Bristol Community Health C.I.C.

Quality Report

South Plaza, Marlborough Street
Bristol BS1 3NX
Tel: 0117 900 2600
Website: www.briscomhealth.org.uk

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Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Bristol Community Health Headquarters	1-304870639
Community health services for children, young people and families	Bristol Community Health Headquarters	1-304870639
Community mental health services for people with learning disabilities or autism	Bristol Community Health Headquarters	1-304870639
Urgent care services	Urgent Care Centre	1-401031903

This report describes our judgement of the quality of care at this provider. It 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.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	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

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Letter from the Chief Inspector of Hospitals

Bristol Community Health C.I.C. was inspected with planned and announced visits over 16-18 November 2016. We visited many community teams, locations, patients' homes, schools, and clinics during this time. We went back to a number of locations and teams for unannounced visits on Sunday 27 November (the urgent care centre), 28 and 30 November and 1 December 2016.

This inspection was a comprehensive look at all services provided by Bristol Community Health C.I.C., with the exception of its prison healthcare service, which is inspected by a specialist CQC team alongside Her Majesty's Inspectorate of Prisons. The core services we inspected were:

- Community health services for adults
- Community health services for children, young people and families
- Community mental health services for people with learning disabilities or autism
- Urgent care services

Among the sites we visited where services are provided were: New Friends Hall in Stapleton, Bristol and The Withywood Centre in Withywood Bristol. This was to meet people and staff in the community learning disabilities service. We visited the urgent care centre in Whitchurch, Bristol. We visited health centres in Bristol, Eastgate Centre Clinic, Osprey Court, local schools, and children's centres to inspect services for children, young people and families. To inspect the community adults' services, we went to a range of health centres, went out with community nursing teams to patients' homes, visited Knowle Clinic, an intermediate care centre, and Southmead Hhospital. We met with the palliative home care team and went on visits with them to meet their patients and families they were supporting. In addition, we went on visits with the 'fast track' team, who arrange care and support for patients being discharged home from hospital at the end of their life.

All staff throughout Bristol Community Health were cooperative, helpful and supportive to us at all stages of the inspection.

Our key findings were as follows:

- We rated services for their safety as good overall, although some improvements were needed to children and young people's services, which were working under a temporary contract managed in conjunction with three other health providers. The contract had now been awarded to the three organisations from April 2017 for the next five years, and work to integrate children and young people's services was commencing. However, this had not affected the quality of care provided by the children and young people's services. Patients were protected from abuse and harm.
- We rated services for their effectiveness as good overall, although there were some areas in the children and young people's services that needed improvement. This included issues arising from problems with the computer systems, the availability of patients' records, and the lack of an effective audit programme. However, patients were receiving good outcomes from their care and treatment. Quality of life was promoted, and care and treatment based upon the best available evidence.
- We rated services for caring as good overall, with outstanding care in the urgent care centre. Patients, their carers, parents and anyone who encountered Bristol Community Health staff were treated with compassion, kindness, dignity and respect.
- We rated all services for their responsiveness as good. Services were planned, organised and delivered to meet people's needs. The organisation supported people in vulnerable circumstances. It listened to people's concerns and improved when it recognised something had gone wrong or could be done better. However, there was a variable performance when endeavouring to provide care to people at the right time. Some services were doing well, but others were struggling with the impact of rising demand and shortages of staff.
- We rated services for the leadership and governance as good overall, although work was needed to

Summary of findings

integrate and improve the systems and use of information in the children and young people's services. Bristol Community Health was an organisation with a strong culture. Staff were open, honest, and wanting to deliver high-quality person-centred care. The organisation supported learning, innovation and improvement.

We saw several areas of outstanding practice including:

- There was an outstanding, dedicated and committed approach to engaging with people who were patients of Bristol Community Health, their families, their carers, volunteers, and the wider community. The Patient and Public Empowerment programme, underpinned by the patient charter, put patients at the centre of decisions, valued their feedback and input, and made changes and improvements from listening to and engaging with people.
- The chief executive and her leadership team had an outstanding commitment to staff. The organisation had been established as an employee-owned social enterprise. It recognised staff for effort and achievement through a number of different schemes, including award ceremonies and personalised contact.
- 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 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. They enabled services to deliver care and treatment, which was accessible to the local population, with no discrimination. For example, through the migrant health services and the Macmillan rehabilitation support service.
- The Haven service recognised the additional support required for staff who were often dealing with difficult, challenging and upsetting situations. Weekly access to a psychologist was made available for staff.
- In children's services, staff respected and recognised each child as an individual. We observed outstanding caring from staff who were singing a song to each individual child and addressing them using their name when they entered the room for their therapy session. These children had profound needs, and we recognised how their faces lit up when they came into the session and had their special song.
- Families and carers of children and young people provided consistent positive feedback about the service. One parent told us "staff are so supportive and helpful," "staff are always there when you need them," while another told us "staff are really friendly, helpful and always welcoming." Another mother told us '"the service is brilliant, couldn't have asked for a better one."
- In adult services, we observed outstanding multidisciplinary team working both across the organisation and with other healthcare providers. In particular, staff worked hard to make sure all involved in a patient's end of life care were up to date with the situation, and their visits were all coordinated.
- There was an outstanding response to people who were coming to the end of their life. The palliative home care team made sure their service worked to meet the needs of the patient and those they were close to.
- 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 staff teams and identify areas of risk to provide active support. These were known as 'hot teams'. This allowed issues and risks to be identified early, and plans to be made to help support these teams.
- In the urgent care service, we heard of numerous examples where staff had gone the extra mile to support patients and those close to them.
- The urgent care staff had developed a comprehensive support network and a range of referral pathways for adults and children in primary, secondary and community health care settings.
- The urgent care service had engaged the support of the lead emergency consultant at the local children's hospital to facilitate joint working, and education.

Summary of findings

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider MUST:

- Take action to ensure all staff in the children and young people's service receive the appropriate level of safeguarding training for their role.
- Ensure a complete set of records are transferred with the child from the health visiting team to the school nursing team in line with Royal College of Nursing guidelines.
- Take action to ensure the health visiting team maintains an individual set of records for each child, which are filed under the individual child's surname.
- Ensure staff in the children and young people's service comply with safe systems to ensure that toys are cleaned in line with the Cleaning and Decontamination of Toys' policy and ensure there is a system to monitor compliance around toy cleaning. We also observed poor compliance with hand washing and cleaning of equipment between use after each child.
- Ensure compliance with staff mandatory training and appraisal in the children and young people's service.
- Ensure there are standard operating procedures for the transition of all children into adult services.
- Take action in the children and young people's service to ensure there is a systematic process of audit to monitor service quality and performance, for example records audits, and auditing the single point of access system.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

Good

Summary

This section relates to the safety of Bristol Community Health as a managing organisation (provider) for its services

We rated safety at Bristol Community Health as the provider as good because:

- There was recognition and application of the legal duty to explain and apologise when something went wrong and caused or could have resulted in significant harm (duty of candour).
- There was a good culture among staff for reporting when things went wrong or there was a near miss. These were investigated, the board were informed, and staff were informed about anything that needed to change. Lessons were learned from incidents.
- There were systems, processes and practices to keep people safe from abuse or avoidable harm. There were regular reports to the board on these procedures, and how they were working. Staff recognised when someone was at risk and needed safeguarding, and knew how to take this forward. The organisation was committed to supporting people and keeping them safe.
- There were staff vacancies, but the organisation was using bank staff and occasional agency staff to fill shifts when needed.

However:

- There were a number of vacancies in the community nursing staff teams leading to some staff with high numbers of patients on their caseloads. This was sometimes stressful for staff, and meant patients did not always get as much time with staff as they would have wanted.

This section relates to the safety of the four core services

We have rated safety of the four core services overall as good because:

- Most staff understood the importance of reporting and acting upon incidents.
- There was a culture of being open, honest and apologising when things went wrong.
- Staff were clear about their responsibilities to report and act upon safeguarding concerns.
- The administration of medicines was safe.

Summary of findings

- Facilities and the environment were fit for purpose.
- The majority of patient records were good, although some were incomplete in places. They were stored securely.
- There was good compliance with mandatory training in all services, with the exception of the children's team, which was being provided at the time of the inspection on a short-term contract. This was not helped by poor quality staff records handed over by the acute trust transferring the service.
- There were good assessments to keep people safe and manage anticipated risks.

However:

- There were teams that were short of staff and pressure on some was high. There was too much variation in the caseloads staff were expected to carry. The staffing tools for rotas and planning were not being used effectively.
- Some staff in the children's service needed to update their safeguarding training.
- There was a variable performance in infection prevention and control protocols.
- Mandatory training was not being updated as required in the children's team.

Are services effective?

Good

Summary

This section relates to the effectiveness of Bristol Community Health as a managing organisation (provider) for its services

We rated effectiveness at Bristol Community Health as the provider as good because:

- The care and treatment delivered to patients delivered good outcomes.
- The organisation focused upon promoting a good quality of life.
- The best available evidence was used to structure care pathways and the standards used in treatment and procedures.
- There was a good multidisciplinary approach to delivering care so it was coordinated, and benefitted from shared learning at all levels in the organisation.

However:

- There was variable quality in the audits around consent. Those we saw did not all provide assurance that consent was being recorded and validly obtained at all times, and that actions were being taken to improve compliance when there were gaps.

Summary of findings

This section relates to the effectiveness of the four core services

We have rated effectiveness of the four core services overall as good because:

- Care was delivered along national guidelines and recognised pathways.
- Pain was well managed, as were nutrition and hydration needs.
- Patients had good outcomes from the care and treatment they received.
- Most staff had been given an annual review (appraisal).
- There was professional development and courses available to staff to give them new and updated skills.
- There was an excellent approach to multidisciplinary working and coordination of care pathways.
- There were proactive services to help discharge patients from hospital, and provide a rapid response to patients in need.

However:

- There was limited use of technology and telemedicine.
- Somewhat unreliable records showed appraisal compliance had fallen behind in the children and young people's services.
- The rapid response team had to go above and beyond the service they were expected to provide, as the social care packages were not always available when the rapid response service should have ended.
- Some of the children and young people's services had no standard operating procedures for handing over patients from child to adult services.
- There was variable access to information due to issues with mobile phone networking in some areas, and IT systems that needed to be upgraded (of which the provider was well aware).
- Recording of consent decisions and mental capacity assessment was poor. Not all consent decisions were following legal principles where they involved children.

Are services caring?

Summary

Good

This section relates to the caring of Bristol Community Health as a managing organisation (provider) for its services

We rated caring at Bristol Community Health as the provider as good because:

- A key principle of the organisation was to involve patients in their care and decision-making and to work with and alongside them and those close to them.

Summary of findings

- The values of the organisation embedded how patients, their carers and families were to be treated with respect and dignity. Staff throughout the organisation, including at the senior level, were kind and compassionate to people they supported and treated them as individuals.
- The organisation encouraged staff to take time to interact with people and be considerate and encouraging. It was recognised, however, this was hard with the limited time and resources available for the small things that sometimes meant a lot to people. Staff interacted with people who supported the patients, such as carers and families, and recognised when patients needed extra support from those around them.
- Staff understood and had training to respect people's cultural, social and religious needs, and took account of these when caring for and supporting people.
- Staff were encouraged to be sensitive with patients to help them maintain or improve their health and their independence. Staff understood the impact of conditions and treatment on people's lives and wellbeing.

This section relates to the caring of the four core services

We rated caring of the four core services overall as good because:

- Patients and those close to them were treated with compassion, kindness and respect.
- Privacy and dignity for patients was respected.
- People were involved in making decisions about what happened to them.
- Families and carers were involved, enabled, and encouraged to support patients.
- There was support for emotional wellbeing for patients and those who cared for them.

Are services responsive to people's needs?

Good

Summary

This section relates to the responsiveness of Bristol Community Health as a managing organisation (provider) for its services

We judged responsiveness at Bristol Community Health as the provider as good because:

- Services were planned and delivered to meet the needs of the local population and communities.

- The organisation worked effectively and cooperatively with commissioners and other providers to deliver appropriate services for people. This included services within acute hospitals to enable patients to leave for more appropriate care-settings when they were able.
- There were professional working relationships with other providers of health and social care in the local communities, including the two major acute hospitals and the ambulance service.
- There was outstanding engagement with local people and communities to shape and provide services to meet their needs.
- Services were planned to take account of people's needs associated with equality and diversity.
- The organisation understood the importance of providing appropriate care for people in vulnerable circumstances. This included people living with dementia, a learning disability, or people who found it hard to access services.
- The board were informed and made aware of people's complaints, how they were listened to and responded to appropriately.

However:

- The reporting of complaints to the board did not show if there were proportionately more complaints in one service than another. There was no record to show what actions were being taken with the leading themes in complaints, and to inform the board of the number of complaints upheld, partially or otherwise. The board was therefore not assured that learning from complaints has been embedded and how changes had made a difference.
- Some parts of the organisation were working above and beyond their commissioned work to support patients. This was particularly in the community adults service, but also in the urgent care centre. This was recognised by the organisation, and showed a dedication to patients, but added to the pressure on services already under pressure.

This section relates to the responsiveness of the four core services

We rated responsiveness of the four core services overall as good because:

- Services were planned to meet people's needs. This included services for vulnerable groups; to get people home from hospital; avoid admissions; and avoid the need to involve the emergency services.

Summary of findings

- Equality and diversity was taken into account when services were planned.
- The organisation supported people living in vulnerable circumstances and made sure services met their needs.
- Complaints were taken seriously, responded to appropriately, and lessons were learned where needed to improve services.
- Many services were able to provide care when it was needed. There was an outstanding contribution from the palliative care home service who responded rapidly to referrals for patients at the end of their life.

However:

- Access to care in the children and young people's services was variable and sometimes not even close to targets.

Are services well-led?

