North Somerset Community Partnership Community Interest Company

Quality Report

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Date of inspection visit: 29-30 November, 1,2, 13 and 14 December 2016
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Core services inspected	CQC registered location	CQC location ID
Community health services for adults	Castlewood	1-310911016
Community health services for children, young people and families	Castlewood	1-310911016
Community end of life care	Castlewood	1-310911016
Community Learning Disability services	Castlewood	1-310911016
Urgent care services	Clevedon Community Hospital	1-310911397

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?	**Requires improvement** 
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

We undertook a planned announced inspection as part of our comprehensive community health services inspection programme on 29 & 30 November and 1, 2 December 2016. We also carried out an unannounced visit on 12,13 and 14 December 2016 and inspected the following core services:

- 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
- End of life services

We did not inspect the inpatient ward at Clevedon Community Hospital as it was closed for refurbishment at the time of our inspection.

We rated North Somerset Partnership Community CIC and the five core services inspected as good overall. Safety in the community adults service and community services for children, young people and families was rated as requires improvement.

Our key findings were as follows:

Safe:

- There was a good incident reporting culture and evidence of thorough investigation leading to learning from incidents across the organisation.
- Staff understood the importance of being open and honest and we saw evidence that Duty of Candour was applied when things went wrong.
- Staff were knowledgeable about safeguarding which was embedded in practices although not all staff had received training to the level required for their role and contact with children.
- There were business continuity plans in place to respond to emergencies and other major incidents.

However

- There was a lack of auditing compliance with assessing risks to patients such as assessment for nutrition and falls assessments.
- The use of both paper and electronic records led to risk of staff being unable to access patient information in a timely manner due to issues with connectivity of mobile devices. This meant staff did not always complete contemporaneous electronic patient records. These issues had been recognised and were noted on the risk register.
- The organisation did not have an effective process for flagging to managers when compliance with training was low.
- There were challenges in maintaining levels of staffing with an inequality of the capacity and the size of the caseload across the localities for community adults services. Similarly in the services for children, young people and families some staff had very high caseloads and funding for health visitors had reduced.

Effective:

- Staff followed care and treatment guidelines and pathways based on current best evidence.
- Staff had the right qualifications to carry out their roles, supported by competency assessment framework.
- There was effective multidisciplinary working across the organisation and staff had good working relationships with GPs across North Somerset.
- Staff were knowledgeable about mental capacity assessment and deprivation of liberty legislation and obtaining consent for treatment and care interventions.

Summary of findings

- Service users had access to psychologists in the team provided by another provider. This allowed them access to therapies recommended by the National Institute for Health and Care Excellence.
- Patients had care from staff who had specialist training in end of life patient care.

However:

- Not all services consistently collect data to measure patient outcomes and they did not participate in national audits to benchmark their treatment and care.
- Health visiting teams provided care as agreed with commissioners. However, this did not always follow national guidance and could have an impact on the health outcomes for children and young people.
- The inadequate mobile working arrangements meant that staff did not always have access to information about the patient.

Caring:

- Patients and their carer's (when appropriate) were routinely involved in planning and making decisions about their care and treatment.
- Staff communicated effectively with patients and took time to answer questions.
- Patients received care from nurses and support staff that treated them with dignity and respect in the minor injury unit (MIU) and they were always listened to and felt able to raise concerns.
- 98.3% of patients in between July and September 2016 said they would recommend the MIU service to others.
- Staff providing end of life care were highly regarded by relatives of deceased patients for their kindness, caring and compassionate attitude.
- Children and families were offered support and staff used caring approaches to help people who found difficulty in expressing their concerns.
- Children and families were offered privacy when it was needed and confidentiality was respected.

Responsive:

- The organisation worked within the contract of the clinical commissioning group to ensure the services met the needs of the local population as far as possible.
- Clinics were scheduled to meet the needs of individuals as far as possible and many patients benefitted from clinics in locations close to their homes.
- The service provided patient group activities, which enabled patients to gain social interaction as well as access to advice, education and support.
- The service received few complaints, but responded to and handled complaints in a timely manner.
- Care was provided 24 hours a day, seven days per week and there was access to end of life and palliative care advice at any time of the day or night.
- The minor injury service (MIU) was planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- The average time to treatment in the minor injuries unit was 47 minutes.Waiting times were constantly monitored in real-time by clinical staff and 99% of patients were treated, discharged or transferred within four hours in the last 12 months.
- In services for children and young people the leads were working with public health and commissioners to identify the priorities for the local population. Staff were encouraged to develop services that worked towards these priorities.

However,

- The waiting time from referral to treatment at times exceeded 19 weeks in the outpatient physiotherapy services.
- Patients were not routinely screened for dementia or referred for further assessment.
- School nursing services had a four month waiting list for children and families who needed routine support.

Well led:

Summary of findings

- Staff were proud to work for the organisation and liked their roles. They felt they could feed issues up to senior managers and executives and they were listened to at board level.
- The challenges of changes at executive level were recognised and much work was underway to ensure a cohesive team which was visible and accessible.
- Public opinions were sought in a variety of ways which was suitable for the service they offered and where possible, changes were made in response to comments.
- Staff were keen to improve services and acted on ideas for improvement.
- Staff engagement was recognised as key in the employee owned organisation with the staff council being at the heart of plans going forward.

We saw several areas of outstanding practice including:

- The community outreach team had adopted an effective approach to reach out to people and improve their access to health care. They set up ten weekly clinics in Weston-Super-Mare for 'hard to reach' groups such as people with substance misuse, homelessness and social isolation. The service provided interventions on a range of public health lifestyle issues such as weight management, healthy eating, reducing substance misuse including alcohol, Between October 2015 and January 2016 the service received 103 new referrals and assisted 11 people to find accommodation.
- Some patients relatives were enabled to give care to relatives after assessment and training by end of life care coordination centre team.
- The end of life care coordination centre had established a library of books in each of the eight teams (for example learning disability, community nurses). This had been enabled by money raised by friends of a patient. They covered all children's age ranges who might be affected by a death in their life.
- The end of life care coordination centre were providing staff with 'shadowing' opportunities so that they could work alongside experienced workers in end of life care.This approach was intended to ensure that workers recruited knew what the role entailed and had the right qualities to work in end of life care.

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

Importantly, the provider must:

- Ensure that staff working in the community adults service have access to a system that enables them to complete all care records contemporaneously.
- Ensure that paper and electronic records for patients contain relevant information and are available to all staff at the time needed to ensure the delivery of safe and effective care.
- Ensure that staff working in the community adults service and the end of life care service are compliant with mandatory training in line with the organisations targets.
- In the community adults service, ensure that patient risk assessments are completed in a timely way.
- In the community adults service, ensure that processes are in place to monitor staff compliance with the completion of patient risk assessments.
- In the community adults service, ensure that processes are in place to monitor staff compliance with the completion of audits.
- In the community adults service, ensure that areas where sterile dressings are prepared are regularly cleaned.
- Ensure there are sufficient numbers of staff to meet the needs of children, young people and families in all areas of North Somerset.

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?

Requires improvement

We rated the organisation as requires improvement for safety because:

- There was a lack of auditing compliance with assessing risks to patients such as completion of Waterlow score, MUST assessments and falls assessments.
- Improvements were required to patient's records across all services. Staff did not complete contemporaneous electronic patient records due to issues with connectivity affecting mobile devices. These issues had been recognised and were noted on the risk register.
- There was a low compliance with some mandatory training across the four localities and in the urgent and specialist care team. There was no process for 'flagging' up when compliance was low which meant in some areas, only half of the required staff had completed the training.
- There were challenges in maintaining levels of staffing with an inequality of the capacity and the size of the caseload across the localities for community adults services. Similarly in the service for children, young people and families some staff had very high caseloads and funding for health visitors had reduced.

However:

- There was a good incident reporting culture and evidence of thorough investigation leading to learning from incidents across the organisation.
- Staff understood the importance of being open and honest and we saw evidence that Duty of Candour was applied when things went wrong.
- Staff were knowledgeable about safeguarding which was embedded in practices.
- Staff in the learning disability service felt their caseloads were manageable and had the chance to discuss their caseloads to ensure they were able to meet the needs of service users.

Are services effective?

Good

We rated the organisation as good for effectiveness because:

- Staff followed care and treatment guidelines and pathways based on current best evidence.
- Staff had the right qualifications to carry out their roles, supported by competency assessment framework.They were encouraged and supported to enhance their qualifications.

Summary of findings

- There was effective multidisciplinary working across the organisation and staff had good working relationships with GPs across North Somerset.
- Staff were knowledgeable about mental capacity assessment and deprivation of liberty legislation and obtaining consent for treatment and care interventions. These were embedded in the way staff worked.
- Service users had access to psychologists in the team provided by another provider. This allowed them access to therapies recommended by the National Institute for Health and Care Excellence.
- Patients had care from staff who had specialist training in end of life patient care.

However:

- Health visiting teams provided care as agreed with commissioners. However, this did not always follow national guidance and could have an impact on the health outcomes for children and young people
- There were inadequate mobile working arrangements, which meant that staff did not always have access to information about the patient.

Are services caring?

Good

We rated caring as good because:

- Patients and their carer's (when appropriate) were routinely involved in planning and making decisions about their care and treatment.
- Staff communicated effectively with patients and took time to answer questions.
- Patients received care from nurses and support staff that treated them with dignity and respect in the minor injury unit (MIU) and they were always listened to and felt able to raise concerns.
- 98.3% of patients in between July and September 2016 said they would recommend the MIU service to others.
- Staff providing end of life care were highly regarded by relatives of deceased patients for their kindness, caring and compassionate attitude.
- Children and families were offered support and staff used caring approaches to help people who found difficulty in expressing their concerns.
- Children and families were offered privacy when it was needed and confidentiality was respected.

Summary of findings

Are services responsive to people's needs?

Good

We rated the organisation as good for responsive because:

- The organisation worked within the contract of the clinical commissioning group to ensure the services met the needs of the local population as far as possible.
- Clinics were scheduled to meet the needs of individuals as far as possible and many patients benefitted from clinics in locations close to their homes.
- The service provided patient group activities, which enabled patients to gain social interaction as well as access to advice, education and support.
- The service received few complaints, but responded to and handled complaints in a timely manner.
- There was coordination with other local end of life care services including hospices, acute trusts and a national provider of cancer nurse services.
- Care was provided 24 hours a day, seven days per week and there was access to end of life and palliative care advice at any time of the day or night.
- The minor injury service (MIU) was planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- The average time to treatment was 47 minutes.Waiting times were constantly monitored in real-time by clinical staff. 99% of patients were treated, discharged or transferred within four hours in the last 12 months.
- In services for children and young people the leads were working with public health and commissioners to identify the priorities for the local population. Staff were encouraged to develop services that worked towards these priorities.

