latest NICE guidance (NG42) on motor neurone disease in respect of how to asses and manage the condition. We were told this was particularly important, as they had experienced a sharp increase in referrals over the past 12 months.
- Staff within the Haven and Tuberculosis services followed NICE guidance on tuberculosis screening. The Haven also followed guidance on Hepatitis and HIV.
- Teams identified any non-compliance with NICE guidelines and developed action plans to address the non-compliance. For example, the documentation audit for podiatry identified the NICE risk had only been recorded in 71% of cases and therefore NICE NG19 diabetic foot problems prevention and management was re-issued to staff. Another example is the rapid response team identified scores were not being used consistently to assess community-acquired pneumonia, in line with NICE guideline CG191 pneumonia in adults' diagnosis and management. As a result, training was provided and the use of scores was being monitored, through audit, which identified improvement.
- The five priorities for care succeeded the Liverpool care pathway as the basis for caring for someone at the end of their life. Qualified nurses working for the palliative care home support service were aware of this. We asked community nurses about the five priorities of care for the dying adult. There was a mixed response to this with some not aware of it at all and others with limited knowledge
- Community nurses told us their GP practices held Gold Standard Framework (GSF, Royal College of General Practitioners, 2011) meetings and registers. These multidisciplinary meetings were used to discuss any potential patients nearing the end of their life, and to assess and plan, who may need additional support. We saw a GSF notice board in one of the community nurses base rooms. This contained details at a glance of where patients were on the end of life pathway and what support was in place or required setting up.
- Guidance about the management of Kennedy terminal pressure ulcers had been devised but was just about to be implemented for staff to follow in relation to end of life patients. Kennedy terminal pressure ulcers develop in some patients in the last hours of life because of multi-organ failure, which includes the skin. These are unavoidable.
- Within the rehabilitation teams representatives attended intermediate care conferences where improved practice and shared learning was discussed. The representatives then updated staff on any new development in practice at team meetings. If required training was arranged for staff to ensure practice was delivered in line with new guidance.
- As part of the musculoskeletal service, two hours of in service training was delivered to clinicians every two weeks. The training was based on guidance from NICE and the chartered society of physiotherapy. Adherence to the guidance was monitored during clinical supervision.

Pain relief

- Patients' pain was being managed effectively across the community adult services. Pain relief was reviewed regularly and changes were made as appropriate to meet the needs of individual patients.
- We attended home visits with community nurses, therapy teams and rapid response and observed patients being asked about their level of pain. Pain was assessed and documented in patient records. For one patient who was receiving medication for pain control we saw evidence of a treatment plan for pain management in their patient record.
- Pain and symptom control was prioritised in the treatment and care of end of life patients. Community nurses administered controlled drugs through syringe drivers in line with the organisation's policy and NICE guidelines.
- Anticipatory or 'just in case' medicines were prescribed to all end of life patients and stored in their homes so they were available to be used when required. Community nurses also made sure there were adequate supplies of these medicines available. Relatives of patients told us the community nurses always discussed pain and other symptoms with the patient and them.
- Community nurses and the qualified nurses from the palliative care home support service told us pain and symptoms were reviewed during each visit and documented in care records. They told us they encouraged patients to describe and rate their pain and

symptoms where able. Patients' relatives were also asked for their views on this. The patient's GP and/or specialist advice was referred to regarding pain and symptom control. Community nurses told us they could arrange joint visits with a specialist hospice nurse to review complex pain and symptom control.

- Specialist palliative care advice was available from the local hospice 24 hours a day.
- Staff on the out of hours team told us they frequently visited end of life patents overnight, and all had completed training to set up a syringe driver and also to administer therapeutic pain relief to patients. They ensured there was time to explain the pain relief to patients and their relatives.

Nutrition and hydration

- Patients were assessed and it was ensured their nutrition and hydration were reviewed and discussed during home visits. Where relevant patient care plans included an appropriate nutrition and hydration assessment. Malnutrition universal screening tool (MUST) assessments were used to assess patient nutrition and we saw evidence of this in patient records. Staff referred patients to a GP and/or dietician where required.
- Patients' weight was monitored and discussed with the patient. We observed nurses assisting patients to weigh themselves using their own home scales, nurses also had access to scales as part of nursing equipment.
- We attended home visits and observed patient eating and drinking being discussed. For example, a nurse discussed with a patient how to improve their eating and increase their weight, build up drinks were considered to be prescribed and despite the patient's lack of enthusiasm for these the nurse maintained a positive manner and agreed the patient would think about it and they would discuss again at the next visit.
- We observed patients being encouraged to drink, particularly if there were concerns with regard to their hydration.
- Mouth care kits were provided for end of life patients and used when required. Staff from the palliative care home support service carried these in their visit bags.

Technology and telemedicine

- Technology and telemedicine was not currently being used to enhance the delivery of effective care. The community nursing team managers told us technology

and telemedicine had been used in the past, mostly for chronic obstructive pulmonary disorder and heart failure. However, feedback was mixed from both staff and patients. The team managers said this was an area that was being explored and may be reintroduced in the near future.

- Bristol community health had trialled a mobile clinical system for reporting and accessing diagnostic tools and patient records, but geographical topography had caused connection and reliability issues.

Patient outcomes

- Information about people's care and outcomes were collected and monitored in community adult teams, with exception for the end of life service. Information could be used to inform improvements for teams and services. We saw examples of audits completed by teams and services. Each team had an audit plan, which was linked to action planning. This allowed teams to identify areas for improvement and follow action plans to allow them to make improvements and achieve desired outcomes.
- The community nursing teams participated in a rolling audit programme across all 12 teams. This included, care plans, syringe driver, pressure ulcer, falls, documentation, catheter, handover and dementia screening. Teams also participated in audits directed by specialist services and introduced their own audits where they saw gaps or areas for learning to improve patient outcomes.
- A catheter audit was completed in the community nursing teams and identified areas for improvement. As a result new tasks were introduced on the electronic template for catheter care, information about the patient catheter, the type and change required, was also recorded on the patient information card. We reviewed the report of the re-audit conducted September 2016 covering four months May to August 2016. The report included a detailed action plan with designated leads and dates to achieve the action. A catheter task and finish group was set up to review progress on a monthly basis, and a third audit was planned for May 2017.
- Goals and targets were set and developed with patients using performance metrics. These goals were reviewed to see if patient outcomes were improved. Personalised

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care plans were used for patients, and the electronic patient record system was audited to look at the percentage of patients with a personalised care plan recorded.

- As part of the domiciliary therapy team-process, patients were given a goal attainment score. This was a process of working with the patient to determine what goal they wanted to achieve by the end of their treatment. This was recorded in their notes and worked towards during each therapy session. When treatment ended, patient goals were reviewed to determine whether they had been achieved.

- As part of the musculoskeletal physiotherapy service, an audit on patient outcomes was carried out; physiotherapists collected data on the actions taken to achieve the required patient improvements. This information was routinely collected and submitted to the audit lead.

- The heart failure service assessed general wellbeing of patients at the beginning of treatment and at the end to determine if patients felt better, worse or scores remained the same. This was done using two audit tools simultaneously and supported patient improvement.

- The Macmillan rehabilitation support service used the Canadian occupational performance measure and the NHS patient activation measure to determine improvements for patients over the course of the six-week rehabilitation programme. This information could be used by the team to identify any gaps for patients and provide additional support where needed.

- The rapid response team collected data about outcomes of treatment provided to their patients. Outcome measures included if the patient had been discharged from the service, or whether their care had continued in either a hospital or social care facility.

- The neurology domiciliary therapy submitted data to the national Parkinson's audit to measure the quality of care available to people with Parkinson's disease. This enabled the organisation to contribute to the national picture highlighting good practice and highlighting areas of improvement, and helps the organisation to measure its services against national guidelines.

- We reviewed the January 2016 sepsis screening tool audit for the rapid response team. The sample included all patients, across the three rapid response team caseloads, who had an early warning score of three or greater or who appeared acutely unwell from December 2015. The audit reviewed completion of the sepsis-

screening tool and ensured sepsis screening tool was completed in line with sepsis guidelines. In 85.5% of cases the sepsis screen was employed when the early warning score was three or greater and 88.5% of patients had a sepsis-screening tool completed.

- Patients' needs and wishes were recorded in their notes. Nurses and therapists assisted them to meet their needs, such as to improve mobility or meet their own rehabilitation goals.