Good

Summary

This section relates to the leadership of Bristol Community Health as a managing organisation (provider) for its services

We have rated well-led at Bristol Community Health as the provider as good because:

- There was a clear vision and strategy for the core services. We were confident a strategy would emerge for the services for children, young people and families now the organisation had been awarded a five-year contract.
- There were strategies for the organisation with the patient at the centre and based upon delivering safe and quality care.
- There was an effective governance framework for the core services, clear lines of accountability, a strong and committed board of directors, regular review of systems, finances, and resources. There was an oversight on services and teams, and the board were assured that the services delivered safe care that met people's needs.
- There was a good culture within the organisation. There was encouragement for all staff to be open, candid and honest, alongside healthy challenge and collaboration. The views of staff were encouraged and represented with the board of directors.
- There was outstanding engagement with people who used the services, and the communities in which they lived. People were actively encouraged to be part of the future of services, and involved in decision-making and feedback.
- Improvements, effort, achievements and success were recognised, encouraged and celebrated throughout the organisation.

Summary of findings

However:

- The children and young people's services (Child and Community Health Partnership) did not, as yet, fit within the governance processes of the core services of Bristol Community Health. There had been, nonetheless, much effort to present the service to the board. We were assured this would be addressed now the contract to deliver these services had been awarded permanently.

This section relates to the leadership of the four core services

We rated well-led of the four core services as good because:

- There was committed and caring leadership in the local teams and services.
- Most staff felt connected to the organisation, and worked hard to do their very best for the patients, parents, carers, and other people they supported.
- There was a clear vision and strategic direction for most services. The new children's service would now be enveloped into the overall strategic direction for the organisation.
- There was a lot of structured governance work, and objectives to deliver safe and quality care through knowing where the risks, problems, and issues lay, but also what was working well.
- There was a strong and notable culture throughout the organisation. This included engagement with patients, the public and staff.
- There was innovation and improvement to services, and encouragement for staff and patients to come up with new ideas and ways of working.

However:

- The audit programme was not working in the children and young people's service. Although a lot of work was being undertaken by staff and the teams, it did not have a clear purpose, and changes because of shortcomings were therefore not in evidence.
- The lone-working policy was not being followed, as it should have been in some services.

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 team included CQC inspectors and a variety of specialist professional advisors. We were joined by community nurses, learning disability nurses, children's nurses, allied health professionals (including physiotherapists and occupational therapists), clinicians specialising in governance, and a nurse specialising in end of life care. 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 Bristol Community Health C.I.C. as part of our comprehensive community health services inspection programme.

How we carried out this inspection

To get to the heart of experiences of care for people who use services, 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 the services, we reviewed a range of information we hold about the organisation, asked the provider to send us a wide-range of evidence, and asked other stakeholder organisations to share what they knew. We carried out announced visits to many different locations and community teams working for Bristol Community Health on 16 to 18 November 2016. Prior to this and during the visits we held focus groups with a range of staff who worked within the services, such as nurses, therapists, administrators, and managerial staff. We interviewed staff working in the community teams, many of the headquarters-based staff, the senior executive team, and members of the board of directors.

We talked with people who use Bristol Community Health's services. Our experts by experience telephoned a group of patients and their carers who were receiving, or who had received care and support. During our visits, we took time to observe how patients were being cared for, and we talked with patients and their carers, and/or family members. We reviewed treatment records and other information about patients' care.

We carried out unannounced visits on 27, 28, 30 November, and 1 December 2016.

Information about the provider

Bristol Community Health C.I.C. is a not-for-profit social enterprise organisation serving community patients in Bristol and the surrounding areas. The organisation was established in 2011, and provides all care and treatment under a contract with the NHS. The status as a community interest company requires a company to conduct a business for community benefit, and not for private advantage.

Bristol Community Health provides a range of services to the community including a learning disabilities team,

Summary of findings

community nursing team, a children and young person's service, diabetic eye screening, falls service, intermediate care, community respiratory and health failure specialist services, migrant health, palliative home care team, physiotherapy, podiatry, rapid response teams, healthcare for asylum seekers, and an urgent care centre. The organisation also provides a prison healthcare service at five prisons in the south west of England. Bristol Community Health was awarded the new Offender Health contract in April 2016 as the prime contractor and is now managing a complex chain of healthcare providers. These services are inspected by another team within CQC in conjunction with Her Majesty's Inspectorate of Prisons, and were not part of this inspection.

In April 2016, Bristol Community Health took on the contract to provide healthcare services for children (Children's Community Health Partnership) in South Gloucestershire and Bristol alongside two other experienced healthcare providers (another community provider and an NHS mental health provider). This was for a 12-month period. During our inspection, the contract was awarded to this consortium for a fixed term of five years from April 2017.

Excluding the prisons, this provider has two registered locations. The majority of services are registered at the Bristol Community Health Headquarters location, and urgent care services are registered at the Urgent Care Centre.

The provider has an income of £75 million to provide services, and employs around 1,700 staff.

Bristol Community Health was last inspected in March 2014 and there were no actions raised at that inspection. This is the first comprehensive inspection of the provider under the new CQC methodology, and the first time the provider has been rated for the safety, effectiveness, caring, responsiveness and leadership of the services it delivers.

Outstanding practice

- There was an outstanding, dedicated and committed approach to engaging with people who were patients of Bristol Community Health, their families, their carers, volunteers, and the wider community. The Patient and Public Empowerment programme, underpinned by the patient charter, put patients at the centre of decisions, valued their feedback and input, and made changes and improvements from listening to and engaging with people.
- The chief executive and her leadership team had an outstanding commitment to staff. The organisation had been established as an employee-owned social enterprise. It recognised staff for effort and achievement through a number of different schemes, including award ceremonies and personalised contact.
- 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 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. They enabled services to deliver care and treatment, which was accessible to the local population, with no discrimination. For example, through the migrant health services and the Macmillan rehabilitation support service.
- The Haven service recognised the additional support required for staff who were often dealing with difficult, challenging and upsetting situations. Weekly access to a psychologist was made available for staff.
- In children's services, staff respected and recognised each child as an individual. We observed outstanding caring from staff who were singing a song to each individual child and addressing them using their name when they entered the room for their therapy session. These children had profound needs, and we recognised how their faces lit up when they came into the session and had their special song.
- Families and carers of children and young people provided consistent positive feedback about the service. One parent told us "staff are so supportive and helpful," "staff are always there when you need them," while another told us "staff are really friendly, helpful and always welcoming." Another mother told us '"the service is brilliant, couldn't have asked for a better one."

Summary of findings

- In adult services, we observed outstanding multidisciplinary team working both across the organisation and with other healthcare providers. In particular, staff worked hard to make sure all involved in a patient's end of life care were up to date with the situation, and their visits were all coordinated.
- There was an outstanding response to people who were coming to the end of their life. The palliative home care team made sure their service worked to meet the needs of the patient and those they were close to.
- 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 staff teams and identify areas of risk to provide active support. These were known as 'hot teams'. This allowed issues and risks to be identified early, and plans to be made to help support these teams.
- In the urgent care service, we heard of numerous examples where staff had gone the extra mile to support patients and those close to them.
- The urgent care staff had developed a comprehensive support network and a range of referral pathways for adults and children in primary, secondary and community health care settings.
- The urgent care service had engaged the support of the lead emergency consultant at the local children's hospital to facilitate joint working, and education.

Areas for improvement

Action the provider MUST take to improve

Note: This section relates to Bristol Community Health and the core services overall

- Take action to ensure all staff in the children and young people's service receive the appropriate level of safeguarding training for their role.
- Ensure a complete set of records are transferred with the child from the health visiting team to the school nursing team in line with Royal College of Nursing guidelines.
- Take action to ensure the health visiting team maintains an individual set of records for each child, which are filed under the individual child's surname.
- Ensure staff in the children and young people's service comply with safe systems to ensure that toys are cleaned in line with the Cleaning and Decontamination of Toys' policy and ensure there is a system to monitor compliance around toy cleaning. We also observed poor compliance with hand washing and cleaning of equipment between use after each child.
- Ensure compliance with staff mandatory training and appraisal in the children and young people's service.
- Ensure there are standard operating procedures for the transition of all children into adult services.
- Take action in the children and young people's service to ensure there is a systematic process of audit to monitor service quality and performance, for example records audits, and auditing the single point of access system.

Action the provider SHOULD take to improve

Note: This section relates to the provider and how it delivers executive oversight to the core services. Other actions the provider should take are referred to in the individual core service reports.

- Review the reporting of complaints to the board so it will be apparent if there were proportionately more complaints in one service than another. Show what actions were being taken with the leading themes in complaints, and inform the board of the number of complaints upheld, partially or otherwise. Ensure the board know that learning from complaints has been embedded and any changes have made a difference.
- Look at the variable quality and presentation of documentation audits to ensure there is consistency and valid actions taken when there are gaps.
- Ensure the newly appointed chair undertakes an annual review for the chief executive officer and the

Good

Are services safe?

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

non-executive directors as required by the requirements of the Fit and Proper Persons' Test. This should be undertaken with limited delay due to the oversight of this important review in recent years.
- Make sure the representation of patient's views are put into context as to what percentage of the patients treated are being reported.
- Work with commissioners to address the additional work the organisation is carrying out over and above it's contract.
- Consider non-executive director oversight for the palliative care service.

Good

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Summary

This section relates to the safety of the provider and how it delivers executive oversight to the core services

We rated safety at Bristol Community Health as the provider as good because:

- There was recognition and application of the legal duty to explain and apologise when something went wrong and caused or could have resulted in significant harm (duty of candour).
- There was a good culture among staff for reporting when things went wrong or there was a near miss. These were investigated, the board were informed, and staff were informed about anything that needed to change. Lessons were learned from incidents.
- There were systems, processes and practices to keep people safe from abuse or avoidable harm. There were regular reports to the board on these procedures, and how they were working. Staff recognised when someone was at risk and needed safeguarding, and knew how to take this forward. The organisation was committed to supporting people and keeping them safe.
- There were staff vacancies, but the organisation was using bank staff and occasional agency staff to fill shifts when needed.

However:

- There were a number of vacancies in the community nursing staff teams leading to some staff with high numbers of patients on their caseloads. This was sometimes stressful for staff, and meant patients did not always get as much time with staff as they would have wanted.

This section relates to the safety of the four core services

We have rated safety of the core services overall as good because:

- Most staff understood the importance of reporting and acting upon incidents.
- There was a culture of being open, honest and apologising when things went wrong.
- Staff were clear about their responsibilities to report and act upon safeguarding concerns.
- The administration of medicines was safe.
- Facilities and the environment were fit for purpose.

Good

Are services safe?

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

- The majority of patient records were good, although some were incomplete in places. They were stored securely.
- There was good compliance with mandatory training in all services, with the exception of the children's team, which was being provided at the time of the inspection on a short-term contract. This was not helped by poor quality staff records handed over by the acute trust transferring the service.
- There were good assessments to keep people safe and manage anticipated risks.

However:

- There were teams that were short of staff and pressure on some was high. There was too much variation in the caseloads staff were expected to carry. The staffing tools for rotas and planning were not being used effectively.
- Some staff in the children's service needed to update their safeguarding training.
- There was a variable performance in infection prevention and control protocols.
- Mandatory training was not being updated as required in the children's team.

Our findings

This section relates to the safety of Bristol Community Health as a managing organisation (provider) for its services

Duty of Candour

- The organisation understood and met the requirements for applying duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires an 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. The organisation had a clear policy and process for invoking this legal duty. Corporate staff had been trained to recognise when the duty of candour should be applied, and those we met described this to us accurately.
- Duty of candour was acknowledged in incident reporting. We reviewed six incident investigation reports and each of these were for circumstances where the duty of candour would apply. Each report had an appendix covering how the duty had been applied. Most of these had been completed or partially completed, but the template did not provide sufficient detail. The template recorded if a patient or family member had been offered written confirmation of the incident or a copy of the incident report. However, if either of these things were accepted, the template did not record if and when they had been provided. Two of the six reports said there was no offer of a written confirmation, or say why. One report had no report on the duty of candour, although it did apply. Only two of the six reports said the family had been asked if they wanted to ask any specific questions about the investigation, and a third was ambiguous. Our reading of the incident reports suggested this part of the template was not well understood by staff completing it.

Safeguarding

- There were appropriate policies and procedures for recognising and responding to adult and child safeguarding. The policies were in date and represented both local arrangements and national guidelines. There were separate policies for safeguarding vulnerable adults and safeguarding children. The processes, as appropriate, were different, to ensure procedures and communication were clear for both adults and children.
- The board of directors were informed about safeguarding matters. The monthly quality report to the board updated the leadership on training, referrals made, actions and recommendations. The report included what level of reporting came from individual teams in the services, and what categories were reported. This enabled the organisation to look for any recurring themes where action might be needed, and review if there were any teams making an unexpectedly high or low level of reporting.

Good

Are services safe?

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

Incidents

- The organisation had a positive and open approach to incident reporting. Senior managers explained the importance of staff being open and honest about incidents. They recognised how good organisations are those prepared to listen, change and improve when things went wrong, or could have been better. Staff we met said they were encouraged to report incidents, received feedback, which usually included thanks for the report they had made, and what had come from any investigation of the incident.
- Serious incidents had reduced over the last 18 months. In the year from April 2015 to March 2016, there was an average of five serious incidents requiring investigation each month. In this period, the number of incidents in a month ranged from one to nine. In the six months from April to September 2016, this had reduced to four per month on average. In this period, the number of incidents in a month ranged from two to six. The services provided by Bristol Community Health had also increased in this period with the inclusion of services for children, young people and families.
- All serious incidents were investigated in line with the organisation's policy and procedures, although there was a variable quality to the investigation reports. We reviewed six serious incident investigation reports. All of these related to the organisation's most frequent serious incident – a patient's development of a category three or four pressure ulcer. These six most recent incidents had occurred when the patient was under the care of Bristol Community Health, but circumstances showed these were unavoidable – although this was not explained directly in the report. Our review of the investigation reports found a lot of good detail, background and care described well. However, some reports skimmed over some key areas (such as staffing levels, which were not then described other than "challenging") and the root-cause of the incident focused on the lack of compliance by the patient, when there were other clear factors contributing. One particular report was also contradictory, or became so due to some factors reported not being clear as to their origin. We discussed our findings in some depth with the organisation and our concerns were understood and acknowledged.
- Incidents and investigations were peer reviewed before they were approved at executive level. Before they could be approved, serious incidents were presented at regular complex case review meetings. Each of the six reports we reviewed had been through this process. We attended one of these meetings during our inspection. The meeting included clinical managers and staff relevant to those investigations being considered. Also in attendance were the safeguarding lead, the manager representing quality and safety, clinical leads, operational, and governance staff. Our view was the atmosphere of the meeting was open and non-threatening. The organisation was not looking to apportion blame, but to look for positive actions and learning from incidents.
- The incidents reported were presented each month to the board of directors for review and comment. The monthly quality report started with a detailed review of incidents that covered over around 10 pages. Each section culminated in a review of incident trends in the various categories. The report concluded with actions and recommendations from any themes developing in that reporting period. One area the report did not cover was how the board were assured that actions taken had produced the anticipated improvement.