However,

- Patients were not routinely screened for dementia or referred for further assessment.
- School nursing services had a four month waiting list for children and families who needed routine support.
- Some aspects of the complaints process required review such as training of investigators and ensuring responses were compassionate and individualised.

Are services well-led?

Good

We rated the organisation as good for well led because:

- The executive team although relatively new were establishing themselves in the organisation and were visible and accessible.

Summary of findings

- Staff were proud to work for the organisation and liked their roles. They felt they could feed issues up to senior managers and executives and they were listened to at board level.
- Public opinions were sought in a variety of ways which was suitable for the services offered and where possible changes were made in response to comments.
- Staff were keen to improve services and acted on ideas for improvement.
- Staff had good practice recognised in the organisation's quarterly magazine and by receiving awards for specific achievements.
- Staff felt supported by their managers and team leaders and felt positive about the new executive managers in place, which they hoped would create stability, and support innovation.

However

- Some areas were working long hours to provide a safe service and were gaining support from their immediate team but could see no way of the situation improving.
- The No Worries service was commissioned as level one service and meetings were held with the commissioners but the service specification had limited detail. The size of the service, and the level of service and the frequency and location of clinics did not appear to be based on an evaluation of the needs of the population it served.

Summary of findings

Our inspection team

Our inspection team was led by:

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

Team Leader: Tracey Halladay, Care Quality Commission

The team included CQC inspectors and a variety of specialists: an advanced nursing practitioner in community nursing, a community nurse, a physiotherapist, a district nurse, health visitor, sexual health nurse, learning disabilities nurse and an emergency care nurse.

Why we carried out this inspection

We inspected North Somerset Partnership Community Interest Company as part of our programme of inspections for NHS and independent community health services.

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the organisation and its services and asked other organisations to share what they knew. We carried out an announced visit on 29, 30 November and 1, 2 December 2016. During the visit we held focus groups with a range of staff who worked within the service, such as nurses and therapists. We observed how people were being cared for and talked with carers and/or family members and reviewed care and treatment records of people who use services. We also attended clinics where people received treatment. We spoke with 183 staff, 72 patients, 24 relatives/parents and members of the corporate and executive teams. We carried out an unannounced visits on 12, 13 and 14 December 2016.

Information about the provider

North Somerset Community Partnership Community Interest Company was formed in 2011 and provides community services to the population of North Somerset.

The organisation has two registered locations Clevedon Community Hospital, and Castlewood which is the base for the corporate, executive and support teams. Services are organised across four localities and compliance within services in each locality is supported by a CQC Registered Manager.

Services provided include: Health Services, Specialist Services, Children's Services and Community Services for Adults with Learning Disabilities which are delivered in patients' own homes and from a wide variety of health centres, clinics and team bases across North Somerset, many of which accommodate integrated teams in partnership with local authority and voluntary sector organisations.

Adult Community Wards and Teams which are multi-disciplinary consisting of nurses, occupational therapists

Summary of findings

and physiotherapists working closely with GP surgery staff and clinical leads who are trained in independent prescribing, physical assessment skills and diagnostics. They also provide high levels of care for people who might otherwise be admitted to hospital.

Rapid response, intravenous (IV), falls service and end of life care for people with complex, substantial, on-going needs are an integral part of the Community Wards and teams and offer continuing care for older people who can no longer live independently due to a disability, chronic illness, or following hospital treatment.

Children and Family services encompass health visiting, school nursing, paediatric diabetes, sexual health and the Looked after Children service. Our children's services are aligned with public health and are delivered to the whole population.

Community Team for Adults with Learning Disabilities teams consist of health and social services workers and support their patients and carers to ensure they have the same chance to lead a full and interesting life as everyone else. The team is successfully integrated with social care.

Community Pharmacy service which supports all the community teams with medicines management and pharmacy advice.

Specialist Services made up of specialist therapists and nurses providing services for people needing rehabilitation, support to manage long term conditions such as diabetes, heart failure and lung disease, or those needing specialist input such as podiatry, tissue viability or continence services.

Services at Clevedon Community Hospital include the Minor injuries unit which is open from 8am – 8pm 7 days a week, outpatient clinics and an inpatients ward which was closed for refurbishment at the time of our inspection and due to reopen in the spring of 20167 with 11 inpatient beds

The organisation provides services with a contract value of £27m with 562 full time equivalent staff and 116 bank staff. For the year 2015/15 there was an operating loss of £84k for 2015/6, compared to a budgeted profit, before tax, of £133k.

Our previous inspections of North Somerset Community Partnership CIC were:

Castlewood in November 2013.

Clevedon Community Hospital February 2014.

What people who use the provider's services say

- Parents we spoke with told us they were made to feel welcome when they attended any clinic or group sessions. Parents felt they were treated with respect and listened to by the professionals and felt staff supported their privacy. They felt confident about attending clinics and that it was a space where they could meet friends and peers. Children, young people and their families were spoken to in appropriate terms and were able to understand the advice given to them about options of care. Parents thought the service was helpful and staff supported them without being judgemental. Children, young people and their families knew how to access services if they needed it and trusted the advice given to them which reassured them about what actions to take if they had any concerns.
- School staff were positive about the support they received from the school nursing service and were able to contact staff for support when they needed it. Young people we spoke with felt they had their questions answered when they attended clinics.
- We left comment cards and boxes in various locations across the service prior to our inspection. We collected 68 completed comment cards. They covered the musculoskeletal MSK (34), physiotherapy (14), podiatry (6), lymphoedema (9) services and four about the organisation in general. All but one were positive about the service they received and the staff providing those services and included comments such as: "Very happy with the service. I did not have to wait long to be seen" and "after an initial long wait for an appointment I am now happy with the service I get" "Can't fault the service", "Care and support from the nursing team is

Summary of findings

outstanding. They are caring and considerate and I would not have got through it all without the support and dedication of those who cared for me". "Excellent service, my child was seen immediately and his injury was discussed with him so I knew his injury was being taken seriously"

- People said staff visited and gave nursing care to their partner until they died, "came in as strangers, left as friends".
- Others said staff offered to come back to wash and dress their partner who had died, as the staff washed and dressed the patient, they heard them chatting to the patient as if they were still alive, which moved them.
- One person told us the staff 'were magnificent, so kind, respectful of [my partners] dignity, funny, friendly, amazing at their job….massively supportive' They said the staff made it possible to keep their partner at home to die, which was what the patient wanted.

Outstanding practice

- The community outreach team had adopted an effective approach to reach out to people and improve their access to health care. They set up ten weekly clinics in Weston-Super-Mare for 'hard to reach' groups such as people with substance misuse, homelessness and social isolation. The service provided interventions on a range of public health lifestyle issues such as weight management, healthy eating, reducing substance misuse including alcohol, Between October 2015 and January 2016 the service received 103 new referrals and assisted 11 people to find accommodation.
- Some patients relatives were enabled to give care to relatives after assessment and training by end of life care coordination centre team.
- The Care coordination Centre Lead Nurse had established a library of books in each of the eight teams (for example learning disability, community nurses). This had been enabled by money raised by friends of a patient. They covered all children's age ranges who might be affected by a death in their life.
- The end of life care coordination centre were providing staff with 'shadowing' opportunities so that they could work alongside experienced workers in end of life care. This approach was intended to ensure that workers recruited knew what the role entailed and had the right qualities to work in end of life care.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure that staff working in the community adults service have access to a system that enables them to complete all care records contemporaneously.
- Ensure that paper and electronic records for patients contain relevant information and are available to all staff at the time needed to ensure the delivery of safe and effective care.
- Ensure that staff working in the community adults service are compliant with mandatory training in line with the organisations targets.
- In the community adults service, ensure that patient risk assessments are completed in a timely way.
- In the community adults service, ensure that processes are in place to monitor staff compliance with the completion of patient risk assessments.
- In the community adults service, ensure that processes are in place to monitor staff compliance with the completion of audits.

Summary of findings

- In the community adults service, ensure that areas where sterile dressings are prepared are regularly cleaned.
- Ensure there are sufficient numbers of staff to meet the needs of children, young people and families in all areas of North Somerset.

Action the provider SHOULD take to improve

- Review processes to flag when compliance with mandatory training is low.
- Ensure compliance with infection control measures including cleaning of equipment and hand hygiene.
- Ensure premises used for care and intervention are clean.
- Ensure the date patients are admitted onto the caseload is clearly stated to ensure timely risk assessments are completed in line with the organisation's policies.
- Ensure patients' vital signs are assessed and recorded when admitted to the caseload and that compliance is audited regularly.
- Ensure nurses who have not undertaken a prescribing course only make recommendations to a GP to change a patient's medication.
- Review staffing capacity and acuity of caseloads across the four localities to ensure these are equitable and manageable to enable delivery of safe care and treatment.
- Review how staff use dementia screening tools, refer patients for assessment and audit compliance with screening
- Review processes for documentation audits and identify effective measures when audits demonstrate an improvement is required.
- Review processes to monitor patient outcomes and evaluate the effectiveness of services in community adult services.
- Review how locality risks are managed in a timely manner to reduce risks.
- Consider how to ensure children's service staff receive feedback of themes and learning points from audits.
- Consider how to support health visiting and school nursing staff to have access to all relevant health information for children they see and reduce duplication of record keeping.
- Consider reviewing the need for formal service level agreements in relation to the provision of premises to provide No Worries clinics.
- Ensure provision of clinical supervision of No Worries staff is through a formal agreement when provided by other organisations.
- Consider developing a formal strategy for the development of the No Worries service.
- Ensure that staff who have face to face contact with young people are trained to safeguarding level 2 in line with national guidance
- Develop the governance arrangements for medicines in MIU.
- Consider how to capture data on patient attendance and those patients who leave without being seen in the MIU.
- Ensure staff in the learning disabilities services have information systems that allow them have easy access to relevant clinical information.