- At the time of our inspection, patient outcome information about end of life care was not being routinely collected or monitored. However, they were monitoring the preferred place of care at the end of life, which is part of national strategy (Department of Health, 2008, Leadership Allowance for the Care of Dying People, 2014). There were plans to undertake audits in the future for the palliative care home support service. These will include audit of the palliative care home support new paperwork and end of life anticipatory prescribing across the community nurse teams.

- The intended outcomes for patients in relation to pressure ulcers were being achieved. Bristol Community Health had a Commissioning for Quality and Innovation (CQUIN) target to reduce all grade three and four pressure ulcers, by at least 5%, between April 2016 and March 2017. We were told by staff there had been no avoidable grade three and four pressure ulcers from April 2016 to the date of our inspection. This was achieved by the embedding of the SSKIN assessments, upskilling of staff and training.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Competency framework workbooks were used across teams and services to ensure staff had received the training and were competent in the care and treatment they were required to provide as part of their role.

- The rapid response team had a competency book for all members of staff, regardless of profession, which covered basic nursing, physiotherapy and occupational therapy skills. Staff told us this approach meant if basic blood tests of physical assessments needed to be done, all staff were competent in completing this without having to wait for another member of the team with the skills to attend.

- New staff were provided with a corporate and local induction and staff told us this was well structured. Staff,

who were new to the organisation, were complimentary about the induction, said this was of good quality, and prepared them for their role. Staff told us they were supported and worked in pairs until they felt confident and competent to work alone. There was one exception to this where one staff member told us they were not provided with this initial support when they were new to their role due to low staffing levels and no capacity.

- Staff were supported and encouraged to undertake training and personal development. Additional training was made available to staff to increase their competencies, for example, compression bandaging and syringe driver training. Training was provided internally or by external organisations in line with the needs for staff. Speakers attended team meetings to ensure staff understanding was up to date, examples included talks on mental capacity act, falls and national early warning score.

- There were mixed accounts from staff on the amount of protected time they were given to complete training. Some told us they had three hours per month and others told us they had some but this was related to in service training only.

- As part of training with the musculoskeletal service, clinicians received two hours of in service training every two weeks. The clinical specialists within the team devised the subject matter for the training; this was based on feedback from staff.

- The wound care service delivered a pressure ulcer prevention day, which was held every two months. It was mandatory for the community nursing team to attend but was also open for other staff to attend. The day was used to deliver advice on pressure ulcer assessment, prevention and management updates.

- Nurse practitioners and senior nurses in the cardiac specialist service, along with community matrons had undertaken training to become non-medical prescribers.

- End of life training was provided by the local hospice for both qualified nurses and health care assistants and covered a number of topics. For example, symptom management in end of life care, talking about dying and identifying end of life and planning. There were 75 members of staff across the organisation who had attended this training and 76 were booked on for training.

- Speaking to one student nurse, they said they felt supported and there was a good learning environment.

- Appraisals were completed twice a year to support staff. On review of data, dated 6 September 2016, appraisals in the adult services were completed for 96% of nurses, 92% allied health professionals, 90% additional clinical services and 95% admin and clerical staff. Senior managers told us how they empowered staff to develop managerial roles by having a system where a band seven carried out appraisals for a band six, and a band six carried out appraisals for a band five.

- Clinical supervision was completed at least three times a year. There was an organisational clinical supervision policy. All teams spoken with had processes to ensure staff received clinical supervision and this was formally documented. We saw examples of completed forms for supervision. Supervision could be completed cross roles or bandings.

- Nurses were required to revalidate with the Nursing Midwifery Council (NMC) from April 2016 onwards. As this is a new process for qualified nurses, a two-hour training programme was available to support nurses in revalidation.

- Managers told us poor or variable performance would be identified via current their processes, for example, clinical supervision, audit and staff and patient feedback. Staff would be supported to improve through regular contact with manager, review of competencies and additional training arranged. This would be reviewed on a case-by-case basis.

- The organisation was enthusiastic to develop their own staff. The nursing fast track programme, which funded staff to complete over a two-year period, and the nationally recognised health care assistant programme were examples of the professional development programme. For newly qualified nurses the organisation worked in partnership with the local university.

Multi-disciplinary working and coordinated care pathways

- All necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. However, it was not always clear when talking to staff who had overall responsibility for each individual's care. For patients who were seen by different services and teams there was not a service or staff member allocated or assigned as having this responsibility.

- Staff spoken with across all teams and services felt the teams worked well together to deliver coordinated care

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to patients. The electronic patient record system promoted good integrated care and inclusive communication between all healthcare professionals. In the 2016 staff survey 82% of staff said there was good cooperation between teams they work with. We observed effective multidisciplinary team working during the inspection. For example, community nurses and matrons discussing patient care with occupational therapists and physiotherapists in other teams. One nurse told us how the palliative care team supported them for their first palliative care patient, talking them through the whole process and being available for further support if needed.

- Specialist services provided support and training to other teams, for example the wound care service, and bladder and bowel service educating staff.

- The community matron service offered support for patients with long-term conditions and acted as specialist nursing support for the community teams.

- We observed some excellent multidisciplinary working between community nurses, palliative care home support and other health care professionals for patients receiving end of life care. Community nurses told us they referred patients to the Bristol end of life care coordination centre who organised and arranged all the personal care needed for the patient. End of life patients who were considered to have a rapidly deteriorating condition could be referred to the fast track who would complete an assessment against a set eligibility criteria and then arrange care from other organisations. This would then all be coordinated to meet the patient's needs.

- Another example of how well different health care professionals worked together was a joint visit between the community nurses and the palliative care home support team. As the patient's condition had deteriorated the community nurse contacted the GP who also visited to review the patient. They had also obtained advice from the local hospice about how best to manage the patient's symptoms.

- We observed how the palliative care team as a whole worked together to help a patient who needed to be discharged urgently from hospital for end of life care. They reviewed their visits to fit this patient in and looked to involve other providers of end of life care to make sure their needs would be met on discharge. They also

liaised with other key staff in their care, for example, community nurses and the hospital. This patient was discharged from hospital during our inspection very quickly and safely.

- Patients' needs were assessed and care planned accordingly. Where appropriate care planning involved joint visits with staff from other specialities or GPs.

- Some teams were well integrated with different healthcare professionals working within one team. For example the rapid response team, who could send both a physiotherapist and a nurse to a patient who had complex needs.

- When assessing patients for continuing healthcare, funding involvement was required from social workers and Bristol Community Health nurses. The clinical commissioning group, local authority and Bristol Community Health clinical team would attend decision making panels to assess patients eligibility.

- Forums were held where all disciplines came together. For example, motor neurone meetings were held bi-monthly which included nurses, physiotherapists, occupational therapists, speech and language therapists and motor neurone disease team.

- Teams worked well with external healthcare providers. Regular contact and communication was held between community nursing teams and GPs, with regular gold standard framework meetings. Joint visits were completed with the local hospice and community nursing teams for end of life patients. Community nursing teams worked with care agencies to address issues surrounding medicines and manual handling. The tuberculosis team had a good working relationship with public health England. The relationships between the community discharge coordination centre and local acute NHS hospitals were good and facilitated effective transfers and discharges from hospital to patient homes or community living facilities.

- There were arrangements for working with social care organisations, which helped provide patients with joined up care. Staff were aware of the relevant contacts, although did say there were difficulties in accessing the appropriate person, we were told this had been raised with the social care organisation.

- Senior managers in the rapid response team told us how they supported other teams outside of Bristol Community Health, including the local ambulance

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service. Where calls had been received for patients who had fallen but not hurt themselves, the rapid response team attended and assessed the patients instead of an ambulance being sent.

- The process for obtaining funding from the local clinical commissioning group (CCG) for end of life patients on fast track was also very fast. Staff from the fast track team said the CCG turned the funding agreement around very quickly to prevent delays for the patient.

- The wound care service hold monthly SSKIN awareness training sessions for social care organisations and private carers. They use this as a method of interfacing with care providers to increase pressure ulcer awareness and improve prevention.

- We observed a handover between a rapid response staff member and a member of staff from an ambulance service. The information shared by the staff member from rapid response was comprehensive and provided written information electronically to confirm what was said.

Referral, transfer, discharge and transition

- Staff worked together to assess and plan ongoing care and treatment in a timely way when people were due to move between teams or services. A single point of access team received referrals and then triaged these referrals before sending to the appropriate team. Referrals were also made between teams and services. The referral processes differed between teams and services and therefore were unique to each. For example patient self-referral or healthcare professional referral, choose and book, email, letter, fax or telephone call. Overnight staff had support from the single point of access team who took calls to ensure prompt receipt of referrals.