Staffing

- The board of directors received an extensive and informative report on staff – the Wellbeing report – each month. The report updated the board on sickness levels, vacancy rates, use of bank and agency staff, staff turnover, and teams where risks had been recognised. The report continued with training compliance in some detail. The report contained details on what the organisation called 'hot teams' which was where certain trigger points (absence rate ≥4%, vacancy rate ≥7.5%, and turnover rate ≥2.5%) had been reached in these teams.
- There were levels of sickness that were slightly below, so better than, those of public sector organisations and other not-for-profit organisations. In the latest board papers for November 2016, sickness absence was reported at 3.7% (for August 2016), which was slightly up on July at 3.6%. This was below the figure of 4.1% for the public sector and 4% in the not-for-profit business sector.
- The organisation recognised it had an issue with recruitment and retention of staff. Bristol Community

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Health competed for staff with two major NHS acute hospitals, a large mental health NHS trust, the private healthcare sector, GP practices who had or were establishing nurse-led services, and other local community service providers. In the services we inspected (so excluding the offender health services) the vacancy rate for September 2016 was 9.5%. When this was reduced through the use of bank staff, the rate fell to 7.6%. The organisation had been addressing this problem, which was included within the strategic risk register and consequently held and discussed by the board each month. The risk was entered onto the strategic risk register in July 2016. The organisation had implemented a number of projects and actions to mitigate the risk. These included, among others, a review to provide assurance that there were no underlying causes of staff turnover the organisation was not aware of. There was the 'Talkback Programme' where senior executives met with staff in less formal atmospheres, and their places of work to have open discussions about pressures and successes. There had been changes to employment terms and conditions, workforce development programmes, and the wellbeing programme, staff events, and career progression.

The section relates to the safety of the four core services

Incident reporting, learning and improvement

- There was a good culture among most community teams and staff around incident reporting. Staff recognised their responsibilities to report incidents and why this was necessary to improve future care. The only area of concern was around inconsistency with the children's service for what constituted an incident. Not all staff were using the organisation's system as they should. This had been recognised to an extent by senior staff within Bristol Community Health and there were plans and work ongoing to raise awareness of the importance of incident reporting.
- Incidents were investigated and lessons learned as a result. We saw examples in each of the services we inspected of good quality investigations and recognition of where something should be changed. Actions to be followed were shared with teams. Staff were given feedback when they reported an incident saying what was being done to learn from incidents and avoid them happening again.

Duty of candour

- Most staff in community teams were familiar with the requirement to be open, honest and apologise to patients if something was to go seriously wrong with their treatment of care. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires an 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. There was some lack of knowledge in the community adults' team and not all staff had received training or direction.

Safeguarding

- There were clear systems and processes for keeping children and vulnerable adults safe from abuse. Staff were confident about making safeguarding referrals and had support from senior staff if they had any concerns, questions or wanted guidance. They were clear about who the Bristol Community Health senior staff were with responsibilities for safeguarding and how to get in touch with them. Feedback was given to staff who made referrals so they could see that action had been taken.
- There were high levels of training in safeguarding for staff working with adults, although this dropped in children' services (CCHP). The board report for November 2016 reported that at the end of September 2016 training in the adult teams was:
  - Safeguarding adults' training for all staff was 97%
  - Safeguarding adults' for relevant staff (level 2) was 92%
  - Safeguarding children for all staff (level 1) was 99%
  - Safeguarding children for relevant staff (level 2) was 95%
  - Safeguarding children for relevant staff (level 3) was 86%
  - Safeguarding children for relevant staff (level 4) was 100%

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The organisation's target for completion was 90%, so just one group of staff were not meeting this level of compliance. The report was not clear, but we understood these numbers did not include CCHP staff.

Further into the report, the CCHP staff training data was:

- Safeguarding adults' training for all staff was 82%
- Safeguarding adults' for relevant staff (level 2) was 46%
- Safeguarding children for all staff (level 1) was 77%
- Safeguarding children for relevant staff (level 3 – level 2 not required) was 81%
- Safeguarding children for relevant staff (level 4) was 100%

In this part of the organisation, only one group of staff met the compliance levels for safeguarding training. This had been recognised in the organisation, and there was an action plan and report submitted to the board to focus upon these areas as a priority.

Medicines

- Arrangements for the management, storage and dispensing of medicines were safe. There were appropriate storage facilities for medicines, including controlled drugs. Any prescription pads were in locked and secure storage and traceable. There were regular stock checks to ensure medicines were not mismanaged.
- The organisation had appropriate use of patient group directions. These were a set of instructions for the use and prescription of medicines in certain situations. Those in use were up-to-date and had been appropriately issued and approved.
- Actions were taken when incidents with medication were reported. A recent trend of incidents with insulin reporting in an area of the community adults' service had been identified. The problem, which was with the records not being used correctly, was discovered, rectified and a new system introduced. Staff had also been reminded to administer medicines, including insulin, with a calm approach and make sure they were not distracted by the environment or other people. The incidents had now decreased and the continuation in this was being monitored at senior level.

Environment and equipment

- The facilities we visited were clean, and relatively well maintained. The urgent care centre was spacious and well laid out. It was easy to clean and maintain and a relatively new premises designed for purpose. The reception areas used by the learning disabilities team were not as secure for staff as they could be, but there were plans to improve this – although with no date for the work to be completed. The community clinics for adults and children were well maintained and appropriate for their use, but some of the premises were old and tired through regular use.
- Equipment was serviced and regularly checked if required. Records we saw indicated maintenance had been undertaken, and other equipment, such as emergency trolleys, was checked on a regular basis as required.
- Most equipment used by staff was in good condition. Equipment used in the urgent care centre was in good condition, and able to be maintained effectively. Anything used by the community adults' team when working with patients was in good condition and fit for its purpose. In the children and young people's services, there were some old and worn out changing mats, which staff had asked to be replaced. Otherwise, equipment was appropriate and available, and specialist equipment would be provided when needed to support children and adults.
- There were arrangements to ensure specialist equipment was provided to patients when they needed it. Bristol Community Health had around 1,500 staff qualified to recommend equipment, which was then managed by the equipment coordination team. The equipment coordination team ensured appropriate equipment was ordered, and tracked any special requests. A senior member of staff approved all orders for equipment on the approved list. Equipment not on the approved list, but seen as necessary for a patient would be formally approved by a specialist group within the organisation. There had been some incidents recently due to confusion with the type of pressure relieving mattresses being supplied. A pattern of issues had been recognised and the system had been amended to solve the problems.

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Are services safe?

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Quality of records

- There were legible, clear and well-maintained records, although some were not as complete as they should have been and some not fully available. Records about people using the learning disabilities service were good, and we reviewed 16 sets of these at random. Records in the urgent care service were clear in relation to the care and treatment provided. However, for example, in the 10 sets of records we viewed at random, the pain scores and consent had not been documented consistently. In the community adults' teams, the records we looked at were legible, accurate and complete. The children's records were completed well, although not all services had full records for each child. Some of the 'red books' used to record significant events for a child were not always complete. There was some duplication in records by the therapy teams in the children's service.
- Records were stored securely. Those records that were hand written by community adults' teams were transferred to secure electronic records when the member of staff came back to their base. Where records were not electronic, these, such as with the children's service, and paper records used in the adult services, were locked away in secure premises.

Cleanliness and infection control

- There was a variable performance in infection prevention and control. There was good adherence to policies and procedures in the urgent care service, the community adults' teams and the staff who supported people with learning disabilities. However, the children and young people's services did not have reliable systems to ensure they were preventing the spread of infection. There was no evidence of preventable infections originating from the service, but some of the practices and equipment we saw did not meet the Bristol Community Health policies or standard operating procedures. The concerns included:
  - Not all clinical waste bins were foot operated. We observed some staff opening the bins by hand and not cleaning their hands after disposing of waste.
  - We observed poor infection control procedures at some staff bases and clinics. Staff were not washing their hands between seeing children and were not cleaning some equipment between use.
  - There was no assurance that toys provided for play or distraction were cleaned effectively. There were some soft toys in use, which were not permitted by the organisation's policy due to difficulties with keeping them clean.
- With the exception of what has been reported above, we observed staff complying with recognised hand-hygiene standards. This included staff in clinical areas being 'bare below the elbow' to make hand-washing more effective. Staff had good techniques when washing their hands, and knew when to use hand gel or when it would not be effective.
- Most premises were clean and tidy, although some were old and showing signs of wear and tear, and less easy to keep hygienic. However, staff worked hard to ensure cleaning was effective and there was no evidence of the spread of infection. With the exception of what has been reported above, we observed good attention to cleaning of clinical equipment, which was the responsibility of nursing or healthcare staff.
- The organisation had policies and procedures for staff and patients when there were outbreaks of illness or infection either on the premises (such as care homes visited by the community adults team) or in the community. Patients arriving at the urgent care centre, for example, were asked to not enter the premises if they had diarrhoea and/or vomiting, and to contact the 111 service for advice. There were otherwise procedures to isolate a patient who was exhibiting signs of infection.

Mandatory training

- Most staff were up to date with their mandatory training and, with the exception of the children and young people's services, most were exceeding the organisation's target of 90%. The children's service was showing compliance of 70%, although this figure had been hard to obtain for the organisation. When the service was transferred over to Bristol Community Health from the NHS in April 2016, there had been a failure to transfer the mandatory training records satisfactorily. This left Bristol Community Health with poor records they were unable to rely upon. An improvement plan had been produced to deal with the perceived lack of compliance and escalated to the corporate risk register.

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Are services safe?

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Assessing and responding to patient risk

- There were good risk assessments for patients to help keep them safe. This was the case in all the core services we inspected. Risk assessments were relevant to the patients being supported. Risks were acted upon in a timely way. For example, in the service for people with learning disabilities, the referrals to speech and language therapists were a priority for patients at a high risk of choking. Patients with a high risk of diabetes were referred to a dedicated team for advice and support.
- Bristol Community Health was committed to a culture to reduce the risk and occurrence of pressure ulcers. There was a dedicated wound-care service, led by a tissue viability nurse specialist. Furthermore, there were skin champions in each community nursing team to support staff with training and advice. The objective was to assess patients in every interaction for the risk of developing a pressure ulcer. This had resulted in a reduction in the incidence of pressure ulcers, and in the year 2016/17 to the end of October 2017, there had been no avoidable pressure ulcers recorded.
- The palliative home care team followed clear procedures when people were at the end of their life. This included when to escalate concerns to the patient's GP or the local hospice. The team had handovers each day to make sure any new or emerging risks were known by the staff coming on duty.
- There was a standard triage system in use in the urgent care service to manage patient risks. Staff had annual training on signs and symptoms for the sick child or adult. There was a fully-equipped resuscitation room for patients recognised at serious or significant risk.
- There was a wide-range of tools used in the community learning disabilities' teams when patients were referred to them. There was appropriate use of crisis plans or reacting to sudden changes or deteriorations in a patient. An appropriate range of healthcare professionals were involved in the patient's care to assure risks were managed by the right people.

Staffing levels and caseload

- As acknowledged by the organisation, there were teams within the organisation that were short staffed and under pressure. There were vacancies across the services, with the exception of the urgent care service, which had recently recruited staff to fill its vacancies. However, the urgent care service was staffed to levels of staff agreed within the contract with the commissioners. This did not take account of the 26% increase in demand for the service in the last 12 months. The organisation was working hard to fill vacant posts, and used bank and agency staff to supplement staffing levels. However, one of the key areas of the staff survey was the high proportion of staff who reported they were concerned about staffing levels and time to do their jobs properly.
- There were significant variations in the caseloads staff were working with. This was the case in all the community teams (that is excluding urgent care). Some staff had caseloads that were double the average in the children and young people's services, and higher than recommended national guidelines. In the community learning disability service, there were some high caseloads, although the staff told us they were safely managing these. However, the staffing levels in this service had not been reviewed for some time.
- The staffing tool used to plan and establish rotas by the community nursing teams in both the adult and children and young people's services were not being used effectively. This resulted in capacity measures not being a true reflection of staffing levels, or the work being undertaken. This resulted in the organisation's escalation procedures when staffing levels were unsafe not being activated at times.

Managing anticipated risks

- In urgent care, the arrangements for providing care and treatment in times of high demand were effective. This meant patients who arrived at a time when the service was at full capacity were redirected to other services. This was only invoked for patients who did not have a life-threatening condition, as they would be urgently treated.
- There were policies and procedures to ensure risks to patients or others were understood and managed. When patients had conditions that were worsening, or patients had been referred with significant concerns, these patients would be seen as a priority.
- Bristol Community Health operated certain services to provide an urgent response to risks. This included the

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Are services safe?

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urgent care centre, the rapid response teams, the Bristol Intensive Response Team (for the learning disabilities service), and safe-haven beds for people who needed protection or urgent support.

Are services effective?

Good

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 of findings

Summary

This section report relates to the effectiveness of the provider and how it delivers executive oversight to the core services

We rated effectiveness at Bristol Community Health as the provider as good because:

- The care and treatment delivered to patients delivered good outcomes.
- The organisation focused upon promoting a good quality of life.
- The best available evidence was used to structure care pathways and the standards used in treatment and procedures.
- There was a good multidisciplinary approach to delivering care so it was coordinated, and benefitted from shared learning at all levels in the organisation.

However:

- There was variable quality in the audits around consent. Those we saw did not all provide assurance that consent was being recorded and validly obtained at all times, and that actions were being taken to improve compliance when there were gaps.