North Somerset Community Partnership Community Interest Company

Detailed findings

Requires improvement

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

We rated the safe domain as requires improvement because:

- There was a lack of auditing compliance with assessing risks to patients such as completion of Waterlow score, MUST assessments and falls assessments.
- Improvements were required to patient's records across all services. Staff did not complete contemporaneous electronic patient records due to issues with connectivity affecting mobile devices. These issues had been recognised and were noted on the risk register.
- There was a low compliance with some mandatory training across the four localities and in the urgent and specialist care team. There was no process for 'flagging' up when compliance was low which meant in some areas, only half of the required staff had completed the training.
- There was an inequality about the capacity and the size of the caseload across the localities for community adults services. Similarly in the service for children, young people and families some staff had very high caseloads of families with enhanced needs and regularly worked beyond their contracted hours to deliver a safe service. However, managers were undertaking work in preparation for using an acuity measurement tool in the near future. This was to ensure that information about population needs, was accurate and would provide appropriate advice about staffing levels.

However:

Requires improvement

Are services safe?

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

- There was a good incident reporting culture and evidence of thorough investigation leading to learning from incidents across the organisation.
- Staff understood the importance of being open and honest and we saw evidence that Duty of Candour was applied when things went wrong.
- Staff were knowledgeable about safeguarding which was embedded in practices.
- Staff had the right qualifications to carry out their jobs, there was a robust competence assessment framework and staff were encouraged and supported to enhance their qualifications.
- Patients had care from staff who had specialist training in end of life patient care.
- Staff in the learning disability service felt their caseloads were manageable and had the chance to discuss their caseloads to ensure they were able to meet the needs of service users.

Our findings

Incident reporting, learning and improvement

- There was a good incident reporting culture across the organisation. Staff understood their responsibilities to raise concerns, knew how to report an incident using the electronic incident reporting system and felt supported if they reported an incident. One of the highest scoring areas in the 2016 staff survey reflected the positive culture for reporting incidents with 94% agreeing or strongly agreeing that they were encouraged by the organisation to report a safety concerns.
- All relevant staff were involved in incident reviews or investigations. Staff received feedback regarding all incidents they had reported. Incident information which was required to be shared more widely was highlighted during shift handovers and during team and learning event meetings.
- Between April and September 2016 the organisation had shown 100% compliance for reporting Serious Incidents (SI) within 48 working hours, this complied with national guidance (Serious Incident Framework Supporting learning to prevent recurrence NHS England April 2015).
- Learning from incidents was demonstrated in an example where there had also been a serious incident concerned with administration of insulin to a patient who had diabetes. The organisation had investigated the incident and identified action and learning to ensure a similar incident would not happen again. The recommendations included a review of processes to ensure re-allocation of daily visits were communicated to staff and sharing of the lessons learnt.

Duty of Candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm which falls into defined thresholds. The organisation incorporated duty of candour principles into the mandatory training for all disciplines.
- Duty of Candour training was incorporated within clinical statutory/mandatory for all disciplines and 2 full days managers' training took place in September and October 2015. 70% of NSCP staff members have been trained at the end of Quarter 3 against an end of year target (March 2015 -2016) of 90%.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied.

  The tissue viability service gave an example of when it had employed duty of candour following the deterioration of a patient.

Safeguarding

- Staff understood their responsibilities and were knowledgeable about procedures for raising a safeguarding alert. We asked staff about procedures to follow, how to seek advice and found that safeguarding practices were embedded into daily practices in the community adults and end of life care teams. Although some policies were seen to require some updating in line with the Care Act 2014.
- In 2015/16 there were 36 safeguarding concerns raised by NSCP staff in relation to pressure ulcers. The organisation's annual safeguarding report 2015/2016 discussed the difference between avoidable and unavoidable pressure ulcers. The report stated staff

Requires improvement

Are services safe?

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

were required to make a judgment, depending upon the presenting history, whether neglect had been a prominent factor if the development of the pressure ulcer and if so staff should raise a safeguarding concern.

- Compliance with adult safeguarding training varied between 89% to 96% across the four localities and urgent and specialist care, against the organisation's target of 90%.
- The organisation had a safeguarding team who operated to support staff across various services. This included the opportunity for individual meetings with staff to offer advice, and debriefing as well as emotional support where needed. The service had a presence on the safeguarding adults board and safeguarding children's board, multi-agency boards used to ensure that safeguarding arrangements across the local area were consistent and effective.
- Policies for safeguarding children followed national recommendations with processes from Working Together to Safeguard Children and were embedded within the workforce. A team of senior staff and executives had responsibility for safeguarding children, young people and their families. Health visiting and school nursing staff worked with partner agencies to identify children and families who need further support. A joint adult and children's safeguarding group met three monthly to monitor safeguarding processes, share national and local learning and identify where improvements could be made.
- Registered nursing staff, including those working in the minor injuries unit, and nursery nurses attended safeguarding children training to the appropriate level for their roles, which followed national guidelines from Safeguarding Children and Young People: Roles and Competences for Health Care Staff, Intercollegiate Document, March 2014. Training figures for September 2016 showed level two training had been attended by 93% of staff and level three training had been attended by 97% of staff.
- The electronic record keeping system had alerts built which we saw highlighted safeguarding concerns and children who were on a child protection plan to any professional who accessed the record. Paper records had a sheet at the front of the record which highlighted any safeguarding concerns. This ensured that professionals could plan care appropriately for the needs of the child and family. Children presenting at MIU were asked about previous attendances in the last 12 months to other healthcare settings and findings were recorded on the safeguarding template.Children frequently attending MIU were flagged to other child services using the appropriate form with details of dates and the presenting problems.
- Safeguarding training at level three was completed by clinicians working within the sexual health service.Administration staff completed safeguarding level one training and also CSE training. However staff who have direct face to face contact with young people should, according to national guidance, be trained to level two. All staff working in the service had completed training on female genital mutilation (FGM) and child sex exploitation (CSE).

Medicines management

- Systems and practices to manage medicines appropriately across the organisation were in place. The medicines policy was due for review in September 2017. However in some teams practice did not fully comply with policy.
- Nurses in the heart failure team initiated and titrated medicines based on their findings from obtaining a patient history, vital observations and electrocardiogram when needed. The organisation had a protocol, which clearly set out guidance on medicine doses and following current evidence-based guidance.
- Medicines for the No Worries clinic were transported and delivered by staff from the main office to the clinic which was not staffed by the provider. We observed on one occasion that these were not transported in a secure tamper proof container as required by regulations. We did not see the storage facility for these medicines but the nurse who ran this clinic explained they were stored separately from the other medicines in the practice and that all unused medicines were returned to the main No Worries office. Medicines were booked in and out of the No Worries office by the lead nurse.
- Medicines were stored safely in minor injuries unit (MIU). Liquid medicines did not have a date of opening (which was not in accordance with the medicines policy) and the clinical room temperature was recorded and added to the daily monitoring sheet.

Requires improvement

Are services safe?

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- During the inspection, we identified that the organisation needed to review the systems for ordering controlled drugs within MIU. All orders for controlled drugs in MIU were signed by a non-medical prescriber (NMP) and put into stock. On the last day of the inspection the organisation reviewed the current system and a process was put into place to quarantine the controlled drugs, which had been obtained in this way.Arrangements were put in place to obtain a supply of controlled drugs using a doctor's signature.
- Medicine management arrangements in the community adults team and end of life service were appropriate. We saw administration of medication records in patient's homes. These were completed comprehensively. We saw separate documentation kept for patients who received insulin. This was aimed at mitigating the risk of errors with this medication.
- However, we saw an example of where community nurses had cared for patients in their home and the process for accounting for medicines had not been properly followed. Not all community staff were aware of the policy to guide how often the controlled drugs should be counted and signed for.
- Where staff had been involved with medicine errors, investigations were thorough including root cause analysis and we saw records of learning shared. Two medicines related errors had been recorded including drugs reported as missing from the most recent event September 2016 both were investigated and actions taken.
- We saw medicines stored appropriately in patients' homes and managed by staff according to policy.
- Clear guidance on medicines was available to assess, manage and review a range of end of life symptoms such as anxiety or shortness of breath. Medicine management information was printed on the back of the 'community palliative care drug chart'. This was kept in each patient's care record and enabled staff to have easy access to additional information.
- Health visiting and school nursing staff used safe practices for the delivery, storage and administration of medicines, which was in line with legislation. Portable electric cool boxes that could be powered by a socket in the car were used to transport medicines at the correct temperature.
- Nursing staff in the childrens services received training on immunisation processes each year and worked to a protocol of using Patient Group Directions (PGD). The PGD is a process that authorises appropriate professionals to administer prescription only medicines to patients without needing an individual prescription for each child.
- The lead nurse for the No Worries service had additional qualifications which enabled them to be a non-medical prescriber. This meant they were able to prescribe and administer certain medicines without a doctor present.
- Medicine audits were being carried out to improve patient care. The End of Life care coordination team were auditing the prescribing rates of just in case medications. This was to inform better practice and identify and issues regarding the prescription and provision of anticipatory medicines. The audit had not been completed at the time of our inspection.
- Medication audits were completed monthly by the lead nurse in the community adults services. We saw that the previous three months had been completed satisfactorily with no identified issues or concerns.

Safety of equipment and facilities

- The design and use of facilities together with organisation polices and processes kept people safe. Clevedon Community Hospital outpatient department (OPD) had recently been refurbished and as a result, it was bright and clean. The consulting rooms, at Clevedon Community Hospital OPD, for general outpatient use and those used by the musculoskeletal (MSK) service were all clean and tidy and housed relevant equipment. Consultations took place in privacy.
- The minor injury service was delivered from a purpose built unit in the community hospital, which was opened in 2013.There were four clinic rooms and a triage (assessment) facility. The design of MIU ensured good visibility of the waiting area, which ensured patients were always observed.
- At clinics there were adjacent waiting areas with seats and toys available for young children. We saw cleaning schedules which documented any toys used had been sanitised appropriately. School nursing and health visiting staff were able to take equipment that was necessary for their activity in a school or alternative location.

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- Access to emergency equipment for staff working in clinics or in patients homes was available either in emergency trolleys or in grab bags.
- Consumables, for example cleaning wipes, gloves, aprons and sharps boxes were readily available to all staff. Stock was held at community bases and collected by staff as required. Staff described that equipment was easy to order and that in most instances there was a same day delivery for standard stock items.
- We saw some staff had allocated responsibilities for ordering stock. We found some storerooms were untidy although there were clear signs asking for storerooms to be kept tidy.
- Specialist equipment such as hoists and beds was available to order and was delivered quickly and often on the same day. Allied healthcare professionals visited patients and their carers to provide training in the safe use of such specialist equipment on the day of delivery. Equipment was maintained and available to keep people safe.
- Nurses confirmed there were enough syringe drivers (a device used to deliver medicines just beneath the skin) in teams to meet patient's needs for end of life care.Although there were times when equipment had been transferred from other teams to meet local increase in demand. Syringe driver usage was audited and tracked so that staff knew where equipment was and when it needed servicing.
- There were systems and processes to ensure the safe management of waste. Staff adhered to, and were aware of safe segregation of clinical waste and arranged for the local council to collect clinical and infections waste following their policy.