- When patients were discharged from specialist services, referred and transferred to the community matrons, a detailed care plan would be written for matrons to continue with the patient care and treatment.

- Patients who were discharged from services were left with a number to contact should they have any problems. The information following discharge was shared with the patient's GP and any other relevant providers. Sharing information with the GP was aided by the interfacing of the electronic patient record system.

- In-reach services were based within hospitals to aid the transition from discharge from an acute trust into the community. This allowed discharge planning to begin at the earliest stage possible.

- The rapid response team service was intended as a short term, seven-day intense service, to prevent patients being re-admitted to hospital. Staff told us while it was often possible to prevent re-admission, patients did however, require some ongoing care and support from an adult social care facility or a package of care. At the time of the inspection, one team had two patients on their caseload that had been with the service for over 25 days. Staff told us they were providing multiple daily visits as the adult social care agencies supplying the patients' ongoing packages of care, were unable to take the patients immediately. Staff told us they continued to provide the visits as they felt it was the right thing to do, and were concerned the patients' care would be compromised while they were waiting for the adult social care support. Managers told us they felt this was not ideal as it affected the number of acute patients the team could see, but could not think of an alternative solution. This had been escalated to the board.

- Referrals to services were handled effectively with clear criteria and a multi-agency approach to ensure patients received the appropriate care and treatment. Patients could be referred to different services once they had been seen by a clinician in the community therapy teams. However, referrals could not be redirected to secondary care, as patients had to be referred back to their GP. This was identified as causing a delay in patient treatment and discussions with the CCG were taking place to alter the patient pathway.

Access to information

- Information needed to deliver effective care and treatment was available to staff. However, with no mobile working this was not always timely or accessible in the community. There were no systems to manage care records for remote and mobile staff, however this had been piloted and the organisation were hoping to roll this out in the near future.

- Staff had access to the organisation's intranet and could access national guidelines, policies and procedures when at team bases.

- All Bristol Community Health staff used the electronic patient record system, therefore staff could access notes

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made by their colleagues in other teams, and this enabled information for ongoing care to be shared appropriately. Patients who were visited and cared for at home had care records at their house and therefore these were available to healthcare professionals who visited.

- The electronic patient record system interfaced with the GP practices and therefore allowed access to the GP notes, if the patient had consented and there was a sharing agreement. Patients' test results were accessible for staff at health centres.
- We saw an example where a patient's 'do not attempt to resuscitate form' was held on the patient record but also the nurse had a copy placed in an envelope for the patient and their relative to present to ambulance crews or the hospital.
- Bristol Community Health IT system was compatible with the systems used in the majority of GP practices in Bristol. Community nurses and staff from the palliative care team as a whole had access to all information about the patient. For patients in the South Gloucestershire region, cared for by the palliative care home support team, the computer systems were not compatible with the local GP practices and community nurses for this area were from another provider. Therefore, the external community nurses did not have computer access to the palliative care records. Nevertheless, the palliative care home support team could access some of the community nurses records electronically and paper records from both the palliative care team and community nurses were kept in all patients homes to access records.
- Bristol Community Health updated the electronic palliative care coordination system, which meant the out of hours GP service could access patient records. Patients' consent was obtained before being added to this system.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff spoken with had an understanding of relevant consent and decision-making requirements of legislation and guidance. Staff had knowledge of the mental capacity act and deprivation of liberty safeguards. Staff also had an understanding of the difference between lawful and unlawful restraint practices; however, they had not needed to use restraint.

- Staff had the appropriate skills and knowledge to seek consent from patients. Staff were able to tell us clearly about how they sought informed verbal and written consent before providing care or treatment. We observed staff interactions with patients where they verbally asked for consent to provide care and treatment. We saw evidence of consent recorded in patient notes in the community evaluation and progress notes section. Consent was also obtained from patients for taking photographs of their pressure ulcers and sharing information with other healthcare organisations.
- Patients and relatives told us staff always explained what they wanted to do and asked for permission before proceeding with any care task or treatment. We observed this in practice and staff checked if patients and their relatives understood or had any questions.
- The service had a non-concordance protocol, which was followed by staff. If a patient refused to follow advice, their refusal was documented and they were asked to sign a document confirming they had been fully advised. Patients' decisions were reviewed regularly. Staff balanced adherence to treatment against their quality of life and compromised if necessary to accommodate patient needs and wishes.
- The organisation had a policy for restrictive practice, which relates to Deprivation of Liberty Safeguards (DoLS). We were told given staff go into homes they do not generally need to make DoLS applications as they are not the managing authority, however staff had knowledge when visiting patients in care and nursing homes.
- If a patient lacked the capacity to make their own decisions, staff made decisions about care and treatment in the best interests of the patient. They involved the patient's representatives and other healthcare professionals appropriately. Mental capacity and best interest tools were available to staff. Staff had a good knowledge surrounding decision making in patients who lacked capacity. This was supported by good results in the mental capacity act audit, completed by the safeguarding team, on making best interest decisions in patients' home in line with current best practice guidance. Staff would communicate to GPs should they have concerns surrounding a person's mental capacity.
- The safeguarding team provided additional mental capacity act training for staff and teams who required

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additional support. The safeguarding team undertook an audit of mental capacity act assessments, which showed only 20% of assessments were complete. This identified staff were not confident in filling out assessments and did not know when or where they could carry them out. Some clinical teams working with complex patients had not submitted any mental capacity assessments between January and July 2016.

Because of the audit, the safeguarding team put together an action plan, which recommended the development of a face-to-face training package to include information about recording of assessments on the electronic patient record system. This was still a work in progress and was being presented to the board in December 2016.

Are services caring?

Good 🟢

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

Summary

We have rated caring of the community adult service as good because:

- Patients were continually positive about the care they received by all community adult services.
- All staff provided kind and compassionate care to patients. Patient privacy and dignity was always respected.
- Shared decision-making was well embedded across the organisation; patients were kept involved in their care and treatment decisions.
- Staff ensured patients and their relatives/carers understood the care and treatment they were receiving and took time to explain this.
- Emotional support was provided to patients and their relatives/carers by staff and staff were able to signpost people to further external support groups.

Detailed findings

Compassionate care

- Staff provided care to patients, which was compassionate; they were observed to respect privacy and dignity. Staff interactions with patients were friendly and kind and they took time to interact with patients in a respectful and considerate manner.
- Patients, relatives and carers spoken with were overwhelmingly positive about the care and treatment they had received. We spoke to 27 patients and 11 carers/relatives. Comments included:
  - "Absolutely brilliant, I can't praise the care enough."
  - "Care was fantastic and very respectful."
  - "Always smiling, professional and they treat me with respect."
  - "If it wasn't for the district nurses I wouldn't know what we would do, they could not do anymore if they tried."
  - "This nurse is worth her weight in gold. I wouldn't be without her."
  - "It has been superb. I could not ask for more care"

- "I am eternally grateful to everyone who came – the district nurses and the palliative care team. There was a follow up by the palliative care team, which went beyond the call of duty. Everything was well coordinated."
- Feedback from patients and their relatives/carers overwhelmingly reported end of life care was provided sensitively, compassionately and with dignity and respect. Relatives told us all staff were very kind and excellent. All said they had no complaints about any of the services.
- We were also shown a number of thank you cards received by some of the community nurses which had the following comments: "to everyone who helped care for our dad, your kindness is very much appreciated", "as a family we wish to send to you our sincere thoughts and thanks for your dedicated nursing care" and "we really want to thank you for all that you have done for our mum, you were brilliant".
- We completed 21 visits to patient homes. Staff rang doorbells before entering if they were aware patients were unable to answer the door. If staff had not seen a patient before they would introduce themselves. Patients were made to feel relaxed and comfortable by staff being sensitive and supportive. We observed good relationships between the staff and the patients and staff took time to interact with the patients. During physical or intimate care staff respected people's privacy and dignity, for example by pulling curtains or moving to a different room.
- During one visit the nurse was required to wake the patient, they got the patient breakfast and helped them open their mail. During another visit, a nurse offered to make a patient a hot drink before they left. The out of hours team were also observed making drinks and offering to make food for patients who were living alone.
- Patients had completed comment cards, and all comments were positive about the services. Comments included:
  - "The quality of the service I have received here has been exceptional. The staff are wonderful. I have been treated with the utmost care, respect and dignity. I feel truly listened to." (Podiatry)

Are services caring?