This section relates to the effectiveness of the four core services

We have rated effectiveness overall as good because:

- Care was delivered along national guidelines and recognised pathways.
- Pain was well managed, as were nutrition and hydration needs.
- Patients had good outcomes from the care and treatment they received.
- Most staff had been given an annual review (appraisal).
- There was professional development and courses available to staff to give them new and updated skills.
- There was an excellent approach to multidisciplinary working and coordination of care pathways.
- There were proactive services to help discharge patients from hospital, and provide a rapid response to patients in need.

However:

- There was limited use of technology and telemedicine.
- Somewhat unreliable records showed appraisal compliance had fallen behind in the children and young people's services.
- The rapid response team had to go above and beyond the service they were expected to provide, as the social care packages were not always available when the rapid response service should have ended.
- Some of the children and young people's services had no standard operating procedures for handing over patients from child to adult services.
- There was variable access to information due to issues with mobile phone networking in some areas, and IT systems that needed to be upgraded (of which the provider was well aware).
- Recording of consent decisions and mental capacity assessment was poor. Not all consent decisions were following legal principles where they involved children.

Our findings

This section relates to the effectiveness of Bristol Community Health as a managing organisation (provider) for its services

Evidence based care and treatment

- Care and treatment provided to Bristol Community Health's patients was delivered along evidence-based guidelines and through specialist staff. Staff had access to a range of guidance for providing effective assessment, diagnostics and treatment.
- The organisation was involved with research projects to improve care and treatment and establish best practice. For example, the urgent care service was involved with a project to better understand why people attend emergency and urgent care services.
- The clinical director – an experienced nurse – was supported by staff leading in various areas where they had training and experience. This included: infection

Are services effective?

Good

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prevention and control; quality and patient safety; medicines management; and clinical audit. The operational team was led by an experienced director with many years of NHS and community service management. Staff with leading roles in this area included: tissue viability (treatment for people with pressure ulcers and wounds); allied health professionals (physiotherapists, podiatrists, occupational health and speech and language therapists); the lead nurse for public health; and the lead nurses for urgent care, community nurses, specialist services, learning disabilities and continuing healthcare, musculoskeletal care, and intermediate care. Those lead staff we met described care and treatment supported by National Institute for Health and Care Excellence (NICE) and other relevant guidance. Examples included support for older people suffering from a fall, where NICE guidance underpinned the falls assessment service, and prevention and pressure ulcer management.

- Policies, procedures and clinical guidance were reviewed each month by the 'clinical cabinet', which was part of the governance assurance framework. The clinical cabinet reviewed NICE guidance, revisions to care pathways, updates, revisions and new clinical policies, and approved any research programmes.

Patient outcomes

- The board was provided with an annual report of clinical audit. Clinical audit work was a contractual obligation of the organisation, as required by the clinical commissioning groups. The board also recognised effective audit as a recommendation of the Francis report, published in 2013 in response to the failings at Mid Staffordshire NHS Foundation Trust. The work by the audit team included local audit approved by the organisation, and audits in response to guidelines from NICE, and NHS England's Commissioning for Quality and Innovation (CQUIN) framework. The most recent report (May 2016) covered the work for the previous financial year – April 2015 to March 2016.
- Audit work provided oversight and assurance, and produced change. It was underpinned by the work of the quality assurance group and the harm-free care group. The audit report described how learning had emerged from clinical audit. In the May 2016 report, the example came from work of the rapid emergency assessment care team (REACT) who found there had been little improvement in the process for falls referrals since the previous year. Work with the local NHS acute trusts had resulted in a new falls' pathway document to enable clinicians to refer patients to the most appropriate service. The objective was to broaden the range of falls' clinics being referred to and reduce waiting lists in over-used services. Early indications showed this had a positive impact for patients.
- Bristol Community Health had a strong focus upon feedback from patients and their carers as a way of determining outcomes of the care and treatment they delivered. As reported in our section on public engagement, there was a strong focus on patient feedback, particularly in real time, rather than annual questionnaires. This had increased feedback by more than 100% since the system was implemented in 2015.
- The organisation had a series of key performance indicators to measure outcomes and specific indicators reported to the board each month. This included harm-free care statistics (pressure ulcers, falls with harm, venous thromboembolism, and urinary tract infections), and health-care acquired infections. Harm-free care was around 94% on average, although no target had been provided to analyse how the organisation was doing.
- There was cooperation and collaboration in the area of clinical audit. The organisation was represented on the Bristol Interface Audit Group and the South West Audit Network. Audits for work that crossed organisational boundaries (called interface audits) were discussed, recommended and implemented by these networks. In the 2015/16 year, Bristol Community Health contributed to, for example, an audit on the use of syringe pumps. There was also work with the local NHS acute hospital trusts on improving pathways of care where they had been seen to be failing in areas. This had included work on improving the referral of patients who had suffered a fall. The organisation had also been part of the development of the South West Quality Improvement Framework for the Prevention and Management of Pressure Ulcers, commissioned by NHS England.
- There was a low level of complaints to the organisation, suggesting patients were happy with their care and the outcomes of any treatment they received. There was a high level of patient satisfaction with services, with the most recent NHS Friends and Family Test (September 2016) reporting that 97% of people who responded would recommend the service.

Are services effective?

Good

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Multidisciplinary working

- Multidisciplinary working was encouraged and valued by the organisation. This was both within teams, between services, with staff in other teams, and with external providers of care. At senior management level there was professional involvement and engagement with the local NHS acute hospital trusts, the local mental health trust, and other stakeholders, such as the local authority.

Access to information

- Bristol Community Health was about to upgrade IT systems to enable staff working out in the community to have access to patient records in the electronic system. At the time of the inspection, staff would return to their base office to input information to patient records to keep them up to date.
- There was access for all staff to relevant information. All staff had access to the Bristol Community Health intranet, and this allowed them to view policies, protocols, standard operating procedures, and other information stored by the organisation.
- There were recognised issues with computer systems, which were to be addressed by the appointment shortly of a Chief Information Officer. The staff survey told us low numbers of staff were satisfied with the IT systems and felt they had good support when they had a problem. The organisation freely admitted there were problems with the infrastructure and there were too make 'workarounds' and disparate systems. Some of this was related to systems and services owned and managed by other organisations, which Bristol Community Health was unable to influence under their contract with the lead clinical commissioning group. We were told by the Chief Executive how "addressing these issues is a key part of our business plan and business cases are currently under consideration by our board to make significant investment in solutions."
- The introduction of the electronic patient record system (known as EMIS) had enabled interfaces with primary care (GPs) and was improving efficiencies for both staff and patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was good staff compliance with training in the Mental Capacity Act 2005. The nature of care provided by Bristol Community Health staff would rarely require a patient to provide written consent, and most treatment would be from gaining implied or verbal consent. However, staff also met with patients who had a lacked the mental capacity to provide valid consent. This would require care to be provided in the best interests of that patient, and this would need to be assessed and recorded.
- There was a variable quality in audits where consent was reviewed, and no overarching assurance it was being consistently sought and recorded across the services. Consent was reviewed within the audits of documentation carried out in many of the services, but the quality of the four of these we reviewed was inconsistent. There was no evidence to suggest consent was being inappropriately or incorrectly sought or recorded. However, the four audits were all quite different and did not appear to follow a set template. This meant there was some inconsistency when looking to consolidate and compare results. For example, not all of the audits looked at the assessment of patients' mental capacity. There were some gaps in actions arising from concerns brought out of the audits. Therefore, the audit reports would not provide the organisation with a consolidated view of whether consent decisions and recording of these was meeting legal guidelines.
- Bristol Community Health specialised in community care, and would therefore not be applying for or able to grant themselves a temporary urgent authorisation to deprive someone in their care of their liberty (a Deprivation of Liberty Safeguard). Nevertheless, the organisation would be caring for and treating people who might be subject to this safeguard. This included people living in a care home or supported setting for the purpose of being given care or treatment. The safeguards applies to people who had a mental illness and lacked capacity to be able to consent to the arrangements for their care or treatment. The majority of these people will be those who had significant learning disabilities, people living with dementia or a similar disability, and people with certain other neurological conditions. Community staff were trained to understand how and why a Deprivation of Liberty Safeguard was applied to a patient they might be treating, for example, in a care home, and their role in keeping that person and those around them safe and well supported.

Are services effective?

Good

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.

This section relates to the effectiveness of the four core services

Evidence-based care and treatment

- Policies, guidelines and the pathways for patient care had been developed across services in line with national and evidence-based guidance. Staff had access to a range of guidance for providing effective assessment, diagnostics and treatment.
- Staff we met described care and treatment supported by National Institute for Health and Care Excellence (NICE) and other relevant guidance. Examples included support for older people suffering from a fall, where NICE guidance underpinned the falls assessment service, and prevention and pressure ulcer management.
- Policies, procedures and clinical guidance were reviewed each month by the 'clinical cabinet', which was part of the governance assurance framework. The clinical cabinet reviewed NICE guidance, revisions to care pathways, updates, revisions and new clinical policies, and approved any research programmes.
- There were recognised pathways for patient care for those at the end of their lives, although this was not as well embedded among nursing staff as it should have been. The pathway included Bristol Community Health staff using the 'five priorities for care' for care of a dying patient. When we asked community nurses about the five priorities of care there was a variable response. Some staff were not aware of it at all, others had limited knowledge, although senior staff were well versed in the pathway. The five priorities for care succeeded the Liverpool Care Pathway (LCP) as the basis for caring for someone at the end of their life. For example, one of the five priorities is tailored to the individual and delivered with compassion through an individual care plan.
- Bristol Community Health was involved with research projects to improve care and treatment and establish best practice. For example, the urgent care service was involved with a project to better understand why people attend emergency and urgent care services.

Pain relief

- Patients' pain was being assessed and managed effectively. This was one of the first questions asked of patients who attended for urgent care. Staff ensured patients who would have potentially long waits had any pain managed while they were waiting. Asking patients about their pain was a key part of visits to people in the community.
- Pain and symptom control was a priority for staff caring for patients at the end of their life. There were anticipatory medicines prescribed for when they were needed, and regular reviews of their effectiveness. There was specialist palliative care advice available from the local hospice 24 hours a day.

Nutrition and hydration

- There was an understanding in the different services about the need for good hydration and nutrition. Health visitors would provide support to parents, and community nurses to patients and their carers. The community nurses discussed eating and drinking with patients where this was an issue, such as the patient being under or over weight. Patients were encouraged to eat and drink well. The importance of good hydration was understood by the staff and explained clearly to patients.

Use of technology and telemedicine

- There was limited use of technology and telemedicine (which was a system to provide diagnostics from a distance). Bristol Community Health had problems with its IT system, which it was well aware of, and was a priority for the near future. This was a particular issue in the children and young people's services, and would be a key area to be resolved now the contract for this service had been awarded to Bristol Community Health for the next five years.
- There were issues with getting good connections for mobile phones, which were not helping, in the use of telemedicine. Bristol Community Health had trialled a mobile clinical system (for reporting and accessing diagnostic tools), but the telephone network had not helped this become a success.

Patient outcomes

- From feedback and conversations with patients and carers, we found patients had good outcomes from their care and support. Patients we met who used services told us they were happy with the outcome of their care and treatment. Staff followed guidelines, quality and innovation targets, and approved protocols to provide

Are services effective?

Good

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.

good outcomes. Care was provided in accordance with a different range of needs for patients and with them as individuals. This meant the way care was delivered was different, but designed to produce the same outcomes.

- There was a range of clinical and other audit used to evaluate practice. This was taking place regularly in all services, with the exception of children and young people's services, where the organisation was yet to embed this practice effectively, and in some elements of end-of-life care. In relation to the children and young people's services and end-of-life care, this was something the organisation was well aware of, and had made plans to expand the audit work into both these services in the near future. There was a range of good information being collected in children and young people's services, but no systematic approach to using this data in audit work or to measure outcomes.
- Most audits were being completed, but some were delayed due to staffing levels and higher priorities. For example, there was a backlog with audit work in the urgent care service due to staff shortages in the recent past, and a vacancy for the operational lead. There was recognised engagement in the audit process among the learning disabilities' teams.
- Audit results were used to improve patient care. When the service had a result that was showing some improvements were needed, and action plan was produced and followed through until completion. A re-audit of the results would then demonstrate if the actions had resolved the problem, or whether there were other factors at work. An audit of the 'easy read' documentation for people with learning disabilities had identified how the care plans were not working for everyone they supported. Work was being undertaken to see how they could be improved to meet patients' needs.
- The annual audit report described how learning had emerged from clinical audit. In the May 2016 report, the example came from work of the rapid emergency assessment care team (REACT) who found there had been little improvement in the process for falls referrals since the previous year. Work with the local NHS acute trusts had resulted in a new falls' pathway document to enable clinicians to refer patients to the most appropriate service. The objective was to broaden the range of falls' clinics being referred to and reduce waiting lists in over-used services. Early indications showed this had a positive impact for patients.

Competent staff

- Staff had the skills and knowledge to deliver effective care. Staff training started with a local induction into the service and continued with learning while observing and then performing the role. For example, there were preceptorships (a structured programme of transition and mentoring) for newly qualified health visitors, speech and language therapists, and school nurses.
- Staff were supported and encouraged to undertake professional development. This included both new and existing staff. The organisation had fast-track programmes to develop and promote their own nursing staff, and were part of the nationally recognised healthcare assistant programme to develop these staff.
- There were training days and sessions, and evening seminars for staff to increase their skills and knowledge of the tools to do their jobs. This was, for example, a popular programme with the urgent care centre staff. There was continual professional development for clinical staff, such as the physiotherapists and school nurses.
- There was some varied compliance with staff appraisals, although most services showing good results. These annual reviews were fully completed for the staff in the learning disability service. Almost all staff in the community adults' team had completed their review and the target of 90% of staff was met. In the urgent care service, 94% of staff had received their annual appraisal. The area of concern was with children and young people's services where only 69% of staff had been assessed for their competency and performance. Due to the quality of data from the previous NHS provider of children and young people's services, the data Bristol Community Health had to rely upon was not of a good quality. The result of 69% could therefore have been better, but was unreliable.