Records management

- Patients' individual care records were not always written and managed in a manner that protected people from harm. The organisation was in the process of introducing electronic care records but was challenged to ensure continuous connectivity of mobile devices. This meant the majority of patient records were paper-based and stored in the patient's home. Some community staff had laptops but did not have access to 'mobile working'. These arrangements affected the community adults teams including end of life care and learning disability team where staff could not access all required information on different systems. The corporate risk register reflected the situation and there were plans in place with actions to help overcome these challenges. Staff working in clinics and the MIU used electronic records which were updated at the time of patients contact and were seen to be complete and accurate.
- Staff completed contemporaneous paper-based records in patient's homes, which were legible, signed and dated entries. Often electronic records were completed when staff returned to the office or the next day if visiting patients later in their shift which could be a risk to the management of end of life patient care for those in their last year of life. If nurses were called out in the evening or overnight, they may not have access to up-to-date electronic records of patient visits until they arrived at the patient's home.
- We found not all patient assessments were reviewed at regular intervals for patients using the adult community services and services for children and young people. There were two examples of frailty assessments not being reviewed. Another instance was a lack of recording of baseline observation such as blood pressure and pulse when a patient is admitted to the care of the adult community team to enable monitoring of any changes over time.
- Six of the eight, end of life patient records we reviewed had a treatment escalation plan (TEP) form in place. Two of the eight did not have all of the information completed in the form although the information was recorded elsewhere in patient notes. This could pose a risk to those patient's care as potential risks had been missed, or not recorded. In the childrens service we looked at eight sets of patient records and most were accurately documented. In the MIU patient risk assessments were integral to the electronic record and competed appropriately.
- Documentation audits were undertaken at different intervals across teams. For community adult services these were once a quarter and for services for children and young people a system of monthly audit by colleagues. Staff had a regular number of records to review using an audit tool. Health visiting teams had achieved 92% compliance with the organisation's record keeping standards in the quarter from April to June 2016. These results were reported to managers and staff told us they were informed by their peer auditor of any improvements needed but did not receive any feedback from managers regarding the overall results or themes.

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Compliance with the audit programme in community adults was poor with the last 12 months having five services which had not participated at all. Also none of the other services or integrated care teams had submitted audit results for all four quarters. The scores were between 56% -100% compliance which meant there were significant gaps in some documentation records. Documentation was not a standard agenda item for all team meetings. It was not clear if any actions were identified because of the audits and implemented to enhance compliance.

Cleanliness and infection control

- There were systems, processes and policies in place to prevent and protect patients from healthcare associated infection. While compliance with hand hygiene practice was good across all services there was a lack of regular audits in line with the infection control programme.
- Facilities we visited were seen to be visibly clean but a lack of assurance and clear guidance in premises not owned by the organisation may have posed a risk of cross infection. The organisation policy set out procedures to ensure clean clinical environments, but there was little reference to outpatient clinics and how it was assured that premises were clean and well maintained. We visited a clinic held in a GP surgery where we noticed that the equipment had last been cleaned on 16 November 2016 according to a chart displayed in the surgery. The service relied on GP practices carrying out their own environmental audits but it was not clear if these were reviewed by the organisation to assure compliance. If staff were concerned the organisation would raise this with the GP surgery involved.
- At a leg club (community-based treatment and advice for patients who experience leg related health problems) staff used a disabled toilet as a preparation area for leg baths. Staff told us they did not clean the toilet area prior to preparing leg baths although staff stated it was cleaned after use. When the premises were not used by the leg club, it was open to the public for various other functions. Therefore the service could not be assured the facility was clean enough before using it. There was an infection control risk assessment for the leg club that included a cleaning regime. However, it did not specifically refer to the toilet area. There was no documentation to demonstrate the toilet area was cleaned prior to use. Therefore we could not be assured the facility was clean enough before using it.
- The infection prevention and control policy stated that compliance was audited through the annual infection control and prevention (ICP) audit programme. A hand hygiene audit from October 2016 had shown Children's service staff were 95% compliant with the organisation's policy on hand hygiene technique. We observed staff displaying good hand washing techniques between contact with babies and children. School nursing staff were informed of any school which was experiencing an outbreak of communicable disease. A member of the school nursing team would attend the school to provide hand washing sessions and information on how to control infection, for the pupils. Hand washing facilities were readily available in the Minor Injuries Unit and we observed staff washing their hands or using disinfectant gel immediately before and after patient contact. Hand hygiene audits took place and monthly and consistently showed compliance between 98% and 100%.
- However we reviewed the infection control audit dashboard 2016/2017 and found that many community adult services did not complete ICP audits regularly. For example out of 22 localities or services, only eight had completed the audit for hand hygiene technique. From September to December 2016 the community nurses teams were on average 100% compliant except from the Gordano Valley team, which were 86% compliant. These were monthly audits but all localities had only submitted one audit result except Gordano Valley who had submitted for two out of the four months. For urgent and specialist care services 17 services had submitted one or two audits out of four but there were three services who had not submitted any audits for the four months. This meant that there was not a robust system in place for assurance of practice and auditing compliance with hand hygiene across the adult services which was recognised by the organisation.
- When visiting patients in their homes we observed staff washing their hands before and after care interventions but in some cases, staff used the patients' own soap or in one incident, staff used the patient's shower gel. This

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was not compliant with the organisations hand hygiene policy which stated staff should use their 'own' soap. Some patients put out a clean towel for the nurse and we saw staff use kitchen paper to dry their hands.

- We observed staff use personal protective equipment such as gloves and aprons for care interventions that involved a risk of spillage or a potential infection risk, these were disposed of in waste bag and then placed in the patient's domestic waste bin.
- Staff were seen adhering to aseptic techniques when carrying out dressings in patient's homes, despite the challenges the environment could pose.
- The infection prevention and control forum met quarterly with representatives from all localities and from the urgent and specialist care team. There was a set agenda and evidence of effective processes to identify areas of risks, learning and good practice. Where improvements were required, actions were assigned to named people and an action log stated a completion date for actions as well as a requirement that it was updated each month until actions were resolved.

Mandatory training

- The organisation supported staff to attend mandatory training to ensure staff were up to date with essential safety skills for their roles. This included subjects such as health and safety, infection prevention and control, basic life support for children, manual handling, prevent training and information governance.
- Staff compliance with mandatory training was targeted at 90%: with staff in the childrens teams and MIU meeting this target. However, in the community adults teams compliance varied across the different localities. The 'Rurals' team was 94%, Gordano Valley 89%, Worle 89%, urgent and specialist care 84% and Weston integrated care team was 81% compliant. The training compliance target was 90%, which meant that five out of six teams were below the target for training compliance in September 2016.
- The organisation introduced pain awareness as mandatory training in April 2016, which required a once only attendance/completion. At the time of our inspection, compliance was between 33% and 53% against a target of 85% across the four localities and the urgent and specialist care team. However, it was recognised there were still three months left for staff to complete this training.
- Staff were given protected time to complete mandatory training and we saw two rotas that showed staff allocated to mandatory training. Compliance was discussed at appraisals and linked to annual incremental pay rise.

Assessing and responding to patient risk

- Systems to assess and identify risk were available to staff in all the community services.
- Risks to children were assessed by staff and advice was offered to parents on how to access further support. Access to The children's service could access immediate advice from the Child and Adolescent Mental Health Service (CAMHS) on how to support the child. If a need arose for urgent medical examinations for child protection cases these were provided by another organisation usually within 24 hours of the request. School nursing staff supported all schools with medical issues including schools for children who had complex needs. Sexual health risk assessments were completed on all young people aged under 16.
- For patients receiving end of life care regular communication and review between teams and other health professionals such as GPS ensured risks were regularly reviewed and where a patient required they could be prioritised.
- In the community adults teams although risk assessments were completed, staff did not always document actions to mitigate the risks of pressure ulcers or malnutrition or it was not documented why the actions had not been followed through. We looked at 31 patient records (paper based and electronic) and found risk assessments were not up-to-date in 11 out of the 31 patient records.
- Community nurses in each of the four localities held a daily handover/safety briefing, which were scheduled at set times that was outside of breaks. They were timed to maximise attendance and allowed for changes in planned visits to be taken account of. Information passed over at handover was relevant and current. Risks were also discussed for both patients and staff.

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- The organisation had introduced a training programme to recognise sepsis using a recognised early warning score. Sepsis is a highly time sensitive condition which in severe cases can be life threating. Compliance with sepsis training exceeded the target and was from 86% to 95% for the four localities and urgent and specialist care services.
- The organisation had a pressure ulcer prevention and management policy, which outlined standards for assessing risk to patients for developing a pressure ulcer. Community nurses used a visual check of all skin areas at risk of breakdown and would recorded findings on the care plan.
- Staff were focused on improving the quality of care. The falls service had implemented a falls risk assessment tool that all staff should use to assess the risk of a patient falling.
- People attending the minor injury service were greeted by a receptionist or a member of staff who had received training in recognising 'red flag' conditions such as chest pain. This initial face-to-face observation provided an immediate assessment. If a person presented with a life threatening condition they were immediately assessed by an ENP.
- Patients who were seriously ill or injured, including children under 12 months, were transferred by ambulance to the emergency department at the nearest acute hospital. Service level agreements (SLA) were in place with local NHS hospitals.
- The national early score system (NEWS) was used by staff in MIU to identify patients whose condition was at risk of deteriorating. There was a similar system (PEWS) in place for children. ENPs and support staff were trained in Immediate Life Support (ILS) and Paediatric Immediate Life Support (PILS) in line with the standard of the unwell child.
- Staff in the learning disability service had a system to triage referrals. A senior staff member would take on the role of senior duty worker and review incoming referrals.