- "Service very good. Staff helpful. Environment safe and hygienic. Had right care and treatment. I was listened to." (Musculoskeletal Physiotherapy)
- "I have found the service excellent and the staff very friendly and helpful." (Dietitians)

- We observed a patient being assessed by a community Parkinson's nurse in a local clinic. The patient was supported, listened to and the staff member showed compassion and empathy towards the patient who could have felt vulnerable at this time.

- Staff were knowledgeable about the need for confidentiality and tried to respect this at all times. We noted it was not always possible to have a private conversation at the reception desks in a number of the treatment locations. However, treatment was carried out in private rooms and there were many opportunities for patients to have a private and confidential conversation if required.

- Bristol Community Health had a privacy, dignity and respect policy, which was accessible to staff and they were aware of its content. All staff were responsible for ensuring the privacy and dignity of individual patients was maintained in line with policy. In clinics, we observed staff requesting permission to examine patients and gave them privacy when removing clothing.

- The migrant health haven service provided high level of compassionate care due to nature of the harrowing experiences the refugees would have faced to get to the UK. Staff within the Haven service understood the asylum process and worked with patients to build resilience to help them cope with the process and any eventual outcome. We observed this during a patient clinic.

- The React team had a clothes store where items could be provided to patients if their clothes had become soiled. This ensured patients were comfortable while being assessed and discharged.

- Staff within the tuberculosis service visited patients on wards, at home and in hostels to ensure they were doing well with treatment, and to support them with any side effects associated with the medicine they were taking.

- The friends and family test was used to obtain patient feedback and whether they would recommend the service to their friends and family. In October 2016 the community adults services, to include clinical services therapy, clinical/specialist services, community nursing,

health assessment/continuing healthcare, migrant health services and MSK/MATS/Physio/Diabetes and nutrition teams had 97% of people say they would recommend the service.

Understanding and involvement of patients and those close to them

- Staff clearly communicated with patients and their relatives to ensure their care, treatment and condition was understood. Staff worked with patients to set goals and targets to achieve at the end of their treatment.

- Shared decision-making was well embedded across the organisation. Staff involved patients in planning and making decisions about their care and treatment.

- The organisation had a number of leaflets available for patients to help their understanding of their condition, how to make choices to improve their wellbeing and things to be aware of and to look out for. We observed patients being provided with these leaflets and staff talking the patient through the key points. One patient told us 'I received leaflets and an opportunity to discuss matters and improve my health'.

- We observed a nurse who had a good rapport with a patient who was living with dementia and kept the relative involved. The nurse listened to the patient and their relative carefully and was supportive to their needs.

- Staff were observed to take time to listen to the patient and discuss any concerns or queries the patient had. One relative told us how they and the patient had been listened to by the nurses and actions taken as a result.

- We observed clinics taking place within podiatry, musculoskeletal assessment and treatment and spinal service and musculoskeletal service, and saw patients were clearly advised on what the clinician thought the problem was, how it should be managed and what treatment was to be provided.

- Staff ensured patients were able to find further information and invited them to ask questions about their care and treatment. We saw clinicians repeatedly advise patients on where to find additional information relating to their condition by signposting, provide information leaflets on conditions and asking patients directly if they had questions regarding the advice they had received. When questions were asked, clinicians explained everything clearly and offered their contact details to patients in case they had further questions.

Are services caring?

- Staff aimed to help maintain patient independence. During one visit to a diabetic patient, we observed the patient's own insulin was drawn up by the nurse but administered by the patient.
- We observed excellent involvement of a patient during one home visit. The patient was key in driving decisions about the care and treatment they were receiving. The matron detailed to the patient the plan for the visit and what would be followed up at the next visit. The matron informed the patient of other healthcare professionals they would be contacting to discuss the patient's care and treatment, for example, they would speak to the GP and phone the patient to update them on the discussion.
- The wound care service was using a video to show patients exactly what happens when a pressure sore develops. It was used to educate patients on pressure ulcers and show them what can happen if they do not adhere to advice or refuse treatment.
- We observed a community nurse speak compassionately and in simple language, which the relative of an end of life patient was able to understand in their distressed state. The nurse sensitively made suggestions about contacting family members to come and see their relative.
- Supporting patients to be in their preferred place of care at the end of life is part of national strategy (Department of Health, 2008, Leadership Allowance for the Care of Dying People, 2014). Bristol Community Health monitored this. The percentage of patients who died in their preferred place from April 2016 to September 2016 was 83% and the organisation's target was 70%, therefore they exceeded this. This was just higher (better than) the national average of 82% (Office of National Statistics, Preferred priorities for care, [last three months] 2016).
- We saw evidence of the correct use of 'do not attempt cardiopulmonary resuscitation' forms. We reviewed four forms, which were all completed by patients' GPs. All had evidence the patient had been involved in the decision. As part of the palliative care home support team assessment, they checked these were completed and available.

Emotional support

- Staff provided good emotional support to patients and their relatives/carers. Staff would ensure patients and their relatives/carers were competent to manage their care when at home. Patients and their relatives/carers told us emotional support was offered and provided whenever required by all staff involved in their care.
- Staff understood the impact a person's care and treatment had on their wellbeing both emotionally and socially. They aimed to support patients to cope emotionally with their care, treatment and condition. Examples of this were evident throughout the organisation and different teams and services. One example is the Macmillan rehabilitation service who offered courses for patients to attend to allow them to manage their condition and the emotional and social impact.
- Staff demonstrated that they understood the importance of providing patients and their families with emotional support. We observed staff providing reassurance and comfort to patients and their relatives. Staff told us they offered support to patients, especially when providing palliative care and agreed extra support visits where required.
- We attended one home visit for a patient undergoing chemotherapy. The nurse offered support and advice to the patient and their family.
- The district nurses told us they attended funerals and sent sympathy cards to the family of deceased patients.
- Bristol Community Health had links with a large number of charitable organisations, voluntary agencies and support groups, which they were able to signpost patients and their carers to for additional emotional support. One patient described how they had been provided with leaflets to get in touch with charities for support.
- The Macmillan rehabilitation support service was able to provide emotional support to patients living with cancer and signpost them to other organisations for example Marie Curie and Bristol Buddies team, a volunteer group run by Macmillan.
- End of life patients and their family were referred to the local hospice for additional emotional support and counselling if required.
- A senior member of staff told us how staff went the extra mile when looking after patients at the end of their life. For example, a community nurse stayed with a family until late into the evening after their shift had finished to

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support them when their relative died. Staff in the palliative care home support team had worked late one evening during our inspection to stay with an end of life patient and family who needed extra support.

- We observed a safety briefing for a long-term conditions team. During the safety briefing, the team discussed the emotional support required for a patient and how although their condition was stable they would regularly visit the patient as a support function.

- People were assessed and monitored for anxiety and depression. The long-term conditions team acknowledged how this was part of their regular checks for patients. Staff had access to tools for assessing anxiety and depression. Teams communicated with patient GPs to discuss management of anxiety and depression.

- Staff told us when they treat a patient who has a learning disability, they work with their family and carers to develop a care plan suited to the patient in order to reduce discomfort, distress and anxiety.

- Haven staff told us they do not wear identity badges as they found they were preventing them from building trust with patients. We were told patients associated badges with officials and were reluctant to share information for fear of having their information shared or not being believed. Staff told us some patients had experienced difficult and challenging encounters with 'officials' wearing badges and found that being more informal helped to build trust.

Are services responsive to people's needs?

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

Summary

We have rated the responsiveness of the community adult services as good because:

- Where possible, services were planned around the needs of the local people.
- Managers and staff had a good awareness of their local population and continually looked at how they could improve their services to meet people's needs.
- The organisation recognised the diversity within the population they provided care and treatment to and had an understanding of patients with complex needs. Adjustments were made so all people could access and use services on an equal basis.
- The end of life care service fitted the patients' needs rather than the patient fitting into the needs of the service.
- Staff worked in partnership with other professionals and services in order to provide responsive and coordinated end of life care and treatment to the patient.

However:

- There were long waiting lists for patients to access some of the community adult services. For example therapy services and podiatry.
- The continuing healthcare team had a backlog and a wait of six to eight months to review patients for funded care.
- Patients commented negatively how community nurses were not able to provide them with a time of their visit, which affected some patients and the ability to plan their day. However, teams were aware of this feedback and were looking at ways they could improve the patient experience.