Multi-disciplinary working and coordination of care pathways

- Bristol Community Health worked with a range of healthcare providers and the local authorities to ensure there was multidisciplinary working and coordination of care. Most of the patients supported by Bristol Community Health would have come into contact with other organisations, such as social workers, GPs, the

Are services effective?

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local acute and mental health hospitals, and schools. There were a wide-range of programmes with these other organisations that Bristol Community Health took part in. This included, for example:

- Work with the local authority to tackle childhood obesity.
- The rapid response team working with the local ambulance NHS trust.
- Care for patients at the end of the life with the local hospice and Marie Curie.
- Liaison with X-ray teams (provided by a local acute NHS trust) at the urgent care service.
- With the pastoral support teams at local schools.

We recognised the multidisciplinary working both internally and with external healthcare providers as outstanding practice.

- There was effective multidisciplinary work for people at the end of their lives. Community nurses were involved with those GP practices that held the Gold Standard Framework – an accredited framework for providing the best care at the end of a person's life. Meetings were held with the GPs to assess and plan care, including effective pain relief. There was a close working relationship with the local hospice and two-way support to ensure patients received the most effective care.
- There was good multidisciplinary working within the organisation. Teams supported one another with advice and guidance. This included, for example, support to the community nurses from the tissue vitality, and bladder and bowel specialist nurses.

Referral, transfer, discharge and transition

- Bristol Community Health had a 'single point of access' team to coordinate referrals to the adult service to ensure patients were provided with the right support. This team took referrals from a number of sources, including patients with a learning disability being able to refer themselves, and from GPs and other healthcare workers.
- There were services commissioned to support the discharge of patients from hospital to home. Services, called In-reach, were based in the local acute hospitals to enable the discharge of patients to be planned at the earliest stage, and any ongoing support needed once the patients was discharged to be organised in advance as much as was possible.
- The rapid response team had to go above and beyond what they had been commissioned to provide in order to keep people safe. This team were required to provide a seven-day service to prevent patients being readmitted to hospital. At the end of this period, patients who needed further or ongoing support were to be handed over to the local authority. However, there were still some patients who were receiving support for over 25 days, as the local authority package had not been provided. This was reducing the number of patients Bristol Community Health staff were able to support.
- Staff were able to refer patients onwards to other services within Bristol Community Health or provided by other organisations. The exception to this was for secondary care, where a patient needed to be referred back to their GP. Otherwise, clinical staff were able to refer patients, for example, to school nurses, for physiotherapy or speech and language therapy, mental health review teams, for X-rays, and sexual-health clinics.
- There was no standard operating procedure to support children transitioning to adult services. The children's teams were doing their best to make the transition work for the child and the family. The physiotherapy team were, for example, endeavouring to hold a joint clinic with the child and adult teams to support the handover, but this was only happening for 50% of children.

Mental Health Act (learning disability service)

- Staff in the learning disabilities' service had a reasonable understanding of the Mental Health Act and its associated Code of Practice. There was information about access to independent mental health advocates in waiting areas and provided to all new patients. Any support or guidance around the Mental Health Act was available from contacting consultant psychiatrists working with the patient.

Access to information

- Bristol Community Health was about to upgrade IT systems to enable staff working out in the community to have access to patient records in the electronic system. At the time of the inspection, staff would return to their base office to input information to patient records to keep them up to date.

Are services effective?

Good

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- There was access for all staff to relevant information. All staff had access to the Bristol Community Health intranet, and this allowed them to view policies, protocols, standard operating procedures, and other information stored by the organisation.
- There were issues with children and young people's services having access to full patient information. Changes to caseloads had resulted in records not being in the right place. School nurses did not have access to some areas of a child's medical history. However, the speech and language team made sure they prepared records in advance with the information they needed to effectively assess and treat and patient.
- In the adult services, some staff had access to GP records. However, this was dependent upon the county in which the patient lived and the system used by the GP, which might not be compatible with the systems used by Bristol Community Health. Nursing staff constructed their own records in circumstances where they were not able to access other information, and requested important information directly from patients GPs.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Training in the Mental Capacity Act 2005 was mandatory for all staff in the learning disabilities' teams. Almost all staff were up-to-date with this area. Staff understood how to provide care and treatment for a patient in their best interests if they were not able to make their own decisions. Across all services, where patients were not able to give their own consent, staff followed the principles of the Mental Capacity Act 2005. Staff recognised they needed to act in the best interests of the patient and seek input from others involved with the patient's care if the decisions were relatively major (such as moving home or having an operation in hospital). The safeguarding team provided support and guidance to staff in relation to assessing and supporting people who fell under the provisions of the Mental Capacity Act 2005.
- Consent from adult patients was gained in line with legal principles. All adult patients who were mentally capable were asked to give consent for any care and treatment. All care and treatment provided by Bristol Community Health staff would require either verbal or implied consent, as the organisation did not carry out treatment procedures likely to require written consent. However, written consent was sought where any photographs were needed to document progress (such as would be needed for pressure ulcers), or any research being carried out.
- We had some concerns about whether consent sought for treatment given to children met the criteria to allow children to give their own consent and what to do when they refused consent. The immunisation programme required parental signed consent for any immunisation, which did not provide children, who were mature enough to do so, with the right to give or refuse consent. If a child refused to undergo screening (such as weight or height measurements), there was no procedure to let their parent know, should the child not be mature enough to make this decision on their own.
- There was poor recording of consent decisions or mental capacity assessments in paperwork. The staff at the urgent care centre were not noting in records that consent was being given by patients, and an audit by the safeguarding team showed assessment for mental capacity were only being documented in 20% of records. The audits of documentation carried out in many of the services did not gather specific data on the seeking and recording of consent and application of the Mental Capacity Act 2005. There was no evidence to suggest consent was being inappropriately or incorrectly sought or recorded, but no evidence to say the provider was assured application of the law or guidance was understood and followed in all circumstances.

Good

Are services caring?

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

Summary of findings

This section relates to the caring of the provider and how it delivers executive oversight to the core services

We rated caring at Bristol Community Health as the provider as good because:

- A key principle of the organisation was to involve patients in their care and decision-making and to work with and alongside them and those close to them.
- The values of the organisation embedded how patients, their carers and families were to be treated with respect and dignity. Staff throughout the organisation, including at the senior level, were kind and compassionate to people they supported and treated them as individuals.
- The organisation encouraged staff to take time to interact with people and be considerate and encouraging. It was recognised, however, this was hard with the limited time and resources available for the small things that sometimes meant a lot to people. Staff interacted with people who supported the patients, such as carers and families, and recognised when patients needed extra support from those around them.
- Staff understood and had training to respect people's cultural, social and religious needs, and took account of these when caring for and supporting people.
- Staff were encouraged to be sensitive with patients to help them maintain or improve their health and their independence. Staff understood the impact of conditions and treatment on people's lives and wellbeing.

This section relates to the caring of the four core services

We rated caring overall as good because:

- Patients and those close to them were treated with compassion, kindness and respect.
- Privacy and dignity for patients was respected.
- People were involved in making decisions about what happened to them.
- Families and carers were involved, enabled, and encouraged to support patients.
- There was support for emotional wellbeing for patients and those who cared for them.

Our findings

This section relates to the caring of Bristol Community Health as a managing organisation (provider) for its services

Compassionate care

- Our findings at Bristol Community Health demonstrated a commitment to compassionate care at all levels of staff. The organisation led by example, and the senior leadership team demonstrated compassion for their patients, and communities. This was largely measured by patient satisfaction (which was high) and relatively low levels of complaints.
- Staff were enabled to raise issues with the organisation about any disrespectful, discriminatory or abusive behaviour. This would be behaviour directed to a patient, family member, carer, or someone close to the patient by any other person, including other staff members. Staff were trained in resolving conflicts and knew when to withdraw from a situation, or how to calm tensions. Senior staff explained how any issues raised with them through the whistle-blower procedures or any other route would be investigated and safeguards for those involved put into place.

Understanding and involvement of patients and those close to them

- People were involved in decisions about their care. Bristol Community Health staff understood how patients needed to be able to make their own decisions, where they were able, and how giving them information to do this was essential.
- One of the key priorities of the board and senior management team was ensuring people were involved and at the centre of decisions about their care. This was one of the priorities for the Patient and Public Empowerment Group and their current and future plans. Involvement extended to families and communities, and groups known to be hard to reach.

Good

Are services caring?

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

Emotional support

- Wellbeing and promotion of self-help were aspects of Bristol Community Health's work. The organisation's website had a number of areas where people were offered both practical and social support. This included support for carers, and Bristol Community Health had run focus groups for carers to understand more about their emotional and other needs.
- Staff were encouraged through training to take account of people's wellbeing and signpost them to services where they might get extra help. The organisation worked with and had links with many local charities and groups that could offer emotional support and guidance.

This section relates to the caring of the four core services

Compassionate care

- Patients, and those who supported them, were treated with dignity and respect. Staff were considerate to their adult and child patients, and this extended to carers and parents. Patients we spoke with, and who had contacted us, were positive about the attitude of staff. Staff recognised how privacy and dignity was important to patients and made sure these were respected at all times.
- Patients, and those who supported them, were treated with compassion. This was particularly evident in the service provided to patients who were at the end of their life, and their relatives and carers, and in the urgent care service. Patients using the learning disabilities service said they were happy with the service and had a good relationship with the staff. We observed staff being kind and gentle with patients.
- The service received frequent compliments about care received. For example, we saw a number of examples of compliments and praise for the urgent care team. Staff went the extra mile to support patients with compassion, and they received letters of thanks and support as this was often recognised. There were compliments otherwise given to all the teams, staff and services.

Understanding and involvement of patients and those close to them

- Care and treatment was explained to patients in a way they could understand. We observed this is all the services we inspected, and were given further examples when we spoke with patients and relatives. Care for patients with dementia was provided with compassion and included those things they were able to understand. Otherwise, staff made sure the relative or carer was fully involved and informed.
- People were involved in decisions about their care. Bristol Community Health staff understood how patients needed to be able to make their own decisions, where they were able, and how giving them information to do this was essential.
- Carers and relatives were involved where this was appropriate. In the learning disabilities' service, staff said this was essential to make sure the care they were giving the patient was right. Carers were able to attend meetings and provide their input, and staff were sensitive to their responsibilities and arranged meetings to suit carers. The children and young people's' teams involved parents and families to make decisions about care plans with appropriate and achievable goals. Staff made sure they engaged with both the patient and the relative and did not leave either of them out of the decisions taken.

Emotional support

- Staff supported people with emotional needs, and this extended, for example, to parents caring for children with complex needs. Staff were said to be reassuring and supportive. There were physiotherapy and occupational therapy sessions for children, which involved groups of families in order to provide them with support from others who lived in similar circumstances. Nurses in the community assessed patients for anxiety and depression and discussed their concerns with the patient's GP.
- Staff recognised how care and treatment affected a patient's wellbeing both emotionally and socially. An example of where this was being addressed was with the Macmillan cancer rehabilitation service where courses were offered to patients focusing upon emotional wellbeing.
- There was emotional support for patients at the end of their life and families who had experienced bereavement. Staff in the palliative care home support service had been known to stay late into the evening, or long after their shift had ended to provide emotional support when the care and treatment support had come to an end.

Good

Are services responsive to people's needs?

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

Summary of findings

This section relates to the responsiveness of the provider and how it delivers executive oversight to the core services

We judged responsiveness at Bristol Community Health as the provider as good because:

- Services were planned and delivered to meet the needs of the local population and communities.
- The organisation worked effectively and cooperatively with commissioners and other providers to deliver appropriate services for people. This included services within acute hospitals to enable patients to leave for more appropriate care-settings when they were able.
- There were professional working relationships with other providers of health and social care in the local communities, including the two major acute hospitals and the ambulance service.
- There was outstanding engagement with local people and communities to shape and provide services to meet their needs.
- Services were planned to take account of people's needs associated with equality and diversity.
- The organisation understood the importance of providing appropriate care for people in vulnerable circumstances. This included people living with dementia, a learning disability, or people who found it hard to access services.
- The board were informed and made aware of people's complaints, how they were listened to and responded to appropriately.

However:

- The reporting of complaints to the board did not show if there were proportionately more complaints in one service than another. There was no record to show what actions were being taken with the leading themes in complaints, and to inform the board of the number of complaints upheld, partially or otherwise. The board was therefore not assured that learning from complaints has been embedded and how changes had made a difference.
- Some parts of the organisation were working above and beyond their commissioned work to support patients. This was particularly in the community adults service, but also in the urgent care centre. This was recognised by the organisation, and showed a dedication to patients, but added to the pressure on services already under pressure.

The section relates to the responsiveness of the four core services

We rated responsiveness overall as good because:

- Services were planned to meet people's needs. This included services for vulnerable groups; to get people home from hospital; avoid admissions; and avoid the need to involve the emergency services.
- Equality and diversity was taken into account when services were planned.
- The organisation supported people living in vulnerable circumstances and made sure services met their needs.
- Complaints were taken seriously, responded to appropriately, and lessons were learned where needed to improve services.
- Many services were able to provide care when it was needed. There was an outstanding contribution from the palliative care home service who responded rapidly to referrals for patients at the end of their life.

However:

- Access to care in the children and young people's services was variable and sometimes not even close to targets.

Our findings

This section relates to the responsiveness of Bristol Community Health as a managing organisation (provider) for its services

Service planning and delivery to meet the needs of local people

- The organisation worked closely with commissioners, local acute hospital trusts, other key providers, and the local authorities to plan services. The chief executive officer, the chair and a number of the non-executive directors sat on the boards and committees of local

Good

Are services responsive to people's needs?

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partner organisations. Furthermore, the chief executive represented the interests of the community in the Sustainability and Transformation Plan team for Bristol, North Somerset and South Gloucestershire.