Staffing levels and caseload

- Recruitment and retention of staff were recognised as risk for the organisation. With changes to working patterns a central aspect of the new service contract with efficiencies in ways of working being explored to meet the need and not compromise quality of the service.
- Staffing pressures due to vacancies and reductions in funding was leading to some challenges for the organisation.A reduction in funding from public health had meant that health visitor staff numbers had reduced from 43 to 39 whole time staff in September 2016. The impact being there was a risk that staff would not be able to meet the contact points recommended in the national healthy child programme. The Community Practitioners and Health Visitors Association (CPHVA) recommend caseloads for health visitors should be a maximum of 400 in the least deprived 30% of the population. In the school nursing team numbers did not meet staffing levels recommended by the Royal College of Nursing, due to the budget provided by commissioners.
- Community teams were affected by some staff shortages and in particular difficulties in recruiting senior nurses. Services were maintained despite the vacancies and increases in demand with monitoring of the appropriateness of referrals to the community nursing services. Inequality in staffing establishments was noted with one team 20.5% over establishment while another were under established by 25%. We also found that the actual patient to nurse ratio varied significantly across North Somerset. Caseload monitoring was not possible with use of nationally recognised tool but in one locality the manager had developed a template to help plan daily caseloads based on the estimated time an activity would take a nurse to carry out.Being able to understand the detail of caseload pressures included monitoring the number of community nurses visits to patient's homes who were not at home.
- Pressures on the team from the high number of patients with diabetes requiring daily visits for insulin administration resulted in a specialist diabetic nurse being appointed. Key to the role was overseeing an 'insulin project,' which reviewed the insulin requirements of patients in partnership with the patient and the patient's GP. This ensured optimal treatment and to reduce the number of visits from community nurses.

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- Vacancies in the physiotherapy outpatient service resulted in the waiting list being high at 22 weeks. This had recently been reduced to 18 weeks as two new staff had started in the department to fill vacancies.
- Other teams and services were staffed sufficiently including the No Worries service, MIU and learning disability teams and end of life care team.
- A capacity and capability review to identify staffing levels and capacity had been undertaken with plans to use the data for workforce modelling leading to work that will identify safe staffing levels. Further data for analysis of team capacity was due in early 2017.

Managing anticipated risks

- Provision had been made to support the No Worries staff to manage any potential risks associated with contact with young people in the clinical areas. In the clinic rooms used by the No Worries team alarm buttons were located for staff to use in an emergency
- We were concerned that where No Worries clinics were provided in premises of and by staff from other organisations there was a lack of robust oversight to ensure clinics would continue in the event the other services ceased to provide them.
- Staff in the MIU were able to summon help and were trained in conflict resolution and felt confident in diffusing aggressive situations. Should there be a risk of violence towards patients or staff the police would be called.
- The winter plan ensured ongoing delivery of services in adverse conditions, including a priority rating of visits to patients and the use of a 4X4 vehicle to help staff get through adverse weather conditions. The plan was available to all staff on the intranet; locality leads who also acted as duty managers, were very knowledgeable about the escalation plan.

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents. The organisation had a business continuity plan with a list of yellow and red triggers to activate an escalation plan to maintain business as usual as far as possible. As an example the health visiting and school nursing teams had plans, which were specific to their service, for when and how to escalate concerns when there was a disruption to the service. It included detailed actions to be taken based on how long a disruption would last and specified identifying vulnerable people and how to ensure they received the care they needed as well as safety for staff. Staff were aware of these plans and knew how to access the information on their organisation intranet.

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

We rated effectiveness as good because:

- Staff followed care and treatment guidelines and pathways based on current best evidence.
- Staff had the right qualifications to carry out their roles, supported by competency assessment framework. They were encouraged and supported to enhance their qualifications.
- There was effective multidisciplinary working across the organisation and staff had good working relationships with GPs across North Somerset.
- There were systems to ensure appropriate referrals were made and when clinical support was needed.
- Staff were knowledgeable about mental capacity assessment and deprivation of liberty legislation and obtaining consent for treatment and care interventions. These were embedded in the way staff worked.
- Pain and symptom relief was prioritised for patients receiving end of life treatment and care.
- Services for children and the MIU monitored patient outcomes.
- Service users had access to psychologists in the team provided by another provider. This allowed them access to therapies recommended by the National Institute for Health and Care Excellence.
- Patients had care from staff who had specialist training in end of life patient care.

However,

- There was not a consistent assessment of pain using recognised pain assessment tool and compliance with pain awareness training was low.
- Staff did not always assess patients' nutritional risk assessment
- Not all services consistently collect data to measure patient outcomes and they did not participate in national audits to benchmark their treatment and care.
- Health visiting teams provided care as agreed with commissioners. However, this did not always follow national guidance and could have an impact on the health outcomes for children and young people
- The minor injury service was unable to record the number of adult patients who left the unit without being seen and the number of unplanned re-attendances within seven days

Our findings

Evidence based care and treatment

- National evidence and guidelines were used to deliver care and treatment across all of the services. A process had begun to replace all of the clinical guidance for staff, with guidance based on National Institute for Health and Care Excellence guidelines (NICE).
- We saw many examples of care based on guidance by the national institute for clinical excellence (NICE). For example, Type 1 diabetes in adults: diagnosis and management (NG 17; Updated July 2016) and Type 2 diabetes in adults: management (NG28; Updated July 2016).
- The leg club based in the community was set up following guidance based upon the Ellie Lindsay Leg Club Foundation's model. The leg club model aimed to motivate and empower patients to take ownership of their care, alleviate their suffering and reduce stigma attached to their condition. Nurses working within the service had received training around these methods, with Ellie Lindsay herself having visited and offered training.
- Pulmonary rehab service facilitated a pulmonary rehabilitation group for patients with chronic lung diseases such as chronic obstructive pulmonary disease (COPD). This was set up to meet the NICE guidelines: Quality Statement 5: Pulmonary rehabilitation after an acute exacerbation (2016). The service recognised the pulmonary rehabilitation did not meet all standards, as it was not possible to ensure all patients could attend within four weeks of discharge. The service had trialled a rolling programme where patients could join at any time but when evaluating patients' feedback, it was decided to run a whole programme for a set group and enrol new patients on the next available group

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- Health visiting and school nursing staff provided assessments and support for children by following the Department of Health, Healthy Child Programme. Performance with the programme which identified the number of contacts made at the key points did not meet the 90% target. For example, for the quarter July to September 2016, staff had performed 54% of required antenatal visits and 62% of planned visits within six to eight weeks of birth. For a period of time prior to September 2016 both visits had been a targeted service only to families with identified vulnerabilities. This had been agreed with commissioners. Since this time they had been reinstated as a 'universal' visit to all mothers and babies which was compliant with national guidance. The impact of the change meant that health visitors were required to perform more visits in total and some health visiting staff had been unable to meet the targets. However the Health visiting staff provided support for mothers with breast feeding and had achieved UNICEF baby friendly level three accreditation.
- Safeguarding procedures followed recommendations in the document Working Together to Safeguard Children 2015. All staff were aware of recognising signs that would suggest children might be at risk of harm or abuse.
- No Worries staff were knowledgeable about guidelines and recommendations provided by the various national bodies including the British Association of Sexual Health and HIV (BASHH).
- The service contributed to the national chlamydia screening programme and staff were aware of and operated within the standards provided by the national programme.
- Staff demonstrated in practice how they supported end of life care for patients and those people close to them with evidence based treatment and care. For example following the guidance, six national ambitions for end of life care (2015). The guidance supported patients to receive individual care, access should be fair, coordinated and equal, it should maximise comfort and wellbeing, with educated and supported staff and communities.
- The service also delivered care based on achieving the five priorities of good end of life care (Leadership Alliance for the Care of Dying People 2014). This included: recognising dying, communicating about dying, the person and those close to them being involved, and exploration of what is important those around the dying person and an individual plan of care agreed and coordinated delivered with compassion.

Pain relief

- Pain and symptom relief was prioritised for patients receiving treatment and care at end of life. Anticipatory or 'just in case' medicines to manage symptoms and pain was prescribed for end of life patients and stored in their homes. This ensured medicines were readily available when required.
- The service used a pain score tool that had been developed for use for assessment of pain in people living with dementia, learning disabilities and patients who did not communicate verbally at end of life. This provided more uniform pain assessment and enabled staff to communicate patients needs better.
- During the unannounced part of the inspection we spoke with one patient about their experience of receiving end of life care and they said that pain and nausea were well managed.
- In the MIU timely pain relief was administered to children in line with the standard operating procedure (SOP) for the minor injury service. All children with a minor injury were required to be initially observed on arrival by an ENP and triaged (assessed) by an ENP within 20 minutes of arrival. Children presenting with moderate to severe pain received analgesia within twenty minutes. The results of pain relief were monitored and additional treatment given if necessary.

Nutrition and hydration

- There was a malnutrition universal screening tool (MUST) in place to assess and monitor patients.
- We found examples where nutrition assessments were not always completed. This was raised at a meeting of the nutrition link nurse meeting (19 October 2016) where it was highlighted there was low compliance with MUST score being entered on the electronic patient records and there was no evidence that compliance with MUST screening for patients new to the caseload or a repeat care episode was monitored.
- There were plans to include a 90 minute training session for all existing staff and new starters on Malnutrition screening, awareness, and management from January

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2017. This was planned to increase awareness of the need to carry out screening, and confidence to screen patients accurately and provide some basic nutrition advice where appropriate.

Use of technology and telemedicine

- Telehealth was in use across a number of teams being used to enhance the delivery of effective care and treatment. The organisation had the facility to monitor 30-35 patients remotely every day through provision of a Bluetooth enabled box, which prompted patients to check their vital signs (blood pressure, pulse rate and oxygen saturation levels) at intervals determined by their condition. The information was transmitted to the clinical hub where clinical staff reviewed data and took appropriate actions, such as making a telephone call to the patient, or referring the patient to the rapid response team for urgent assessment or, if required, they could arrange for a paramedic ambulance to assist the patient. Staff in the clinical hub felt a review of the effectiveness of telehealth technology was needed as patients were seldom discharged from the service and there was no real plan for its use.
- Community nurses were able to photograph wounds to assess the progress or deterioration of wound healing. The photographs were uploaded to the electronic patient record which enabled staff to discuss treatment options with colleagues at handovers and refer patients to the tissue viability service.
- The falls service made use of telecare equipment, such as falls detectors and bed occupancy sensors. Staff felt these were effective and helped to reduce risk of falls effectively.
- The Speech and Language Therapy (SALT) service used technology to assist with communication. NHS England had cut funding for the Bristol Communication Aids Service (BCAS) run by a nearby NHS trust. This service previously provided communication aids to patients with varying levels of need. Only patients with the most complex needs could now access equipment.
- The organisation had plans to roll out mobile working devices and this was still ongoing in Children's Services, in line with the delivery plan.

Approach to monitoring quality and people's outcomes

- Since April 2016 the clinical commissioning group had awarded the contract to the organisation which was "outcome" based for all services. This meant funding depended on a set of agreed outcomes being achieved. At the time of our inspection the organisation was introducing processes and systems that were better able to collect such information. Such processes included plans to collate information from feedback from friends and families of patients, and staff survey data. In addition, the introduction of more electronic records aimed to capture, more accurately information about the activities of staff. However, at the time of our inspection, these processes were in their infancy and were not embedded in practice.