Detailed findings

Planning and delivering services which meet people's needs

- Services were planned and delivered to reflect and meet the needs of local people, ensuring flexibility, choice and continuity of care. We found the organisation had a wide range of services to meet the needs of its population across a wide geographical area. It was

noted the complexity of the different commissioning arrangements had an impact on the organisation's ability to streamline some services and make best use of resources.

- Staff had an awareness of the local population and challenges in specific areas. Staff told us they tailored care to take account of factors which were attributable to the different areas of Bristol, engaging external organisations or families to assist patients. For example, they found the North had people who were more isolated and needed additional support.
- Prevalence of individuals affected by a disease against population was reviewed through the capacity tool and learning from case management. For example, community-nursing teams looked at the number of long-term condition patients in the area and the location of care homes. Teams reviewed where patients were living and which team they were receiving their care from and caseloads were adjusted or moved between teams to reduce staff travelling.
- The organisation looked at priorities of the joint strategic needs assessment, looking for the right skills and staff, prevalent conditions and resources needed for an area. They used public health data to help plan and deliver services, which were appropriate for the local population.
- It was identified there was a prevalence of diabetes among Somali women and there was a big Somali community in Bristol. The diabetes and nutrition service identified patients were not attending clinic appointments and therefore drop in clinics were introduced which had seen an increased uptake.
- One community nursing team were trialling zonal working, where teams of staff work within specific zones or locations; this was introduced following patient negative feedback about the number of different nurses they were seeing. The zonal working and a named nurse aims to achieve continuity of care for patients and their relatives/carers, it will also allow for stronger relationships with the GPs in the area. The team reported an improvement in wound care for patients because they were being seen by the same nurse each visit. A number of community teams mentioned how they would like to introduce a named nurse system.

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- One community nursing team had set up a catheter clinic for patients who were non-housebound; this improved infection control and allowed support from the GP practice.
- The Macmillan cancer rehabilitation support service regularly reviewed the delivery of their service to be effective and responsive to people's needs and make the service more accessible to people. In January 2016, the team started the HOPE course; a self-management programme for people living with cancer, the standardised course was designed by a university. This was introduced as a course over six weeks where people attended for half a day each week; however, the team found the dropout rate was high. As a result, the course was changed to two days over two weeks, which has seen people complete the course. Additionally, a take-control taster session had also been done twice, which included all elements of the HOPE course put in to three hours.
- Volunteers were used across the organisation to help support patients; volunteers were attached to services to include respiratory and Macmillan rehabilitation support. The Macmillan rehabilitation support service felt their volunteer was invaluable, and volunteered two hours a week to phone patients providing additional support and reducing the workload pressures of the staff. The volunteer was due to run a support group for people who had left the HOPE course. A new volunteer was due to join the Macmillan rehabilitation support service and the service was exploring how this could best be delivered, we were told the new volunteer might be used to promote health in catchment areas and advertise the service in an aim to improve outcomes in areas where specific cancers were prevalent and outcomes were poor.
- There was a difference in the number of visits provided for end of life care depending on which geographical area the patient lived in. For Bristol patients they were able to have three visits per day between 9am and 9pm, but for patients living in South Gloucestershire they were only able to have two visits per day between 9am and 5pm. A senior member of staff told us changes to the clinical commissioning groups (CCG's) was due to take place in the future and end of life care would be standardised across all geographical areas.

- Many patients seen by the Haven service did not have much money and staff recognised travel in Bristol was expensive so planned home visits and outreach clinics to ensure they delivered their services and granted access to as many patients as possible.
- Bristol Community Health had access to beds within other providers for example, nursing homes or a local community hospital for end of life patients if the family felt they could no longer manage at home.

Equality and diversity

- Services were planned to take account of the needs of different people. The organisation recognised the diversity of the local population.
- Equality and diversity training was mandatory to staff. Staff received this training on corporate induction and an update every three years.
- The organisation's quality account priorities for 2016/17 recognised meeting the diverse needs of patients by implementing the accessible information standards, a legal requirement for providers of NHS funded services. These standards required the organisation to meet the communication needs of people with a disability, impairment or sensory loss. The organisation planned to work towards five areas of the accessible information standards:
  - To ask patients if they have information or communication needs
  - To record these needs in a clear and standardised way
  - To highlight a patient's electronic record so information or communication needs are clear and explained how needs should be met
  - Share information about a person's needs with other healthcare and adult social care providers with consent.
  - Act and take steps to ensure individuals receive information, which they can access and understand by adapting appointment letters, patient information and face-to-face communication.
- We observed identified cultural needs were recorded in the clinical record as part of the care and treatment plan. This ensured people's cultural needs were known to staff and could be met when caring for and treating patients.
- Language translation services were provided by the organisation and available to all teams and services to access for patients who have English as a second

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language. Patients were able to access this service directly. We saw evidence of patient leaflets, information and feedback questionnaires translated in to non-English languages. Staff described their experiences in accessing interpreters to help them communicate with patients. They said it helped them to understand the patient's care needs and helped them gain consent before providing any support.

- The Haven service provided care and treatment to patients who were asylum seekers, refugees, trafficked men, women and children with complex problems. Staff told us a high level of patients could not speak English so they provided information leaflets that had been translated in various different languages to assist with patient understanding of the treatment and making services accessible to them. For example, we saw leaflets had been translated into Arabic, Farsi, Kurdish, Somali, Tigrinya, Amburic and Kurmanji.

- The Haven service regularly treated and cared for patients in extremely vulnerable circumstances and provided them with advice on how the NHS worked, what services were available and how to access them. Patients were provided with a variety of information in their language and detailed advice was provided verbally with the aid of translators. We saw evidence of the information given to them, which included but was not limited to free shelters, free language classes, befriending services, free financial advice and HIV support networks.

- Staff within the Haven service told us many of the patients they see have mental health conditions such as post-traumatic stress disorder (PTSD). The service had strong links with external organisations providing advice and treatment to patients with PTSD and they provided a caseworker one day a week to see patients at the treatment base.

- The Haven service was involved in caring and treating families that have been victims of the Syrian war. As part of this service, staff attended meetings with the local authority to identify the most vulnerable individuals and/or families and arrange health assessments. During the meetings, staff were able to collect information prior to seeing the patient and could start arranging plans prior to their arrival.

- Staff within the Haven service attended wellbeing forums, which took place bi-monthly. During these forums, attendees discussed how they could effectively support patients in vulnerable circumstances.

- The organisation also utilised services to communicate with service users who had specific protected characteristics, such as a sign language service for people with a hearing impairment.

- Community nursing and therapy teams regularly visited patients in their own homes; this meant people with disabilities were able to access these services on an equal basis to others. Some clinic-based services were also able to provide home visiting services in exceptional cases.

- Health centres that held clinics were accessible to wheelchair users; however, some doors were heavy to open and could pose a problem to patients with mobility issues.

- For one patient it was clearly recorded in their records how they communicated, as they were unable to communicate verbally. Staff were therefore able to communicate with the patient in a way that could be understood and enabling the patient to be included in the decision making of their care and treatment.

- One patient did not want a female nurse to perform a skin check. Following the visit, the nurse contacted a male healthcare assistant and they performed a joint visit where the patient was happy for the male healthcare assistant to perform the skin check.

Meeting the needs of people in vulnerable circumstances

- People with complex needs, for example those living with dementia or those with a learning disability, were encouraged to use the community adult services provided by Bristol Community Health. The adult community service had a number of teams set up to provide emergency support to people in vulnerable circumstances.

- Nursing assessments identified patients living with dementia or learning disabilities and care was provided to meet their needs. Staff could give examples of how they had supported patients living with learning difficulties.

- Community adult services would work with the organisation's learning disability teams to ensure there were no barriers in people receiving care and treatment.

- Staff had an understanding of dementia and were able to undertake training to ensure they delivered care and treatment, which met the needs of people living with dementia.

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- Some clinicians, wherever possible, would ensure patients were seen by the same clinician for continuity of care. This was recognised as important when treating patients living with dementia or a learning disability. Staff told us in the majority of cases they see a patient from the start to the end of treatment. They explained it was important to the effectiveness of treatment and care, provided to patients in vulnerable circumstances, as the needs of patient were understood and communication and relationships could be maintained.

- Patients with complex needs were discussed between services and a coordinated multidisciplinary plan of care was agreed. We saw nursing and therapy staff liaised with other agencies, families and carers to maintain routines and support patients in vulnerable circumstances.

- Community nurses were unable to visit people who were homeless and living on the streets. However, they had relationships with staff working at hostels and were able to visit patients at these locations, allowing vulnerable people to access the service.