- The services were delivering to their commissioned contracts, but due to pressures within the rest of the healthcare economy, were sometimes providing care and treatment beyond what was expected of them. This showed compassion and caring by the staff, but added to the pressure on these services. The organisation was aware this was happening, but was not addressing with its commissioners how to resolve this reduction therefore to their funding, and exposing the failure in the wider healthcare system.
- Bristol Community Health had recognised and was putting into practice the requirements of the Accessible Information Standard. This is a legal requirement of all NHS and NHS-funded organisations (and adult social care) to meet the needs of people with a disability, impairment or sensory loss. The organisation had produced an action plan and set-up an implementation project team to implement this standard. The majority of the actions had been completed or were on target. Although some of the areas, including identifying what patient information leaflets were needed, had slipped from their completion date, although had been progressed.
- There were interpreter and advocacy services to support patients whose first language was not English. A number of key leaflets had been translated into different languages. The Bristol Community Health website was also available in other languages using a recognised third-party automated translation system.
- There were connections and promotions with local groups and people with different needs. In the 2014/15 year, up to 1,000 people each month accessed the in-house service, Health Links. The Health Links team encouraged people living in communities recognised as harder to reach, to attend health checks. Bristol Community Health attended the Celebrating Age festival in Bristol in both 2015 and 2016. Clinicians provided advice to people, including arranging over 50 health checks and mobility tests for people who were mostly over 65 years of age. Staff also attended the Bristol Pride festival in July 2016 and carried out over 50 health checks, and provided advice and support.
- Bristol Community Health was running a successful volunteer programme. The organisation had established six different roles in the community and in November 2016 had 25 people enrolled in the programme. The roles included getting feedback from patients and carers, welcoming volunteers at the Urgent Care Centre, volunteers in the MacMillan Cancer Survivorship Service, and volunteer exercise buddies in the pulmonary rehabilitation programme.

Meeting needs of people in vulnerable circumstances

- The organisation had sight of and consideration for people in vulnerable circumstances. It was recognised by the senior leadership that the communities served by Bristol Community Health and its staff had areas of deprivation, and disadvantaged people often with multiple problems. Staff were trained in dementia awareness and there was a high level of compliance with the requirement to update this training.
- The organisation delivered services to people in communities with learning disabilities. There were well-trained and experienced staff supporting these people, including providing them with skills and experience to enhance their lives and wellbeing.
- There were translation services, and leaflets in different languages, formats and styles to suit different people. The complaints, concerns and compliments leaflet had been produced in a number of languages other than English (those spoken most commonly in the area). There was a complaints leaflet in an 'easy read' format with images and larger print. Leaflets for feedback were also produced in other languages and formats. The leaflet for people using the learning disabilities service had straightforward questions that could be answered with 'yes' or 'no' or circling the thumbs up or down symbol.
- There was information produced for carers (including young carers) to help them get support and guidance. The leaflet covered the various organisations in Bristol and the surrounding areas. It suggested action to take for carers (such as making sure their GP knew about their responsibilities), allowances they were entitled to, and how to get help for their own health and wellbeing.

Access to right care at the right time

- There was a focus upon getting care to people when it was needed. Around 95% of patients referred to the organisation were seen within 18 weeks, where this was

Good

Are services responsive to people's needs?

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

a measureable target, and 98% of patients were seen in urgent care within four hours. However, there were problems with access for other services, including adult podiatry and children's occupational therapy.

- There was an outstanding service for responding to people at the end of their life and providing support to them and their families.
- Bristol Community Health played its part in helping to avoid patients being admitted to hospital, or getting them home as soon possible. In 2015/16, the organisation prevented 4,577 admissions to hospital, and facilitated 2,060 early or supported discharges from hospital.

Learning from complaints and concerns

- The number of formal complaints coming into the organisation had been relatively stable. In the year from April 2015 to March 2016, there were 7.8 complaints each month on average. The highest in this range was 11 and the lowest was four. In the six months from April to September 2016, there were 7.5 complaints on average each month. The highest in this range was 11 and the lowest, in September 2016 was two.
- The organisation had completed an exercise to benchmark itself against other community healthcare provided in terms of formal complaints made. There were three comparisons used:
  - In the year April 2015 to March 2016, Bristol Community Health (BCH) recorded the lowest number of complaints when measured against other organisations with monthly contacts with patients of 15,000 to 22,000 (BCH had 18,000 per month). BCH was also among the lowest in the previous two years. There were 16 organisations in this comparison.
  - Bristol Community Health recorded below, so better than, average complaints when comparing itself to other community interest companies providing healthcare. However, the result would have been slightly above average if BCH removed the effect of another organisation where complaints soared from around 60 in 2014/15 to almost 350 in 2015/16. There were nine organisations in this comparison.
  - Bristol Community Health recorded below average complaints when comparing itself to geographically local health providers. However, this included two large local acute NHS trusts and the comparison therefore had limited value – which had been recognised by the report to the board.
- Complaints coming into the organisation were reported to the board at each monthly meeting. The board were given headline details of the new complaints, which service they related to, and what they were about. If the investigation into the complaints had not yet been completed, the board would be informed if the deadline for responding would be met. The investigations and responses for the two complaints arriving in September 2016 had not yet been concluded, but the board were informed these would be done within the required timescales. The board was informed about the number of complaints in each service. There was an attempt to give this some perspective by reporting how many contacts with patients were made by the service. However, there was no table or graphic to show if any service was therefore, on a weighted average basis, having more complaints than others. The themes of the complaints were highlighted, but no particular evidence to show how the top themes (attitude of staff, followed by clinical care) were being addressed. The information missing from the board report was how many of these complaints had been upheld, partially, or otherwise.
- The board was informed about complaint investigations. There were detailed highlights in the quality report from complaints investigated in the month. The report went on to talk about learning and improvements from complaints in the month. In the November 2016 board report (covering information from September 2016), learning from one complaint was recorded, but there was no assurance in the board report to show these lessons had been delivered or any improvements had been a success.
- Complaints were dealt with promptly through a dedicated person in the organisation's headquarters. In the 2015/16 year, the organisation closed all but four of the 94 complaints received. In the April to September 2016 six-month period, the organisation closed 43 of the 45 complaints received, and the four pending from the previous financial year.

Good

Are services responsive to people's needs?

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- There was helpful and prominent information for people who wanted to complain. The organisation had produced a large leaflet (which stood out due to being larger than typical leaflets) called 'How are we doing'. This was a guide to:
  - Making a complaint
  - Giving a compliment
  - Providing feedback and telling your story
  - Getting involved.
- There was also an 'easy read' leaflet for making a compliant and this information included further leaflet on advocacy services. The complaints' leaflets had been translated into four of the most spoken languages after English in the local communities.

This section relates to the responsiveness of the four core services

Planning and delivering services which meet people's needs

- Services were planned with people's needs in mind, and delivered to meet these. We recognised this with all the services we inspected. This was done through a mixture of work with the clinical commissioning groups, the Joint Strategic Needs Assessment (a formal assessment by the local authority and healthcare providers of the needs of people in the area), the local acute hospital trusts, schools and GPs, and other health and social care providers.
- There were a wide-range of services provided across a large area. This took a great deal of careful organisation to provide the services in the right place and at the right time. The complexity of working with a number of different clinical commissioning groups made this less easy at times to get right with the most efficiency. However, the organisation was used to this, and endeavoured to work with this to be the creative and optimise efficiency to get the best out of the arrangements for the community it served.

Equality and diversity

- The organisation took care to account for people's different needs. There was careful attention to this in the services we inspected, which supported a wide range of people in the communities. The services we inspected recognised that not everyone was the same, and some people needed different inputs into their care, so they had equal outcomes.
- Bristol Community Health had recognised the need to commit to the Accessible Information Standard. This is a legal requirement of organisations providing NHS services to meet the communication needs of people with a disability, impairment, or sensory loss. Training was being developed and rolled-out, and the progression to meet the five key areas within the standard was work-in-progress.
- There was some inequality in access when it came to arranging interpreters for children and young people's services. There was sometimes a poor response from the translation service, despite the best effort of staff to make arrangements well in advance. The poor service being provided to Bristol Community Health was leading to inefficiencies in the system, and inappropriate arrangements. Although it was regarded as unacceptable practice by the NHS, unless in a dire emergency, the service had used a child to provide translation for an adult patient.

Meeting the needs of people in vulnerable circumstances

- There were a number of examples of good practice to meet the needs of vulnerable people. This included group therapy sessions for children with complex needs, to provide support for their families to feel less isolated. The triage system in the urgent care service prioritised patients who were vulnerable, had complex needs, anxiety or other mental health problems. The community adults' service had emergency support for vulnerable people. They tried to use the same clinical staff to limit anxiety, and there was partnership working for patients at the end of their life.
- Bristol Community Health ran services for people who were homeless, refugees or asylum seekers. The Haven was a local centre for asylum seekers or refugees who were new to the Bristol area, and needed help to access services. There were GPs and nurses to provide initial assessments, management of health problems, and help to register with local GP surgeries. Community nurses linked up and worked with local hostels to provide support and treatment for people who were homeless.

Good

Are services responsive to people's needs?

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- The learning disabilities team supported people who were vulnerable, as part of their day-to-day work. They provided healthcare support and guidance, which extended to mental and physical wellbeing, and general care and compassion.

Access to the right care at the right time

- Access to care at the right time varied across the organisation services. Some teams were able to do this well, but the response times of others were less good. Some of this was connected to the increase in demand for services, which was increasing over time. For example:
  - The urgent care centre had seen a rise in demand of 26% in the past year, amid issues also with staff shortages. The staff shortages had been addressed with the appointment of new staff but the increase in demand remained a challenge for the service to respond and see and treat patients within the required timescales. The urgent care service was delivering the service it had been commissioned to provide, but the increase in demand had not been anticipated by the commissioners.
  - The learning disabilities' service was seeing almost every patient within the 18-week referral target, and the majority sooner.
  - In the community adults' service, access to therapy and podiatry services was not being met, although other services were doing well. This service had also seen a rise in demand.
  - In the children's service, the physiotherapy teams and school nurses were meeting their targets to see people within 18 weeks, but there had been some delays in occupational therapy. This was made more difficult by staff sickness and maternity leave. All the services did their best to prioritise patients who were more vulnerable or urgent.
- The services set up for preventing hospital admission (REACT), and supporting people when they got home (community discharge coordination centre) were not meeting targets due to high demand and targets that did not match the service provision. The REACT service, which worked with the two acute hospitals' emergency departments, to attempt to prevent hospital admission, were expected to see patients in four hours of being requested. The commissioned hours of working were 8am to 8pm. However, the emergency departments were open 24 hours a day. The ability to see patients within four hours had been reached only 60% of the time, but since this had been adjusted to more fairly reflect the working hours of the team, had risen to 87%.
- The community discharge coordination centre, supporting people who had been discharged from hospital to home, was to see people within 48 hours of referral. These targets were not being met. However, the staff caseloads were high, and led to a lack of capacity impacting on the ability to meet the targets. There were actions being taken to prioritise patients using an alert system, which was seeing improvements.
- The rapid response team were usually meeting their targets to see the patient within an hour of referral. This team attended patients at home to endeavour to avoid a hospital admission. In the year from April 2015 to March 2016, these teams avoided 3,699 unnecessary admissions to hospital. We recognised the multidisciplinary approach by the rapid response team to speed up discharges and prevent admissions as outstanding practice.
- There was a fast response from the palliative care home team to patients who needed treatment and care at the end of their lives. The team were seeing almost all patients within 24 hours to provide their assessment. When patients were referred to this team for fast-track support, the team worked exceptionally hard to set up packages of care for patients being sent home from hospital and get people to their preferred place of dying. We recognised this as outstanding practice.

Learning from complaints and concerns

- Complaints were used to improve care. In urgent care, for example, dedicated time had been introduced for nurses reviewing X-rays. In other services, communication and documentation had been considered to see how this could be improved.
- Complaints were responded to appropriately. People were given information and access to the various ways to make a complaint, and the organisation was keen to make sure this information was always available. In those complaints we reviewed, we found them responded to with empathy. They were responded to in time, and after a comprehensive investigation. There were no particular trends in the complaints with the services we inspected, so there were no areas of specific concern being raised by patients or carers.

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Summary of findings

This section relates to the leadership of the provider and how it delivers executive oversight to the core services

We have rated well-led at Bristol Community Health as the provider as good because:

- There was a clear vision and strategy for the core services. We were confident a strategy would emerge for the services for children, young people and families now the organisation had been awarded a five-year contract.
- There were strategies for the organisation with the patient at the centre and based upon delivering safe and quality care.
- There was an effective governance framework for the core services, clear lines of accountability, a strong and committed board of directors, regular review of systems, finances, and resources. There was an oversight on services and teams, and the board were assured that the services delivered safe care that met people's needs.
- There was a good culture within the organisation. There was encouragement for all staff to be open, candid and honest, alongside healthy challenge and collaboration. The views of staff were encouraged and represented with the board of directors.
- There was outstanding engagement with people who used the services, and the communities in which they lived. People were actively encouraged to be part of the future of services, and involved in decision-making and feedback.
- Improvements, effort, achievements and success were recognised, encouraged and celebrated throughout the organisation.

However:

- The children and young people's services (Child and Community Health Partnership) did not, as yet, fit within the governance processes of the core services of Bristol Community Health. There had been, nonetheless, much effort to present the service to the board. We were assured this would be addressed now the contract to deliver these services had been awarded permanently.

This part of the report relates to the leadership of the four core services

We rated well-led as good because:

- There was committed and caring leadership in the local teams and services.
- Most staff felt connected to the organisation, and worked hard to do their very best for the patients, parents, carers, and other people they supported.
- There was a clear vision and strategic direction for most services. The new children's service would now be enveloped into the overall strategic direction for the organisation.
- There was a lot of structured governance work, and objectives to deliver safe and quality care through knowing where the risks, problems, and issues lay, but also what was working well.
- There was a strong and notable culture throughout the organisation. This included engagement with patients, the public and staff.
- There was innovation and improvement to services, and encouragement for staff and patients to come up with new ideas and ways of working.

However:

- The audit programme was not working in the children and young people's service. Although a lot of work was being undertaken by staff and the teams, it did not have a clear purpose, and changes because of shortcomings were therefore not in evidence.
- The lone-working policy was not being followed, as it should have been in some services.