Outcomes of care and treatment

- The organisation had a clinical audit programme which ensured clinical audits were carried out across different services benchmarking practice against national guidelines (NICE), CQUINs and as requested by the clinical commissioning group. Audit results were discussed in the monthly 'quality and performance' meeting.
- Outcomes of interventions for children, young people and families and adult services were monitored and information contributed to some national audits.
- The audit programme demonstrated how the organisation took part in some national audits such as infection control and safe and appropriate use of antimicrobials and the pulmonary rehab audit. However, the adult community service did not participate in the national intermediate care audit. Staff told us there were plans for engaging with national audits in the future and were working to identify these in time to register when the window for such opened.
- Reducing the incidents of pressure ulcers was one of six quality priorities for delivering safe care and preventing avoidable harm. The aim was to reduce the incidents of grade three pressure ulcers by 30% and grade four pressure ulcers by 50% by March 2017. The overall incidents of pressure ulcers reduced by 52% for grade three and by 63% of grade four pressure ulcers for the year 2015/2016, when compared to the number of pressure ulcers from the previous year. This meant the organisation was on track to improve pressure ulcer prevention and care.
- The outreach team collected data about how many new patients they met with each month and how many of these registered with a GP for ongoing healthcare. The

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service reached out to groups of people in the local community that were not registered with a GP, but had healthcare needs that were not met. The care the service provided included wound care, safe injection technique, sexual health advice and signposting to GP services or to a regional mental health care trust for treatment.

- Discharge to assess (DtoA) service recorded outcomes, for example, in October 2016 there were 41 discharges from the service which demonstrated the majority of patients were managing independently at home after being assessed with support from the team.
- The falls service carried out a review of each patient six months following their discharge from the service. There had been a 50% in reduction in falls during this time. This compared favourably with the national target of 30%.
- Health visiting staff collected data which contributed to national audit for breastfeeding and was compared with rates for other areas in England. The percentage of mothers still breast feeding their infant at six to weeks of age was between 51% and 53% over the 12 months from April 2015 to March 2016. This was better than the national average of 42%.
- The school age immunisation programme was being administered by North Somerset Community Partnership. Uptake for children in school year 9 meningitis immunisation was 80% for 2016 which was slightly worse than the England average of 84%.
- Immunisation against flu had been provided by an alternative organisation until September 2016. After this time North Somerset Community Partnership had been providing flu immunisations for school age children. Uptake of the flu immunisations in school years one, two and three had increased from 54% in November 2015 to 67% in November 2016. This was at the higher end of the national target range of 40 to 65% for 2015/16.
- A smoking cessation programme was delivered by the health visiting service. Success rates used national measures to determine activity outcomes. Data was used as motivation to improve their quit rates from good to excellent and the health visitors were piloting a revised service.
- Health visitors used a variety of methods to support gipsy and traveller families and measured their success by the number of children from these families, who attended baby clinics and went on to attend local schools and nurseries. At the time of our visit staff told us that all children who were eligible to be in school were attending.
- Supporting end of life patients to be in their preferred place of care is part of national strategy (DH, 2008, Leadership Alliance for the Care of Dying People, 2014). Information collected showed that some of the intended outcomes were being achieved for patients at end of life in last few hours or days of care. For example in October 88% of patients died in their preferred place. However other month's figures were lower 39% in June 2016. Figures were often influenced by availability of care, speed of referral or quality of discharge planning by other organisations.
- The majority of audits for end of life and palliative care were planned for completion during 2017. The lead nurse for the end of life coordination centre who was the strategic and operational lead for end of life had begun collating performance and outcome information for the first annual report for end of life care due to be published April 2017. Due to this starting only recently they were unable to provide comprehensive figures with how outcomes compared with other services or information relating to patients in their last year of life.
- Staff in the community teams were aware of the type of conditions that were categorised as 'end of life'. However it was not possible during the inspection to accurately measure the total number patients who were in their last year of life which would assist in managing community and district nurse case load as there was no central record.
- The minor injury service was not recording the number of adult patients who left the unit without being seen or the rate of unplanned re-attendances within seven days as the patient information system did not record this data. However, the minor injury service had put in place robust systems to contact children who left the service without being seen.

Competent staff

- The organisation ensured staff had the skills, knowledge and experience to deliver effective care and treatment and were competent to undertake their roles. Provision of training opportunities, clinical support and monitoring professional development contributed to staff competence.

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.

- Staff had monthly one-to-one meetings and received appraisals and supervision from their line managers. Staff we spoke with told us that they had received an appraisal which were positive with an emphasis on development which was discussed at regular supervisions throughout the year.
- Appraisals occurred during a three month window at the beginning of the financial year with compliance being generally high. Compliance with annual appraisal exceeded the organisations target of 95% apart from the Weston integrated care team of whom 85% had had their appraisal (September 2016). For health visitors from January to March 2016 92% of staff were up to date. This met the organisation's target of 90%.
- Staff at all levels had opportunities for professional development and felt supported to develop with managers telling us they supported people to develop. Practice educators supported the learning and development of staff in school nursing and health visiting. Student nurses felt the organisation offered a good placement with plenty of scope for learning and development.
- Assistant practitioners were supported to obtain the foundation degree and secured a job within the organisation and through supervision were supported to obtain extended skills needed for their role.
- Health care assistants were supported to complete a national vocational qualification in health care and to gain additional skills required to undertake their role.
- ENPs and support staff were experienced and fully trained in the assessment and treatment of adults and paediatric minor injuries. All ENPs had undertaken a recognised course in autonomous practice, followed by a six-month preceptorship programme to consolidate their learning post completion of the course.
- The end of life team felt there were not enough staff with all the skills needed to provide the optimum end of life care. Lack of specific training, for example, verification of death and use syringe drivers was recognised and was logged on the risk register.
- The organisation employed one consultant, a GP as a medical advisor one day a week, and GPs on sessional basis in the MSK service and to support Clevedon Hospital when it is open. All had an annual employee appraisal at which they had to show evidence of ongoing revalidation.

Multidisciplinary working and coordination of care pathways

- Staff in all services worked in partnership with appropriate internal and external professionals and agencies, which included a number of voluntary organisations, to provide coordinated care and treatment for patients.
- Nurses and allied healthcare professionals working in the community attended monthly multidisciplinary team meetings with GPs, and hospice nurses, held at GP surgeries. These teams also liaised with each other internally if there was a need for input from or referral to an alternative professional.
- The specialist older people's team (SOPT) described successful multidisciplinary working with internal and external services such as the falls team, discharge to assess, local GP's, mental health consultants, Age UK and the Alzheimer's Society.
- Liaison with the acute hospital for children with diabetes was pro-active in identifying children with diabetes who needed support by contacting local children's hospital wards to find out about children who had been admitted with diabetes.
- In the No Worries service there were clear referral pathways to other services when this was as required. For example there were pathways for termination of pregnancy, referrals to young people's mental health services and for young people who may have been the victim of sexual assault there was a clinical pathway to a Sexual Health Referral Centre (SARC).

Referral, transfer, discharge and transition

- There were clear and effective processes for staff to communicate when referring patients to other teams or services including GPs and acute hospitals.
- Community nursing teams and allied health professionals, including end of life care, received referrals via the 'single point of access' (SPA) or the 'clinical hub'. The SPA processed referrals for managed care whereas the clinical hub managed urgent and emergency referrals, which they received from GPs, the ambulance service, clinical leads, or community nurses who needed additional advice and support.
- Regular liaison with the local acute NHS trust ensured appropriate plans were in place when patients were discharged from hospital into the care of the community services. For example, the diabetic service had worked

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closely with staff at the local NHS trust to ensure all patients with diabetes were discharged from hospital after a review by a nurse specialist or consultant. This was to optimise treatment and if possible, reduce the need for multiple visits by community nurses each day to administer insulin.

- The DtoA service enabled patients discharged from hospital to receive assessment of their needs in their home. The team visited the patient within two hours of discharge and put in place additional aids and arranged for up to three daily visits, these were reviewed regularly to reduce the visits as the patient regained their independence.
- Sometimes a lack of care agency staff (external provider) could delay the start of a patient's care package for end of life care which was particularly problematic during holiday season and within rural areas. The community nursing teams, working in partnership with local hospices and other providers were able to fill some gaps in care until care packages could be sourced.

Availability of information

- Risk assessments were not always completed in a timely manner and it was not easy to see when the dates of when patients were admitted into the community services or a new care episode started.
- The organisations policies and procedures were all available on the intranet system and staff knew how to access the information they needed, to deliver effective care and treatment.
- There were effective processes for staff to communicate between teams and when referring patients to other teams or services including GPs. The electronic patient records allowed staff to share information about patients with GPs.
- Staff had access to up to date information regarding the care of children they were visiting. Paper and electronic records were completed for each child and visits with ongoing plans of care were recorded for relevant staff to view. Electronic records were only available to view at health visitor bases but staff could carry paper records for reference.
- Staff followed the organisation's information sharing policy when children moved between services and in or out of the area. Staff showed us the flow chart they used which indicated how and when to share information about a child.

Consent

- Staff had access to and understood the relevant consent and decision-making requirements of the Mental Capacity Act 2005 and code of practice. Patient's consent to care and treatment was sought in line with Mental Capacity Act 2005 legislation and guidance. Patients who lacked capacity for decision-making were supported by staff and best interest decisions were made when required in accordance with legislation.
- Training around the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DOLS) was provided to all staff and highly regarded for its quality. Training compliance for MCA and DOLS was below the organisation's target of 90% across some community nursing teams.
- Staff gave us examples of joint visits with senior members of staff or allied health care professionals when they were concerned about a patient's capacity to make decisions about their care.
- We heard a community nurse asking a patient for their consent to discuss their current situation at a multidisciplinary team meeting planned for the following day. We also witnessed nurses ask for patient's permission or consent before discussing their care and treatment with other healthcare professionals such as the patient's GP or specialist services delivered by nearby NHS hospitals.
- Staff obtained consent before any clinical and care interactions and documented this in patient records. There was a policy for procedures to obtain consent when taking photographs of wounds
- Staff we spoke with understood and followed legal guidelines of seeking consent from children, young people and their families and were aware of and knowledgeable about Fraser guidelines and Gillick competence. The Gillick competence identifies children and young people under the age of 16 with the capacity to consent to their own treatment. Fraser guidelines refer to the provision of contraceptive advice and treatment for children and young people without their parents' consent.