- The organisation had links with support services for which they could signpost patients and relatives/carers to, for example dementia support, age UK and GP befriender services.

- One example was provided of how a patient was not cooperating. The nurse explained how they found an area of interest, which allowed them to interact with the patient, and subsequently the patient allowed the nurse to look at their pressure sores and do dressings. The nurse suggested they completed a joint visit with a colleague so the patient did not become amenable to one member of staff.

- Staff told us they worked in partnership with other services to ensure all end of life patients' needs were met and supported. We were shown a recent patient case history, which had included partnership working the learning disability team and local NHS acute trust. This showed how they had worked together to provide the best care to this patient which maximised their inclusion, understanding and choices.

Access to the right care at the right time

- Access to care and treatment differed between services and teams. Data showed access to therapy teams and podiatry was not timely. Where possible, services prioritised care and treatment for people with the most urgent needs.

- The referral to treatment pathway data, meeting a national indication of 18-week referral time to treatment, and a 95% target was not achieved in all services. Between August 2015 and July 2016 data showed the 18 week referral to treatment time compliance was:
  - 79% elderly occupational therapy and physiotherapy
  - 83% neurological occupational therapy and physiotherapy
  - 91% diabetics and nutrition
  - 93% musculoskeletal physiotherapy
  - 94% podiatry
  - 99% heart failure
  - 98% musculoskeletal assessment and treatment service
  - 98% musculoskeletal assessment and treatment service spinal
  - 100% dermatology

- Services had experienced an increase in demand over the previous 12 months with referral rates making it increasingly difficult to meet referral to treatment time targets. The clinical services manager had identified this as the services toughest challenge and had taken steps to address it. Discussions were taking place with the CCG to implement changes to ensure patients received the best possible treatment as early as possible. For example, in the podiatry service there were plans to create risk classifications and introduce caseload profiling which was to restrict the service to urgent patients only. It was thought this would result in patients with urgent needs being seen as early as possible, reduce caseloads and referral to treatment times.

- Bristol Community Health identified in their 2016/17 quality account improvements to the neurological and elderly services pathway 18 week waiting times was required. Additionally, they aimed to improve waiting times for the podiatry service so at least 40% of non-urgent patient were seen within four weeks of their referral being received.

- The podiatry service had self-imposed targets of seeing urgent patients within four weeks of referral and were successful in seeing 90-95% of patients within that time. They set a target of seeing routine patients within 12 to 14 weeks.

- The domiciliary therapy team split referrals into urgent and routine patients. They placed a target to see urgent

patients within eight weeks of referral and routine patients within 12 weeks. At the time of our inspection, the elderly domiciliary therapy team were seeing urgent patients within 12-16 weeks of referral and routine patients within 30 weeks of referral. The neurological domiciliary therapy team were now meeting their 18-week target for routine physiotherapy and occupational therapy patients but six patients had recently breached for physiotherapy. The speech and language therapy service had recently breached the 18-week target but were meeting it at the time of the inspection. The breaches were recognised as serious issues by the operational lead who told us the issue was related to the increase in referrals and current patient pathway. We were told work was taking place to change the care pathway by collaborating with the local authority to combine domiciliary care and the intermediate care services to improve efficiency, manage referrals and reduce duplication of care.

- Staff within the domiciliary therapy team told us there was also a third category of referral, which could be referred onto the urgent therapy team if the patient required immediate intervention. The urgent therapy team could see patients within seven days. If the urgent therapy team lacked capacity to see a patient within seven days, the domiciliary therapy team would discuss the referral together to determine who had capacity to see the patient urgently and would allocate accordingly.

- The domiciliary therapy teams were responsible for forecasting when a referral would breach treatment time targets and when a referral had actually breached, all of which was recorded in a spreadsheet. The spreadsheet was checked and updated every time a referral was added. All the data collected was provided to the operations lead and discussed as part of the operational and clinical governance process.

- The community adults waiting times for district nurses were just below target. Between April and September 2016, 73% (target 75%) of non-urgent patients were seen within one day and 87% (target 90%) of urgent patients were seen within four hours. Community nurse team managers would review any breaches and often these were an administration error.

- The continuing healthcare team were not meeting key performance indicators with a six to eight month backlog for funded nursing care reviews. Processes were being followed in an aim to clear this backlog.

- The rapid response teams provided treatment to 98% of their patients within 24 hours of their referral. Between October 2015 and March 2016, rapid response teams avoided 2,191 unnecessary hospital admissions and facilitated 1,175 discharges.

- We were provided with data to show how many palliative care referrals to the Bristol end of life coordination centre were received from April 2016 until the end of September 2016. They had received 169 of these 16 did not meet the criteria. There were 153 patients who had been assessed and offered a care package and of these 100% had received this within two days.

- The fast track service for end of life care told us their timescale to carry out an assessment was one working day following referral. However, they told us in November 2016 they were not always meeting this target due to staff sickness in the team, but they were working hard to minimise this and were prioritising patient referrals.

- The wound care service received referrals from patients, community nurses and care homes by telephone and email. Staff told us the service received on average 90 referrals a month and were able to see routine referrals within two to four weeks. However, we were told the time to see one patient had reached six weeks. When a referral was made, specialist nurses gave initial advice to clinicians over the telephone and provided additional information as required.

- Staff reported good access to other services and worked collectively to discuss and meet the needs of service users.

- The community nursing teams were unable to give definitive times to patients for home visits. Negative patient feedback was received with regard to not knowing when nurses would arrive. Patients spoken with had not had any cancelled appointments and said nurses would phone if they were running late. The community nursing teams explained how the caseloads were fluid and should an urgent patient need visiting this would affect visiting times of other patients for the same day, and therefore they do not provide a time to patients. We were told when the following day was predicted to be busy patients might be brought forward to the day before. We did observe nurses planning suitable days and morning or afternoon appointments with patients for their next visit.

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- Continuing healthcare (CHC) and the health assessment and review team (HART) assessed patients for funding. Patients were reviewed after three months and annually. If a patient's condition deteriorated or improved, they were reviewed sooner. If a patient did not qualify, it was explained to the patient why they did not meet the criteria and the patient was referred back to the local authority. There was an appeals process should a patient not be happy with the decision. A complex case manager would investigate if the family or patient were unhappy they were unable to access this service.

- The rapid response team had undertaken some work to increase their visibility to the GP's in their area. The numbers of referrals from each GP practice was gathered monthly and if no referrals were being received from some practices, a member of the team visited the practice to alert the GPs to the services they provided. This ensured services were accessible to all people.

- The rehabilitation service manager was reviewing the intermediate care service to identify ways to improve waiting times for patients. A plan was in development to combine the intermediate care service with the domiciliary therapy service to reduce the amount of duplicated work as patients were being inappropriately referred to both teams, which increased each caseload. By combining the teams, referrals would be allocated to clinicians appropriately resulting in the efficient management of patients and a decrease in waiting times.

- The React service was a multidisciplinary team consisting of physiotherapists, occupational therapists and nurses who assessed patients from the emergency department at two acute NHS hospitals in the region. The teams' purpose was to prevent hospital admissions by assessing whether patients were suitable for alternative care and treatment in the community. This meant patients were receiving appropriate care and avoiding stays in hospital. The service had a target of seeing a patient within four hours of referral and discharge accordingly. Once an assessment of the patient's needs was carried out, they were referred to the appropriate community services in the appropriate region for treatment. Referral to treatment times for the React team were monitored and logged on a spreadsheet, which was reviewed regularly. Staff told us the four-hour target was hard to meet as the service operated 8am to 8pm but the emergency department was open 24 hours a day. We saw the team were only

achieving the four-hour target 60% of the time. However, staff told us if a patient attended the emergency department at 1am but were not seen until the React team started at 8am then this would affect their referral to treatment time. The team had started recording their referral to treatment times within operating hours and we saw evidence they were meeting their target of four hours 87% of the time.

- The community discharge coordination centre had target times for seeing patients following referrals. Their target was to see patients and carry out an initial assessment within 48 hours of referral. Over the previous six months (April to October 2016), the service had only achieved their target of seeing 85% of patients within 48 hours once for one local NHS hospital and twice for the other. They recognised this as an issue, which was due to their large caseloads and lack of capacity within the community therapy teams. In order to improve their target rates they had introduced a spreadsheet, which recorded patient status to track when patients were due to be seen. Each patient was given a red, amber or green rating depending on if the patient had been seen within 24 hours, amber if not seen until the last 24 hours or red if seen after 48 hours.