Our findings

This section relates to the leadership of Bristol Community Health as a managing organisation (provider) for its services

Leadership of the provider

- There was experience, commitment, professionalism and dedication in the leadership of the organisation. We met with the non-executive director who was acting chair of the board (a new chair was being ratified after the current chair had come to the end of their tenure), the chief executive, her executive team, including the

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directors of human resources, finance, clinical services, and operations, and two of the non-executive directors. Each member of the executive team talked about strong support to and from each other. They described a strong board of directors where there were both high levels of support alongside high level of challenge and enquiry.

- There was thoughtful and experienced leadership from the chief executive. Each member of staff received a hand-written card from her when they had been with the organisation for a year, and then after five years. The staff who were transferred to the organisation from an NHS trust in April 2016 were also all sent a hand-written card, welcoming them to the organisation. Staff spoke with respect and affection for the chief executive and described her "commitment", "enthusiasm", and "pragmatism" as particular strengths. In conversation with Ms Clarke, the patients, the community and the staff were how she described her top priorities.
- The clinical commissioning group (CCG) had complemented Bristol Community Health on how it worked with them to address system issues, responding to winter pressures, delivery of service at short notice, and acting quickly when any safeguarding issues had been identified. There had been an open, positive and transparent relationship with the CCG and in-depth and focused discussions on quality issues and priorities.

Vision and strategy

- There was a clear vision and strategy for the future of the organisation. This was presented in a number of formats, including a colourful graphic representation of the future direction and plans. The strategy was based upon and linked with Bristol Community Health's vision, mission and core purpose. The organisation recognised the challenges it faced in its strategy, including financial pressures and the interim management of the children and young people's services. The plans included those areas required by the clinical commissioning groups, and priorities from staff and patients. The organisation was also preparing a "compelling bid" along with local partners, for the long-term contract to provide children and young people's services. We heard on 2 December 2016 that this bid had been successful and services awarded for a five-year team from April 2017.
- There were longer-term strategies for patient care. The organisation had a five-year quality and patient safety strategy, with the current version for 2016-2021. This was based upon the organisation's values and those areas recognised as important to people who used the services. The strategy focused upon the work of the quality and patient safety team. Their objectives were to:
  - Deliver an improved incident management system which demonstrated learning from adverse events, and being able to show how changes made had delivered better and safer care
  - Be a hub for all safety activities
  - Ensure patient safety was part of the work of the Patient and Public Empowerment Team
  - To work to increase harm-free care through learning and change
  - To demonstrate an open culture of reporting.
- Bristol Community Health produced a business plan for each coming year. The informative plan for 2016/17 included the views of both the communities served by the organisation, and Bristol Community Health staff. The key priorities for 2016/17 were efficiency and productivity, investing wisely, and designing 'the perfect team'. The business plan presentation also included the achievements of 2015/16 against the objectives for that year.
- There were strategies to deal with the relatively high levels of vacancies and staff turnover. The organisation recognised the pressures on staff working in community settings and often with disadvantaged people often with multiple problems. This included, but was not limited to, offering training opportunities, fast-track promotion opportunities, looking at how to introduce flexible working, and development of a set of standards for all teams (the 'model team').

Governance, risk management and quality measurement

- There was a straightforward structure to the board of directors. It was led by the chair and chief executive officer. The position of the chair was on a fixed term, and the appointment of the chair had just changed after the previous chair had served and three-year term. The organisation had five non-executive directors, one of whom was the deputy chair and acting chair until the new chair was appointed by the board in December 2016. The non-executive directors brought different strengths to the board, including financial, business,

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clinical input and the interests of the staff council. The chief executive was supported by the clinical director, the director of operations, the director of human resources, director of finance, and head of marketing and communications. Each of these directors of senior managers had teams of managers with key areas of responsibility. For example:

- The clinical director and deputy clinical director were responsible for staff working in safeguarding, infection prevention and control, patient and public empowerment, quality and patient safety, medicines management and clinical projects.
- The director of operations and deputy director of operations were responsible for community service management, children and young people's services, business development, compliance, and prison health services.

- There was an effective quality assurance and clinical governance structure within the organisation, where this extended to the embedded core services. The central governance structure was not over-complicated, or extensive and did not consist of many wide-ranging and disparate committees. The governance was therefore well contained and considered by an appropriate and limited number of people. The structure consisted of the quality assurance and governance committee (QAG), who met quarterly and reported to the board. The QAG received reports from:
  - The senior management team risk group, who met monthly, and were responsible (with the quality and harm-free care group) for delivering the monthly quality report, which went to the board each month. The group reviewed incidents and risks, health, safety and security, complaints and compliments, records management and information governance, and compliance.
  - The quality and harm-free care group, who met quarterly and reviewed causes of harm, trends causing harm, quality assurance of root-cause analysis reports, and commissioned improvement work.
  - The 'clinical cabinet', which met monthly, and ratified and commissioned clinical policies, reviewed NICE guidelines, and approved research processes.
  - The monthly governance meetings of the Child and Community Health Partnership (children and young people's services).
  - The integrated governance committee of the Offender Health Service.

The area where governance needed development was with the Child and Community Health Partnership services. This was an area of concern escalated to the risk register, and was an inherited problem that was complicated by the temporary nature of the contract awarded to Bristol Community Health for one year.

- There were various groups with key responsibilities for specialist areas, each providing either annual or more frequent reports to the board or governance committees. These included:
  - The senior operations group, who discussed issues with the core service sectors. Operational issues were raised that were affecting the safe delivery of services. This included workload pressures and proposing solutions to operational problems.
  - There was a health, safety and security group meeting to promote cooperation, and develop, implement and monitor strategies in line with legislation.
  - The equality and diversity steering group was established to drive the organisation's strategy in this area. The group was also directed to ensure equality and diversity objectives were known throughout the organisation and track their progress.
  - There were also safeguarding groups (for both adults and children), an infection prevention and control group, the clinical audit group, patient and public empowerment steering group, and strategic workforce development group.
  - The learning and development steering group was established to understand the differing learning needs across the organisation and prioritise use of resources.

One area, which did not have individual board oversight, was palliative care. This service, which, with a key member of the service absent on long-term sick leave, did not benefit from non-executive director input or interest.

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- There were clear and well-maintained risk registers at board level, and they were reviewed by the board on a quarterly basis. There was a corporate risk register, accompanied by a 'hot risk' register which were areas that were to be reviewed as urgent emerging risks that might need escalating to the corporate register. As was good practice, the date the risk was raised was reported to give some sense of how long the risk had been an issue. Some of the risks were actual – in that, they were recognised as occurring within the business, and others were potential risks or threats, which the organisation felt needed to be reported and kept on a maintenance footing. Those more significant areas we have recognised during this inspection and the areas Bristol Community Health brought to our attention, were mostly recognised within the risk registers.

Culture within the provider

- Bristol Community Health had been recognised for work to increase diversity at board level. The chief executive officer and one of the non-executive directors had been awarded an NHS Recognition Award for their work creating a development programme to support aspiring non-executive directors from diverse backgrounds.
- There was employee involvement with oversight of the organisation. One of the primary examples of this was the staff council's annual appraisal of the board of directors. The summary report from the staff council in November 2015 reported how "there is an extremely positive dynamic across the board as well as a sense of commitment that once a decision has been made all board members will be behind it." The discussions between the board and the staff council were described as "open and engaging."
- Bristol Community Health evaluated and reported on its contribution to addressing inequality and exclusion for patients and other the service supported. The organisation produced an annual report on equality and diversity for the first time in the year 2015/16, which recognised how progressive employers have been integrating this into the way in which they operated. The report acknowledged the key benefits set out by the Chartered Institute for Professional Development about developing diversity-focused organisations. For this type of organisation, this included, importantly:
  - Greater access to different perspectives and sources of community insight.
  - Greater understanding of the needs of and communication with patients and the workforce.
- Actions from the review of equality and diversity had included, but were not limited to: starting to routinely collect patients' protected characteristics; updating the interpretation and translation policy; reviewing of the image library to improve the diversity of photographs available; publishing the first Workforce Race Equality Standard; launching an equality and diversity e-learning module and revamped induction training; and appointing a non-executive director to the board with the objective of increasing diversity at board level.
- Bristol Community Health was addressing any perceived or actual discrimination of ethnic minority staff. The organisation had produced an action plan, currently being progressed, to address the areas of concern from the 2016 staff survey where there was a significant difference in responses from black, Asian and minority ethnic (BAME) staff. Of the 616 staff who responded (66%), 5% were identified as BAME or with one or more of the protected characteristics from the Equality Act 2010. The actions included, among others, creating a BAME forum, reviewing the recruitment processes for conscious or unconscious bias, reviewing the acceptable behaviour policy, and reviewing the equality and diversity training in terms of its frequency and relevance.
- Bristol Community Health had been accredited by Jobcentre Plus to use the 'Positive about Disabled People' symbol. This meant the organisation would interview all applicants who declared a disability in the recruitment process, and met the minimum criteria for the vacancy advertised. In the 2015/16 year, the number of candidates interviewed who declared a disability had risen by 10% to 34%.
- Senior executives at Bristol Community Health gave time and expertise to other organisations. This included:
  - Mentoring people in other organisations, particularly charitable trusts.
  - Volunteering for boards in local schools and neighbourhood groups.
  - A non-executive directorship and trustee for charitable organisations.
  - Voluntary teaching to young people.

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- Collaborative working with voluntary sector organisations.

Fit and proper persons

- The Bristol Community Health board of directors met the requirements relating to the Fit and Proper Persons' test, although some of the evidence required was not up to date. We reviewed a sample of six directors of Bristol Community Health. These demonstrated:
  - Prior to the appointment of a director, satisfactory professional and character references were obtained.
  - Disclosure and Barring Service checks were made, proof of address obtained, along with occupational health and the 'right to work' clearances.
  - On an on-going basis, members of the board had received a six-monthly and an annual review by the chief executive officer.

Another requirement of the FPPR test was a requirement of the chair to conduct the chief executive's annual review and those of the non-executive directors. This was the one aspect of the requirements not undertaken by the outgoing chair of the organisation.

- As required by Bristol Community Health as part of their Fit and Proper Persons' regime, board members were subject to an annual evaluation by the staff council. This evaluation is reported on in the above section of this report.
- The board made annual declarations of fitness to hold office. The April 2016 board papers included a declaration that all directors had been subject to a Directors' Annual Check with reference to the Individual Insolvency Register and Disqualified Directors' Register. None of the directors had been included in the children's or adults' barred lists. None had been responsible for, privy to, contributed to, or facilitated any serious conduct or mismanagement (lawful or otherwise) in the course of carrying on a regulated activity, or discharging any functions relating to any office or employment with a service provider.

Staff engagement

- The organisation promoted and supported a staff council, which had been operating since 2013. The current membership was 13 elected staff from a maximum of 19 permitted as members. The council drew its members from the five core areas within Bristol Community Health and proportionate with the number of staff working in those areas. Members were required to seek and represent the views, opinions and interests of employee-shareholders at individual and group level. Among other things, the staff council had the power to nominate non-executive directors to the board, make recommendations to the board, and to scrutinise the board each year. The council met monthly, produced, and circulated minutes. Achievements of the staff council so far included, for example:
  - Working with the board on the offering of the NHS pension scheme to all staff.
  - Involvement in the recruitment of, and increase in, number of non-executive directors.
  - Communicating staff concerns over resident parking schemes.
  - Fundraising for the organisation's selected charities.
  - Representation on the judging panel for the Bristol Outstanding Service Care Awards (or BOSCAs) – this was the annual staff award and recognition celebration.
- The organisation had a number of different ways of communicating with and listening to its staff. This included:
  - Team 'talkback' sessions where members of the board and senior executives met with staff in different teams to listen to their concerns and hear of their successes. However, the board recognised there was yet to be a process for giving feedback to teams to show they had been listened to when things were improved.
  - Newsletters weekly and monthly.
  - A staff section in the organisation's website.
  - Training for management staff in giving and receiving feedback.
  - The staff Wellbeing Programme.
  - A 'Shape our Future' event designed for and attended by staff in 2015.
- There had been fundraising activities by staff and provision of skills and expertise for the local community.

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This had included fundraising to purchase tablet computers to improve the quality of life for older people. There had been coaching sessions and football tournaments for schools in Bristol, helping children from disadvantaged backgrounds. The Community Learning Disabilities team had run a seven-week horticulture therapy group linking with Avon Wildlife Trust.

- There as an annual award ceremony recognising staff. This was called the Bristol Outstanding Service Care Awards or BOSCAs. These were well received by staff as a way of recognising their contribution to the organisation. There was also an annual summer party for staff and their families.

Public engagement

- There was outstanding engagement with and opportunities for patients, carers, families and member of communities to get involved with healthcare and the organisation. Bristol Community Health published a three-year patient and public empowerment strategy in 2014, following a public and stakeholder launch event. In the first year, the objective was to understand the experiences of patients and carers. In the second year, the focus was to look at learning from what patients and carers had said, and use the feedback to improve communities. Four themes had emerged from the feedback in the second year. These were:
  - Appointment times – specifying morning or afternoon visits
  - Communication about waiting times
  - Involvement in shared decision making
- Some of the statistics about people's views, quoted by the organisation on their website, and in annual reports, were not placed into context. Bristol Community Health had not intentionally, but nevertheless, was reporting percentages of people's views without the necessary caveat that this was of people who had expressed an opinion. For example, on 9 December 2016, the Bristol Community Health website quoted that 100% of chronic obstructive pulmonary disease rehabilitation patients felt they were treated with respect and 96% of rapid-response patients felt listened to. What this, and the Friends and Family Test data did not explain, was the percentage of patients who had responded. In the Friends and Family Test, for example, this was the opinion of around 10%, which were those who had taken the time to respond. In the Patient and Public Empowerment Review 2016, the statistics to show patient experience did not say how many patients had made the comments.
- In conjunction with the two acute hospital trusts in Bristol, Bristol Community Health had launched a patient and community leadership programme. The plan was to engage and train 16 people termed 'healthcare change makers' who will have a voice on the organisation's board and with local hospitals to help direct future plans. In return, the people who signed up for this would be provided with free professional training; gain new skills and confidence in problem solving and negotiation; and enhance their job prospects or standing in the community.
- The organisation participated in the Friends and Family Test with positive results. The month of September 2016 was reported to the board of directors as the month with the most responses (838). Of those people who responded, 97% of those seen at home (part of the community adults service) would recommend the service to their family and friends (385 people – around 10%). The other survey was carried out in the urgent care centre where 90% would recommend the service (453 people – around 11%).
- Real-time patient feedback was being obtained using as many options as practically possible. The organisation had professional support to design a patient feedback process. Staff were asked to design questions for patients about the service they delivered. Feedback was then designed to be provided in a number of ways. This included using electronic systems, written questionnaires, capturing verbal feedback, and questions being put in a variety of languages. Feedback to the service had consequently increased from about 200 statements per month in November 2014 to around 1,000 per month in September 2016.
- There was a variety of ways to communicate with people and communities. This had included:
  - Focus groups through the Carers Support Centre.
  - Setting up of a focus group for users of the Urgent Care Centre.
  - Appearances on local radio programmes. This included the migrant health, Tuberculosis nurses,

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and the diabetes and nutrition service being interviewed by a local community radio station and social enterprise foundation celebrating African and Caribbean culture.