Are services effective?

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Adherence to the Mental Health Act 1983 and the Mental Health Act Code of Practice

- The organisation was not registered to care for patients detained under the Mental Health Act 1983. Advice would be sought from Avon and Wiltshire Mental Health Trust where necessary.

Good

Are services caring?

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

Summary of findings

We rated caring as good because:

- Patients and their carer's (when appropriate) were routinely involved in planning and making decisions about their care and treatment.
- Staff communicated effectively with patients and took time to answer questions.
- Patients received care from nurses and support staff that treated them with dignity and respect in the minor injury unit (MIU) and they were always listened to and felt able to raise concerns.
- 98.3% of patients in between July and September 2016 said they would recommend the MIU service to others.
- Staff providing end of life care were highly regarded by relatives of deceased patients for their kindness, caring and compassionate attitude.
- Children and families were offered support and staff used caring approaches to help people who found difficulty in expressing their concerns.
- Children and families were offered privacy when it was needed and confidentiality was respected.

Our findings

Dignity, respect and compassionate care

- We accompanied nurses visiting patients in their homes and observed staff treating patients with compassion, dignity and respect. Patients called nurses by their first names and nurses formed appropriate relationships with patients, based on compassion and care.
- For some patients, the visit by staff may be their only social interaction. We observed, staff adopting a holistic approach to the patients. For example, one member of staff closed a birdcage before providing wound care but remembered to open it again afterwards, as this meant a lot for the patient.
- During one visit, a nurse had remembered a patient's daughter was away and offered to make a hot drink and prepare food. During another visit, a staff member checked that it was acceptable to speak in front of a family member to ensure privacy was maintained.
- We received 68 comment cards back from patients prior to our inspection. Feedback was very positive with patients giving examples of how kind staff had been, how they had explained what they were doing and in a lot of cases how much better they felt following their consultation/treatment.
- Health visiting staff were sensitive to the needs of families from alternative cultural backgrounds and supported them to engage with health services in a way they could accept. As an example, the respect that staff showed to travelling families helped them to engage with health services. A parent told us they attend a clinic every two weeks and meets friends there.
- We observed young people were treated with respect and that staff were polite and helpful during conversations. Staff were clear regarding the confidentiality of the patient.
- The Friends and Family Test (FFT) was in place in MIU and patients were asked to record their experiences on an electronic tablet, which had additional space for patient comments. 98.3% of patients attending the MIU between July and September 2016 said they would recommend the MIU service to others. Patients comments said, "A very caring service and treated with the greatest respect" and "Thank you for the very prompt, kind and understanding treatment" and "I was treated with dignity and respect by very caring staff". Information in the friends and family test results patient experience surveys for community teams said in 2015/16 98.5% (5992 of 6086) patients returned the survey and said that they were treated with dignity and respect.
- We spoke to a recently bereaved relative who had provided care for their partner at home. They told us the staff providing care had talked with their relative at every stage of care. The relative said, "There were lots of tears and laughter" with staff.
- We heard how staff cared for the body of a person who had died, in a sensitive and dignified manner. A relative told us staff offered to come back when their partner died to wash and dress them, as they had cared for the patient for a long time. As the staff washed and dressed the patient, the partner heard them chatting to the patient as if they were still alive, which moved them.

Good

Are services caring?

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

Patient understanding and involvement

- Staff in the MIU explained care and treatment to patients in one example the patient said "I feel so relieved having seen the nurse (ENP) and know what to do to protect my dressing when I next take a shower".
- Patients and their carer's were routinely involved in planning and making decisions about their care and treatment. We observed a nurse advising a patient's next of kin about their entitlement to claim carer's benefit as they were the main carer for the patient. The patient's next of kin was present and was encouraged to join in the conservation when appropriate and with the patient's permission. During another home visit, a nurse explained the results of blood pressure readings to both a patient and their relative in a way they could understand. The nurse confirmed what this meant and agreed a plan of action with the patient.
- During a home visit, we observed a patient who had not wanted a certain type of dressing on their leg ulcer. The nurse had assessed that the individual had the capacity to make choices in this situation and used a different type of dressing which suited the patient. Staff spoke with confidence about individual's goals and their right to make choices about their care. One staff member commented that they would do everything in their power to 'reach the goals of the patient'
- Staff organised relevant equipment and district nurses visited and organised care to meet the patient's needs and wishes. One relative told us the staff 'were magnificent, so kind, respectful of [my partners] dignity, funny, friendly, amazing at their job….massively supportive' The relative said the staff made it possible to keep their partner at home to die, which was what the patient wanted.
- Staff understood the impact of care, treatment or the condition had on patients' wellbeing and on those people close to them, both emotionally and socially. The lead nurse for the end of life coordination centre had established a 'lending library' of books available for patients and relatives. Patients and relatives could keep the books if they wished. Staff gave an example of how this library service had helped a patient with a young family, who was struggling to talk with their children about the illness. The library provided them with a copy of a book that enabled them to talk with their children and prepare them for their death.
- We saw staff giving reassurance to parents about their child's health and ensuring parents were able to access reliable information before making further decisions about their care. Staff made sure parents felt able to contact them again if they needed further support. Parents with English as a second language were supported by staff to use a language translation service to ensure they understood their options.

Emotional support

- Patients and their relatives received the support they needed to cope emotionally with their care, treatment and condition. Staff recognised the broader emotional wellbeing of patients.
- Care provided to people at the end of life met the psychological needs of people receiving care and those close to them. A relative gave us an example of where the staff rang and said they had some time free and asked would the patient like some company. This provided the relative with a much-needed break. The relative told us they were very touched by this 'little act of thoughtfulness'.
- District nurses completed a post bereavement visit to relatives about a week after death. A district nurse we spoke to said the removal of equipment and nursing notes from the patients had to be done with sensitivity and compassion in the post bereavement visit.
- Staff from the outreach team told us of an incident where they had escorted a patient to hospital for a procedure to offer emotional support. The patient had capacity and consented to the procedure but had nobody that could accompany them to hospital and offer emotional support. The patient was very nervous about being in the hospital environment and had appreciated that staff had taken time to go with them.
- Health visiting staff used an assessment tool to identify if new mothers needed further emotional support. Parents told us they appreciated these questions and felt it was supportive.
- For new mothers emotional well being and health was assessed after the birth of their child. Emotional support was built into health improvement initiatives such as smoking cessation programmes where new and expectant mothers were encouraged to connect with their expected baby (love your bump).

Good

Are services caring?

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

- School nursing staff helped children and young people to express their feelings and concerns. They continued to see young people who had to wait for an appointment with Child and Adolescent Mental Health Services to ensure the young person was supported.
- Some school nursing staff used emotionally supportive strategies that helped to promote children's positive thoughts and reduce the risk of low mood. These strategies involved action from parents and supported the child's emotional needs when they were at home.
- There was a North Somerset Learning Disability Partnership Board that had representatives from different services in North Somerset to help give a voice to service users with learning disabilities in the area. This board had a person with learning disabilities on it, as well as representatives from the team.

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

We rated responsive as good because:

- The organisation worked with the clinical commissioning group to ensure the services met the needs of the local population as far as possible.
- Clinics were scheduled to meet the needs of individuals as far as possible and many patients benefitted from clinics in locations close to their homes.
- The service provided patient group activities, which enabled patients to gain social interaction as well as access to advice, education and support.
- The service received few complaints, but responded to and handled complaints in a timely manner.
- There was coordination with other local end of life care services including hospices, acute trusts and a national provider of cancer nurse services.
- Care was provided 24 hours a day, seven days per week and there was access to end of life and palliative care advice at any time of the day or night.
- The minor injury service (MIU) was planned to meet the needs of all patients, including those who were vulnerable or who had complex needs.
- The MIU was easy to access and there was sufficient car parking spaces for the number of people using the service.
- The average time to treatment was 47 minutes. Waiting times were constantly monitored in real-time by clinical staff. 99% of patients were treated, discharged or transferred within four hours in the last 12 months.
- In services for children and young people the leads were working with public health and commissioners to identify the priorities for the local population. Staff were encouraged to develop services that worked towards these priorities.

However,

- Patients were not routinely screened for dementia or referred for further assessment.
- School nursing services had a four month waiting list for children and families who needed routine support.

Our findings

Planning and delivering services which meet people's needs

- In April 2016 the organisation had been awarded the contract to provide community services for the population of North Somerset for five years beginning in September 2016. The contract is based on patient outcomes and involves the community services as part of the journey for patients to become more independent. Planning the new contract and transformation of the services to deliver the outcomes for patients focused around redesign of locality team structures. Some aspects of service detail being nonspecific within the new contract led to teams and the board needing to be innovative in understanding of how teams would need to work.
- As part of the Bristol, North Somerset and South Gloucestershire (BNSSG) sustainability and transformation programme (STP) the executive team recognise the importance of working within the scope of the plans and how the service model needed to be aligned to the wider area.
- Services were planned and delivered to meet the needs of the local communities. Within the adult community services division staff spoke about the commissioning of services to meet the needs of the people in the community. Staff spoke with passion and enthusiasm for services that they had been instrumental in developing, with the support of the clinical commissioning groups (CCG) for North Somerset. The challenges were around how soft data is collected in order to evidence outcomes. A process was described whereby in future, patient stories would be captured, as would the F&F data, staff survey data etc. The challenge was to ensure this data could be tangible.
- The organisation worked to increase the number of clinic based treatments to enable more people to access the right treatment in the right place and to reduce waiting times. This included additional weekly clinics set up in Weston-Super-Mare, for community physiotherapy. The falls service extended the number of clinics run in communities, which, as well as encouraging people to get out of their homes, also increase the efficiency of managing caseloads.

Good

Are services responsive to people's needs?