- When a referral was received by the rapid response team, their target was to see the patient within an hour. Staff told us they were hitting their target but occasionally fail to meet it. Their performance was monitored using the electronic patient record system and managers attended performance meetings bi-monthly. During the meetings, the data collected from the record system was reviewed to check whether targets had been met and the rate of rejected referrals and the reasons for rejection.

- The Haven service provided care and treatment to patients until they were able to access primary care services directly. The staff would ensure patients were registered with local GP surgeries and liaise with GPs to ensure they understood patients' circumstances. They also provided maps and advice on GP practices to ensure patients could access services.

Learning from complaints and concerns

- Patients were provided with the appropriate information on how to make a complaint or raise a concern. Contact details were made available to

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patients when they were first seen by the service and included within information booklets, patient care records and available in waiting areas at treatment bases.

- Between the 1 April 2015 and 31 March 2016, 56 complaints were received for the community services for adults, 29 were upheld or partially upheld and two were referred to the ombudsman. Between 1 April and 31 August 2016, 45 complaints were received for the community services for adults, 20 were upheld or partially upheld, and none was referred to the ombudsman.

- Complainants were asked to complete a complaints feedback form and only 12% returned their forms. The organisation was, therefore, exploring ways to receive more feedback on the complaints process.

- Staff understood the process for receiving and handling complaints and were able to give examples of how they would deal with a complaint effectively. Managers discussed information about complaints during staff meetings to facilitate learning.

- Two members of staff described how they had met with a patient following a complaint and taken steps to ensure they improved their communication with patients and their families in a timely manner.

- Seven complaints related to end of life care across the organisation. Two complaints related to the same patient. We were shown all documentation relating to these two complaints. This included the full response to the patient's family with the outcome of their investigation and an apology. We saw in one report how changes had been made to documentation in relation to verification of death. A senior member of staff told us learning from complaints was shared with all staff across the community nursing teams and palliative care home support teams through team meetings. We reviewed the monthly community nurse team manager meetings following this complaint, which did not contain details of the learning or how this was shared with the wider community nursing teams.

Are services well-led?

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

Summary

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

- The organisation had a clear vision and set of values and staff were aware of these.
- There was an effective governance framework with clear lines of accountability so information was cascaded upwards to senior management and downwards to staff on the front line.
- A programme of audit was followed to monitor quality and systems, we saw examples of how changes were made and action plans developed because of these audits.
- Risks were regularly identified and managed, there was an alignment of recorded risks and what management and staff told us were the risks within the organisation and their services.
- Leaders were well respected at both executive and local level. They supported staff to deliver patient focused services.
- A highly positive culture was evident in community adult teams, with a great sense of teamwork.
- The community adult teams sought people's feedback about their service and implemented changes where possible.
- Staff felt actively engaged and felt their views and experiences were listened to, to help shape and improve services.
- The organisation was willing to pilot schemes to allow innovation, improvement and sustainability of services.

However:

- Lone working processes to protect the safety of staff were not well embedded across the organisation, with teams having different levels of success with these processes. Staff were not provided with equipment to improve their safety and there were no safe words used.
- There was no oversight on the board for the services provided to people at the end of their life. The service had no specific risk register and there were no audits being undertaken.

Detailed findings

Service vision and strategy

- The vision for Bristol Community Health was for all communities to lead healthier, better lives, with a mission to provide person centred care through quality services, sustainable business, partnership with the community and engaging staff owners. The values map against the four strategic themes is set out in the fit for future business plan. Staff spoken with were aware of the organisation's values and visions. Appraisals were completed in line with the organisation's values. When speaking to staff, two people told us they chose to work for the organisation because of its values.
- Visions for the community adult teams were in line with the sustainable and transformation plans (STP), for example integrating community therapy services and intermediate care and standardising working in line with the STP. Management recognised the challenges they faced, with the biggest challenges being capacity, demands and caseloads, particularly for community nurses, rapid response, podiatry and therapy teams. The organisation had identified to the clinical commissioning groups activities, which they were not contracted to do, however were completing out of good will for patient care. These were affecting capacity and workload. We were told the vision was to look at integrating services and clustering key areas, strengthening the core of community nurses being supported by other teams and continuing to build on primary care relationships.
- The caseload for podiatry had risen from approximately 2,000 to 10,000 in 12 months and the service was unable to cope with patient demand. The service leads had recognised this as a significant issue and devised a strategy for improving the service and decrease referral to treatment times. The strategy involved discussions with the CCG to change the current service model. Senior staff told us this would mean the service would be restricted to high risk and urgent patients only which would result in decreasing referrals and increasing staff capacity.

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- Some staff we spoke to were aware of some of the strategies for improving the service. Staff told us they were aware of the issues regarding referral to treatment times and senior management were looking at ways to recruit more staff to help with capacity.
- Individual teams and services had their own visions and goals to improve the services they were providing. Management told us staff were enthusiastic and contribute their ideas to make improvements to the services.
- Senior staff told us they did not have a strategy in place yet for end of life care. They told us this was an area they had plans to work on in the near future. All community nurses told us end of life care was a priority for them and they worked in partnership with other health care professionals to make sure patients and their family's needs were met.

Governance, risk management and quality measurement

- The governance framework ensured the responsibilities were clear and quality, performance and risks were understood and managed. There were clear departmental and divisional arrangements, and staff knew who was accountable to whom. Staff said information was cascaded upwards to senior management team and downwards to the clinicians and other staff on the front line.
- There was a structure for holding meetings from team meetings, management level meetings, operational meetings and eventually feeding into the board. We saw evidence of meeting minutes for local team meetings, monthly community nurse team manager meetings, monthly clinical service managers' operational meetings and the board reports. Adult community health services were regularly discussed at divisional and board meetings. The safeguarding team and medicines management team told us there was a clear pathway to the board and they were able to present quality reports.
- Monthly assurance reports for the adult services were submitted to the board, we saw recent examples of these reports submitted. Performance reports reported by exception against key performance indicators, an explanation, the impact and actions were included within the performance report. A detailed report on quality was also produced looking at incidents, CQC notifications, complaints, patient and public

empowerment, harm free care of the patient safety thermometer and infection prevention and control. A report on staff wellbeing was produced looking at short term and long-term sickness absences, vacancy rates, clinical bank fill rates and voluntary turnover. Services where trigger points with wellbeing were reached were discussed in more detail. Training compliance was also included as part of the monthly wellbeing report.

- There was no designated board member with end of life responsibilities. Senior staff told us they were able to speak with a member of the board to pass on information. However, there was no structured or formal process for sharing end of life feedback, risks or concerns with the board.
- There was a programme of clinical and internal audit to monitor quality and systems. These audits identified areas where action should be taken. Audit data was fed monthly in to quality reports, which were presented to the board. However, there were no systems for monitoring end of life care across the organisation. Audits were planned to take place in the future.
- The diabetes and nutrition service did not submit data to the national diabetes audit. We were told by staff this was because of time pressures and the process for obtaining consent takes too long. However, we were told the services were discussing this and looking at ways they could submit data.
- The organisation actively monitored risks; these were identified, recorded on risk registers and mitigated. Each team, directorate and programme board held their own risk register. We reviewed the operations directorate risk register for October 2016, which included 34 risks across different adult services. We also saw examples of local team risk registers for the musculoskeletal service, and all 12 community nurse team risk registers. Recorded risks included a description, risk rating, actions to reduce the risk, target for completion, a review date and comments on progress on actions. Risks were reviewed regularly at local management meetings, and high risks were fed to the operational risk register. There were additional risk registers, for example the safeguarding team held their own risk register.
- Risks in relation to end of life care were recorded on risk registers but there was no risk register specifically for end of life care. A senior member of staff told us they had oversight of risks in relation to end of life care as they also over saw the management of community nursing services.

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- The organisation identified teams with areas of risk or concern who required monitoring, called 'hot teams'. For example teams who were overwhelmed with demand and caseloads, staff shortages and skill mixes and rising trends with incidents. One community nursing team was currently identified as a hot team at the time of inspection. There were action plans for this team.

Leadership of this service

- Leaders were visible and approachable. Staff spoken with were complimentary of their leaders at all levels from organisational management to local management and found them to be supportive and accessible. Leaders supported staff to deliver patient focused services but were aware of the challenges they faced. Staff said they felt supported by management and management listened and tried to implement things to make improvements.

- Staff in management roles attended the NHS leadership programme, which allowed them to have the skills to lead effectively. The organisation also had programmes looking at how to deliver leadership.