- Translating the feedback and complaints leaflet into five of the most spoken languages after English in the local communities
- Creating a live feedback area on the organisation's website
- Holding a participation event with 70 members of the community

- The board were informed of compliments made to the organisation. These were reported by the team receiving them, and then some examples provided of this positive feedback.
- The organisation produced and distributed a quarterly newsletter for local communities called Community Health News. The most recent issue (summer 2016) contained news, health advice, information about new services, a report about autism, palliative care, and support for a patient with a learning disability. In addition was information about being a volunteer, and how to get in touch, work for or support the organisation and its communities.
- The engagement team had produced action plans for delivering improvements in these areas. This included introducing a new role for volunteers, which had been achieved; promoting patient stories, and this had developed with recognition there was still more work to be done; and ensuring the complaints, concerns, compliments and comment process was accessible and as simple as possible, and this had been delivered.

Innovation, improvement and sustainability

- There had been cooperation and central involvement with the Sustainability and Transformation Plan. The Chief Executive Officer was a member of the committee in Bristol working on this project, and represented the viewpoint and needs of the community.
- There were clear service improvement priorities for the 2016/17 year. These included key performance indications and quality improvements targets from the clinical commissioning groups and NHS England.

Alongside these were local priorities, which had been identified from what the organisation understood of its community and patient needs. These included (paraphrased from the Quality Account 2016/17:

- The electronic patient record system being rolled-out to all services to ensure data will be provided to the highest standard and improves operational efficiency.
- Commitment to the Bristol diabetes transformation programme.
- Management of the capacity of services to reduce waiting times.
- Improving the 18-week waiting times for elderly and neurological patients.
- Improving waiting times for the podiatry service.
- Further implementation of the Health and Justice Indicators of performance in the prisons' services (not reported on in this inspection – they form a separate part of CQC's work alongside HMIP).
- Improving monitoring of equality across the nine protected characteristics to progress better access to services.

- A new service had commenced in April 2016, which saw two Bristol Community Health nurses working with the local mental health trust to deliver improved care for people in mental health settings who were living with dementia. This had led to reductions in the number of admissions to the acute hospitals. A business case had been submitted to continue this service.
- The innovative Discharge to Assess service (known as D2A) was delivering faster discharge and access to care packages for particularly frail elderly patients. There was a multi-professional approach involving the two acute hospital NHS trusts, social care and voluntary sector.
- The Latent Tuberculosis (more commonly known as 'TB') clinic had been established to provide a one-stop clinic. The team were now supporting around 110 people with active or latent TB in Bristol and South Gloucestershire, of which around 70% were migrants. The team visited people at home, or they came to the clinic for advice, support, and to ensure they were completing their course of treatment. There were also check-ups for people who had encountered someone who had an infectious case of TB.

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This section relates to the leadership of the four core services

Leadership

- The local leadership teams were respected and were given the authority to make decisions to improve and enhance patient care. Most of the managerial staff at local level were approachable and around when needed to support their staff. Staff in all the services spoke highly of their managers. This was particularly in the children and young people's services, where local operational support managers and area support coordinators were well respected and appreciated for their support in the difficult transition period.
- There was strong support for the services by the senior leadership teams. The senior management used the 'hot team' methodology to identify from various metrics where teams were under unusual pressure. This was from high caseloads, higher sickness levels, staff reporting stress, and increases in demand for services. This brought extra support and senior leadership input into services to try to find solutions to support staff. The situation was constantly monitored to check whether mitigating actions had delivered results. Members of the senior leadership had been to almost all areas of the service and were recognised as listening and genuinely interested in staff and their work. There was particular high regard for the interim management team in the urgent care service who were described to us as inspirational and motivational.
- Staff and teams felt connected to the organisation. Most of the staff in the new children and young people's service felt positive about the transition to working for Bristol Community Health. They were confident about improvements to their service, and their hard work being recognised. Many staff in the community services worked remotely, but were connected to their bases and each other on a regular basis. Staff wellbeing and safety was a key priority for the organisation, and staff were regularly reminded of this by senior management.

Vision and strategy

- There as a vision and strategy for the core services in Bristol Community Health, and this was to be widened in the coming year to include a five-year strategy for the new children and young people's service contract. Each services was included in the vision "for all our communities to lead healthier, better lives" along with the mission "to provide person-centred patient care."
- There were individual goals, business plans or strategies in most services or teams. This was, however, not the case in urgent care, where patient care had been the priority among shortages of staff, or in end of life care, where there was long-term sickness for a senior manager. There were some good business plans in the children and young people's services and visions to improve services through integration and shared working. There was a transformation plan being put into practice in the children's speech and language therapy service.

Governance, risk management and quality measurement

- There was a good governance programme within the organisation, but due to the temporary nature of the children's contract (which had now been made permanent), this service was not well integrated. The organisation was aware of this, and knew work needed to be done to bring the processes for governance for children and young people's services into the Bristol Community Health framework. In the other services, governance processes were integrated well, and the information they provided being monitored and reviewed by the organisation and the local teams.
- There was good information provided for clinical governance, and this included the information put together by the children's service, which was presented separately. Across all services, incidents, safeguarding, complaints, patient safety and performance targets were monitored and discussed at local level meetings and onwards to senior management meetings.
- There was some good audit work, but integration into an audit programme was yet to be achieved for children and young people's services. There was good audit work in community adults, the learning disabilities' service, and urgent care. Some of this was local level work to look for good practice and where improvements were needed. Some was more corporate clinical audit to look for quality work or trends where improvements needed to be recognised and made. There was little evidence in the children and young people's service of learning from audit or taking action when areas of weakness were discovered.

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- Staff at Bristol Community Health worked hard to produce data and reports for quality measurement. The issues with the children and young people's services were not because of the local staff and teams not working hard or diligently. Staff were dedicated, committed and caring. However, there were disjointed operational processes, which were a legacy of the previous system, and the complication of working between three different providers.
- There were operational risk registers and a good system in use to capture risks. However, the risk registers were only as good as the entries made. Not all risks discussed at clinical governance or other meetings in children and young people's services had found their way onto the risk register. Bristol Community Health had the framework to put this right, as the other services had comprehensive and well-managed risk registers.

Culture across the provider

- There were concerns with the application of the lone working policy, which the organisation had acknowledged. There was inconsistent levels of success with the lone working policy in the community adults' services. There were extreme examples of no one checking when a member of staff did not report they were finished their shift on more than one occasion, and the police arriving at someone's home when they had not done so. In the children and young people's team, there was inconsistent application of the policy. This had been escalated to the risk register for the service and there were actions being taken to try to address this problem.
- Most staff felt respected and valued. There was good morale and camaraderie between teams. Even teams under pressure or having been through changes and concerned about future reorganisations were passionate and committed to what they were doing. Each person we met put the patient and service they delivered at the forefront of their work, and this ranged from nursing staff, administration staff, support staff, allied health professionals, and management.
- There were concerns in the children and young people's service where the risks and problems associated with change and uncertainly had not been given enough consideration. The dedicated mini staff survey had raised concerns, including a lack of trust in senior management, lack of career progression, a variable quality and quantity of supervision (clinical and otherwise), and insufficient time to deliver their roles to a high standard. This was, nevertheless, among a team of committed staff and managers at local level. These serious themes were being taken up by the senior management and work was ongoing to produce an action plan to address them.

Public engagement

- There was active engagement with the public at all levels of the service. Everything reported to the organisation by a patient, carer, interested party, or through questionnaires was valued. People were constantly being encouraged by all the services to talk to the organisation to drive change, innovation and improvement.
- There had been tireless work by the children and young people's service to engage with their patients, and those who supported them. There was work with charities on getting feedback from children in the best way; involvement with children in the planning of services; and involvement of children in the recruitment of staff. The learning disabilities service had also involved patients they supported in recruitment and engagement.

Staff engagement

- Most staff felt actively engaged with the organisation, and that their views were important. Staff felt they were able to make suggestions about improvements and these were listened to. Staff told us the organisation was open to listen to them, and valued their opinions. Staff said they were encouraged to engage with each other, and share ideas, values and viewpoints. The 'talkback' sessions where senior management would listen to staff in a more informal atmosphere were making progress in demonstrating the values and vision of the organisation.
- There was an annual staff survey, along the lines of the NHS staff survey. Actions from areas where concerns had been raised were addressed by the board. There had been a mini survey in the children's service, where it had been recognised there were inevitable issues from change and uncertainty.
- Staff we met said they felt confident to raise any concerns they had with their line manager in the first instance. No staff said they felt they would be in any way

Are services well-led?

Good

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.

disadvantaged if they wanted to take matters that concerned them further, or use the whistleblowing policy to raise serious concerns about quality and safety.

Innovation, improvement and sustainability

- There was a strong sense among the services to drive improvement, innovation and sustainability. Examples of this included:
  - Work by the learning disabilities' team to identify patients to participate in an important bowel-screening programme. This was a recognised area of concern in people in the learning disabilities' community.
  - In urgent care services, almost all staff agreed with the statement "my team regularly looks at ways to improve services."
  - Urgent care had secured the support of the lead emergency consultant at the local children's hospital.
  - Children and young people's services were bidding to purchase a Cerebral Palsy Integrated Pathway database to provide a standardised approach to care for children with this condition. There was also a drive towards providing an integrated therapy service for children.
  - The rapid response team had grown out of an idea in the community adults' team. This was now a fully-fledged and highly valued service.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12 (2) (h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated; 12 (2) (i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users. 12 (2) (h) There was no assurance of staff adhering to toy cleaning policies, rotas or schedules for the toys owned by the clinics used by Bristol Community Health staff. Staff were unaware of who oversaw the toy cleaning schedule and how often toys were cleaned. The staff were unaware of any risk assessment carried out to determine the rationale for toy cleaning, how toys were cleaned and how often. There was no frequent, robust cleaning system to ensure fabric toys were cleaned after use with children. We observed collections of toys, which were made from fabric, and materials, which could not be cleaned with a disinfectant wipe following use. None of the toys was dirty or stained but there was a lack of awareness of infection control risks of not cleaning these toys. We were told these toys were taken home termly by a member of staff in the department and cleaned. Toys like this were used by different children during treatment sessions increasing the risk of spread of infection. We observed poor infection, prevention and control practice with regard to hand washing and the cleaning of

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Requirement notices

equipment at various bases. Staff did not wash or gel their hands between each child. We observed staff use the same set of scales for all children in one session without cleaning it between each child using it.

12(2) (i)

There were no standard operating procedures or guidelines to support transition from children into adult services, with the exception of the transition of children from the health visiting to the school nursing service. Teams would do their best to make transition as simple as possible for the child and family.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular to – (a) assess, monitor and improve the quality and safety of the services provided in the carrying out on of the regulated activity (including the quality of the experience of service users in receiving those services. (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of the service users and others who may be at risk which arise from the carrying on of the regulated activity; (c) maintain securely an accurate, complete and contemporaneous record in respect to each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; 17 (2) (a) There was no systematic programme of clinical or internal audit to monitor quality. We saw evidence in some areas, information had been captured such as reviewing records, but there had been no further action taken to identify any themes or trends from the information and or action plans to address these. 17 (2) (b)

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Requirement notices

There was a comprehensive system to record and manage risks; however, not all risks to the service had been identified and recorded on the risk register. Other risks not added to the risk register were, the transfer of health visitor records from the Children's Health Information Centre, IT issues, paper-based referral systems and appraisals.

17 (2) (c)

A complete set of children's notes was not transferred to the school nursing team on transition to the service.

Health visitors did not keep individual records for each child. Instead, one record contained information of all children under their care in one family. Each set of records contained individual charts or developmental reviews for each child, but the notes documented following each visit by the health visitors contained information about all the children. If an agency required a copy of an individual child's case notes, this would breach the confidentiality of the other children in the family, due to all of the children's case notes being recorded on the same document. Health visitors told us the change to managing records per family, rather than by individual child, came about three years ago following feedback from a serious case review.

The school nurses held drop in clinics for young people to attend in each secondary school. Staff made a record of each young person's attendance at the clinic and the reason for their visit. Records were then transferred to the young person's electronic medical records and the original notes recorded during the consultation were destroyed. However the Records Management Code of Practice for Health and Social Care 2016 defines a clinical record such as the ones made by the nurses, 'a predefined record that needs to be kept,' according to the organisations retention policy. The code of practice states, the retention period for the children's records made by school nurses is the child's 25th or 26th birthday.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Treatment of disease, disorder or injury	

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18 (2) (a)

Receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

18 (2) (a)

Not all staff had received a recent performance appraisal in the last 12 months. Between April 2016 and October 2016, 69% of staff had received an appraisal. Poor compliance with staff appraisal was not on the service risk register.

At the time of our inspection, data provided by the service showed 70% compliance with mandatory training in October 2016, meaning not all staff were up to date with their skills and knowledge of safe systems to enable them to care for children and young people appropriately.

Staff were not fully compliant with safeguarding training. In September 2016, 77% of staff had completed level one children's safeguarding training, whilst 81% had completed level three training. Staff also completed safeguarding adults training; with 82% having completed level one training, but only 46% of staff were complaint with level two adult safeguarding training. This was against the organisation's target of 90%.