- Although teams predominantly worked out in the community, staff and teams felt connected to the organisation as a whole. The chief executive and other members of the executive team visited teams, for example, the executive team visited teams approximately four times a year and other ad hoc visits. One staff member said, "The executive team are good at listening and are genuinely interested". Staff recognised there was an open door policy. The chief executive was known to send hand written cards to staff on the anniversary of their start date to thank them for their hard work and commitment.

- One community nursing team had a change of local leadership, with five different team leaders in a one-year period. The team was identified as a hot team to be monitored. Despite these changes, the team remained positive. New leaders were in role at the time of the inspection to support the team.

Culture within this service

- Staff told us they felt respected and valued. When visiting teams we observed good team morale and strong camaraderie. We found staff were passionate about making a difference and the organisation encouraged staff to develop. Staff agreed the culture of the organisation encouraged candour, openness and honesty. We did identify staff did not log extra hours and worked additional hours out of good will.

- All staff told us about the importance of the multidisciplinary person centred approach to the care and support of patients and their families. We observed many examples of this throughout our visit. It was evident the focus of the community adults teams was on helping people to continue in their own homes, and this was embedded within the culture of the services. Staff told us they were proud of the care they provided to patients and they felt they were supported by the organisation to give high quality care.

- Staff told us they were proud to work for Bristol Community Health because they said they felt patients and their families received excellent care. They also said they all worked as part of team internally and externally to achieve this. It was apparent staff cared avidly that patients' received care to fit their own needs. We saw this culture and these attitudes were embedded across community services.

- We identified staff safety as a risk area, where staff work alone and as part of a dispersed team working in the community. The organisation had a guidance document on managing personal safety risks. This guidance states 'it is the responsibility of each manager to ensure that local procedures are developed, in place, effective and are applied to staff'. Teams had their own local lone working procedures, however we found differences in the level of success these procedures had. We were provided of an example from a community nurse who had not phoned in at the end of their shift on a number of occasions; however, this was not followed up. On the other hand, we were provided with examples where police have turned up at a staff member's house because they had not reported in and were not contactable. Staff were not provided with equipment to protect their personal safety, for example a panic alarm and there were no safe words or distress codes used.

- Other measures were evident to protect the safety of staff to include training in conflict resolution, alerts on the electronic system concerning patients and staff safety in the areas visiting and the ability to visit in pairs. The out of hours' team operated in teams of two and no staff member would work alone. Risk assessments were completed for high-risk patients and areas. Staff provided us with both positive and negative examples of

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how the organisation responded to their concerns about risk when visiting patients. The majority of staff felt supported in identifying risk areas, for example, where risk was identified two members of staff would attend or the patient would no longer receive care following an assessment process as staff were put at too greater risk. We were provided with one example where a family had a dangerous dog; the nurses did not visit until the dog was put safely away. However, we were provided with examples where staff felt they had raised concerns about their safety and the conditions in which they had to visit patients and these had been dismissed and staff were still expected to visit patients despite their concerns.

- Haven staff were given additional support due to the nature of the service. Weekly access to a psychologist was available to help them manage the stories and images the service would expose them to.

Public engagement

- People who use the services and their relatives/carers were encouraged to provide feedback to help shape and improve the service and culture. Patient questionnaires were used in paper form or electronically on staff tablets to capture feedback. Monthly reports were provided to the teams on their feedback. We saw feedback questionnaires translated to non-English language. Teams and services produced patient experience action plans because of feedback; we saw examples of these action plans, which included 'you said we did' comments.
- Bristol Community Health participation community was made up of 120 patients, carers, members of the public and voluntary sector representatives. These people worked together with the organisation to develop and shape community health services. The level of involvement varied by member, ranging from attending events, running peer support, service focus groups, organisation development groups, volunteering or reading patient information leaflets to ensure they are accessible.
- Many of the specialist teams often held public awareness days where teams gave talks to local groups and sheltered housing. A monthly telephone service with local radio allowed callers to call in and chat about the service and access to the service with a clinician.
- Teams ran individual focus groups to obtain feedback from people. For example in September 2016 the

Macmillan rehabilitation support service held a focus group. Three people attended who had gone through the HOPE course and feedback was sought from these people on what support they felt they required following completion of the course and to guide what the service needs.

- Bristol Community Health published a newsletter for the public and staff four times a year. In the summer 2016 addition, an article was included about end of life care. A family member had written this about the positive end of life care provided to them and their partner.

Staff engagement

- Staff said they felt actively engaged and their views and opinions were listened to, to help improve the delivery of services. One staff member told us "the organisation is dynamic, you can have an idea and they want to know your ideas". Staff received communication via email and newsletters, with weekly bulletins and updates to keep them informed. All staff, regardless of seniority, understood the value of raising concerns, and were confident to do so.
- The board and senior management team attended talkback sessions with teams. These sessions listen to staff and find out how they feel about their work and to hear key issues.
- Staff engagement events were held when changes were made to the organisation, for example four staff engagement events were held in February and March 2016 to gather input from staff for the 2016/17 business plan and revised vision statement, and staff engagement events were due to be held with regards to flexible working proposals.
- An annual staff survey was sent to staff to obtain their feedback. In June 2016, there were 735 responses, a 66% response rate. The organisation used the staff survey to try to make positive changes and identify themes and areas of strength so improvement can be made to work more effectively. The 2016 data had only just been released, however we saw an example of a document 'what you said, and what we did' for the staff survey 2015. For example only 41% of staff felt the board was sufficiently visible, action was taken for the board and senior management team to continue to attend talkback sessions with every team and attend events to hear staff feedback.

Are services well-led?

- The organisation held a staff council. Staff representatives across the organisation sat on this council with a purpose for a staff voice to drive changes and improvements.
- The Bristol Outstanding Service Care Awards, also known as BOSCAs, were well received by staff as recognition for work over the year, gave staff a chance to feel part of the whole process, and valued. A family day was also organised in the summer for staff to attend.

Innovation, improvement and sustainability

- The organisation continually considered developments to the community adult services and have been open to changes to improve quality and performance. The organisation was willing to pilot schemes and review success and sustainability before full implementation.
- The rapid response team was piloted as a result of an idea from the team. Rapid response is now an effective team, providing a full assessment for the patient and includes a number of advanced practitioners across all specialities.
- The Macmillan cancer rehabilitation support service, funded by Macmillan, was delivered by two community organisations, which includes Bristol Community Health, and two acute trusts. The organisation has been innovative in looking at ways to best deliver the service and has trialled different methods of delivery. The partner community organisation was now working in parallel because of Bristol community health changes and successes.
- The tuberculosis team worked with the local clinical commissioning group and pharmacies to allow patients to have their tuberculosis medicines under supervision at a local pharmacy at their convenience.
- The bladder and bowel service was creating a strategy to develop a nationally recognised female genital mutilation training course.
- The fast track district nurse programme was allowing nurses to move from a lower grade to a higher grade. The first cohort started in October 2015. Support included relevant training and preparation for the new role. This was a proactive incentive allowing for retention of staff and job satisfaction.

- Senior staff told us they needed to develop the end of life strategy and look to move forward their service in meeting all the national and best practice guidance.
- A physiotherapist within the musculoskeletal team had been undertaking research in respect of patients with rheumatoid diseases accessing the service.
- The musculoskeletal assessment and treatment and spinal service had developed a shared decision making aid for patients suffering with frozen shoulder.
- The wound care service submitted a business case to have a tissue viability bed, within one of the community bed locations, which resulted in funding being granted for one year. The bed provided intense therapy to aid patients who had severe difficulties with non-healing wounds. We were told the bed had been in operation from April 2016 and it was proving to be a success. The service had been monitoring outcomes and we were told the majority of patient wounds had improved, community-nursing time was saved and hospital admissions had been avoided, although it was hard to quantify success. Planning of patient admission had been effective with there being only one week when the bed was unoccupied. We were told there were ongoing conversations with the CCG to determine whether the service would continue.
- A business case had been submitted for the acquisition of a pressure-mapping tool. This device can be put underneath a patient and can determine what the risk areas are for them developing a pressure ulcer. It was believed this would improve patient care, as it would show the potential risks for patients and help to determine the measures that should be put in place to reduce the risks. We were told it would also help to empower patients to protect themselves, as it would visually show them when and why a pressure ulcer could develop. The acquisition had not yet taken place at the time of the inspection.
- The intermediate care lead was working with the local authority to develop the service to ensure it worked cooperatively and efficiently with regular meetings taking place to discuss how it could be achieved.