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

- A 'discharge to assess' (DtoA) pilot service was in operation to enable patients to return to their home once medically fit for discharge following a stay in hospital. The service aimed to accelerate discharge from hospital, for those with rehabilitation needs, without the limitations of accessing care packages prior their discharge from hospital. The DtoA team visited patients within two hours of discharge from hospital, assessed their needs and facilitated the delivery of specialist equipment. Community nurses or allied healthcare professionals carried out daily visits, until the patient had regained their independence or a package of care was arranged with social services.
- Specialist therapists and nurses, supported by administrators, facilitated patient group activities to meet the needs of people in the community with specific healthcare needs. We visited an exercise group for 15 people with Parkinson's disease. The group met once a week to exercise to music to enhance movement and promote wellbeing.
- The community pulmonary rehabilitation group, included education and support from staff about different aspects of living with a chronic pulmonary (lung) disease. The group was led by a physiotherapist, with extended qualifications in treating patients with chronic lung disease, a respiratory specialist nurse and an assistant therapist. The programme ran over 6 weeks and introduced patients to exercise in a safe environment under supervision.
- We attended a 'Leg Club', which was a joint venture with a volunteering committee. The leg club provided both a social and clinical opportunity for patients to attend. The club, which was run by volunteers, offered hot drinks and social opportunities for patients to sit, talk and socialise. It also had facilities, and clinical staff, to offer leg and foot dressings to four patients at once in individual clinical areas. In addition, on alternative weeks, the group offered a Doppler test, a diagnostic test of circulation in the lower limbs. Patients told us, it was a good opportunity to meet other people with similar conditions and that it got them out of the house.
- A project called 'residential home support service team' had been set up to upskill and train carers in residential homes to help with admission to hospital avoidance. The team concentrated training around the four causes of hospital admission for people in residential homes (falls, pressure ulcers, end of life care and infection) but also included diabetes, dementia, delirium and constipation. The project was due to finish in March 2017.
- We visited outpatient clinics and patient groups in different locations across North Somerset. The podiatry and lymphoedema services offered clinics in a number of areas in North Somerset, to allow patients to access the service nearer to home.
- For end of life care there was coordination with other local end of life care services including local hospices, acute trusts and a national provider of cancer nurse services. Commissioners and other stakeholders were involved in planning services. The services provided reflected the needs of patients and those close to them who were referred to the care coordination centre and the community nurse teams. They ensured flexibility of choice and continuity of care wherever possible. The strategic and locality leads had identified local challenges, such as increased availability of palliative care support workers and better education for the provider as a whole for end of life care. We were shown action plans and team reports, which took account of the challenges both within and outside of the service. These documents had been reported to the executive team and shared within clinical teams. The action plans enabled the service, to understand the challenges and the changes needed and supported monitoring of progress. The lead for End of Life Care Coordination Centre attended regional strategic meetings to inform the development of services in the region.
- The minor injury service was provided in a purpose built minor injury unit (MIU) based at Clevedon Community Hospital which had opened in 2013. MIU provided easily accessible unscheduled care to adults and children aged over 12 months with minor illnesses and injuries. The opening hours were 8am to 9pm, seven days a week, which included bank holidays. Patients told us they appreciated the short waiting times in comparison to the two local accident and emergency departments. Attendances had increased from 96 a week in 2014 to 230 a week by October 2016. X-ray facilities in the MIU were provided by a third party provider and were not always available. The X-ray department closed between 1pm and 2pm and at 5pm on weekdays. There was no X-ray service available at weekends.

Good

Are services responsive to people's needs?

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

- The Joint Strategic Needs Assessment informed the children's service managers of the local population's health needs. These supported decisions made about prioritising public health activities. For example, all staff were aware Weston Super Mare included a population of young parents living in an area of high deprivation. A health visiting team was set up to support the needs of young parents in this area.
- The service specification for school nursing and health visiting services held little detail. However, this contract had been developed by the CCG and not North Somerset Community Partnership.The level of service expected was to meet the needs of children according to the healthy child programme.
- School nursing staff had identified low attendance at sexual health clinics which were previously school based. A project had been developed to provide holistic health clinics in their place. These were held in the secondary schools and included sexual health advice, emotional health support and signposting advice to other health services. Three schools in North Somerset had these clinics in place and seven other schools had expressed an interest in offering the service from their premises. The bladder and bowel service had a four month waiting list to see children with continence problems. They offered initial support to parents by inviting parents of children who were on the waiting list to attend an information evening. This promoted a first line of action that parents could try to potentially resolve any problems.
- Sexual health services throughout the county and surrounding areas were commissioned by the local authority, local commissioning groups and NHS England. The No Worries service was commissioned as a level one service that was part of the overall provision. The size of the service, and the level of service and the frequency and location of clinics did not appear to be based on an evaluation of the needs of the population it served.

Equality and diversity

- Services took account of the needs of individual patients and staff spoke about the importance of not being judgemental in the way they cared for patients and spoke of respecting people's choices as to their way of living. The tissue viability service had developed a non-concordance protocol, which described the processes staff should follow if patients chose not to comply with their recommended treatment plans. This gave nurses a structure on which to base their decisions and clear guidance, but also allowed staff to feel safe to respect the decisions of their patients.
- Advocacy Services were available through the Patient advice and liaison service for people with disabilities and those with a physical or sensory impairment aged 18 or above who were eligible for services provided by North Somerset Council.
- Where the organisation used other locations for example for the leg clubs, the Parkinson's group and the pulmonary rehabilitation group, the premises had disabled access and parking. To enable patients to attend the leg club local company was able to pick up patients in the Weston area. Parking at the MIU was sufficient to meet the needs of patients.
- It was recognised that some parents and children would have difficulty engaging with services, which could be because of language difficulties or lifestyle. A telephone language service was used by staff to help parents with language difficulties to understand support that was available and access health care for their children. School nursing staff liaised with schools and health visiting staff used questionnaires for parents to complete and through these had learnt of parents who may have literacy difficulties. Staff could tailor their support to these families and help them to access health services

Meeting needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take account of people with complex needs and those in vulnerable circumstances.
- Within the learning disability services staff could access information to support service users and were developing more information in an easy to read format. Staff had also helped to create a website for service users in an easy to understand format. This website had information for service users, carers and professionals.
- Examples of where reasonable adjustments were made in order to help people with disabilities or learning difficulties included, space being made available for those patients who required a carer to remain with them during treatment in outpatient clinics. Disabled parking spaces were available at all main entrances of the sites we visited. GP surgeries used for patients to attend

Good

Are services responsive to people's needs?

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

clinics had lift access to the floors where services were provided and there were disabled toilets in all of the areas we visited. In the recently refurbished outpatient department at Clevedon Hospital, The area had doorframes painted in bright colours to help people who lived with dementia to negotiate the environment.

- There was an organisation priority to become dementia friendly. A dementia specialist nurse was in post and provided dementia training of all staff. At the time of our inspection dementia training compliance exceeded the organisation's target of 85% with more than 97% of staff in community adult nursing teams and urgent and specialist care teams having completed the training. In addition, the organisation's residential home support team facilitated teaching in the home to support people with late stage dementia and end of life. However, dementia screening was not embedded and we did not see any care records where patients had been referred for dementia assessment although staff were aware of signs and symptoms.
- We saw the discharge to assess team discussing a patient who was living with dementia and became upset when their door alarm sounded. The team discussed ways to overcome this for the patient whilst still keeping them safe.
- Services for children and families provided a range of ways to support people in vulnerable circumstances to access health by assessing needs, carrying out home visits and providing clinics and drop ins in local areas. Staff used a framework to identify individual needs and vulnerabilities which identified the level of support the family needed. Health visiting and school nursing staff provided enhanced visits for all traveller families on their case load using a health promotion bus, holding clinics within the traveller sites and using informal walk around visits to engage with families.
- Young parents were supported by a dedicated team of health visiting staff called the young parents team. They offered enhanced visits to parents who were under 21 years of age who were having their first baby or were in vulnerable circumstances.
- School nursing staff used health questionnaires to identify and support children who had additional caring responsibilities for a member of their family. They could offer drop ins and school visits and ensure they were put in touch with other organisations which could offer peer support for the young people.
- Staff showed an understanding of patients' support networks and packages of care were arranged to assist patients based on individual needs. There were examples where carers had asked that they support their partners both of whom were considered potentially vulnerable adults and teams had worked to keep both people supported and to enable the choices of the patient at end of life..
- The organisation had a quality priority to become a dementia friendly organisation, which included dementia training for all staff. At the time of our inspection dementia training compliance exceeded the organisation's target of 85% with more than 97% of staff in community adult nursing teams and urgent and specialist care teams having completed the training.
- In aiming to reach vulnerable people the community outreach team set up ten weekly clinics in Weston-Super-Mare for 'hard to reach' groups such as people with substance misuse, homelessness and social isolation. The service provided interventions on a range of public health lifestyle issues such as weight management, healthy eating, reducing substance misuse including alcohol, Between October 2015 and January 2016 the service received 103 new referrals and assisted 11 people to find accommodation.
- When appropriate, staff used an assessment tool, with a particular focus on a patient's mental health named the PHQ9. The outcome of this assessment allowed staff to identify if there were any additional mental health needs of the patient. Nurses then referred to appropriate services when necessary.

Access to right care at the right time

- Patients had timely access to assessment and treatment in most services.
- In community teams daily teleconference were held to review and discuss, staffing levels, caseloads and safe haven in order to reach an overview and assessment of operational pressures. Community nurses aimed see patients at times in the day or evening that suit the patient's best and worked in a three shift pattern covering from 8am to 5pm; 2pm to 10pm and 10pm to 8am in the morning. We observed nurses contacting patients to discuss when they would arrive and this system worked well. Patients we spoke to said they were generally happy with the times that nurses arrived.

Good

Are services responsive to people's needs?

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

- The average waiting time for musculoskeletal interface service from referral to treatment time was 5.4 weeks. The physiotherapy outpatient waiting list was around 18 weeks although this was an improvement as waiting times for first assessment had at times been up to 23 weeks. The service had recently filled vacancies employing two new physiotherapists and hoped this would help reduce the waiting time.
- Referral to the occupational therapists (OT) was via the single point of access team and at the time of our inspection, there was a waiting list of three to four weeks for assessment for non-urgent assessments. All referrals were triaged by an OT, which ensured timely assessment and intervention. For example, the OT team had a referral from a nursing home where there was no hoist in place to help when transferring a new patient in and out of bed; the OTs were able to assess and request appropriate aids (hoist) which was in place by then end of the same day.
- Discharge to assess service triaged referrals onto two different pathways; one for patients suitable for home based and another for patients admitted to local nursing or residential homes for rehabilitation. In October 2016, the service received 53 referrals for patients discharged for home-based rehabilitation, of which 47 patients were accepted onto the pathway. The team saw all patients within two hours of discharge for assessment and the service was available Monday to Friday. The average length of stay with the service was 20-35 days. From April 2016 to end of October 2016 the majority of patients were discharged from the service (average of 68%) with no further care needed, some were discharged from the service with a package of care (average 11 %) while 15 % (48 patients) were emergency transfer back to the acute hospital.
- The rapid response service provided care to patients in urgent circumstances for example if they had fallen - this operated 24 hours a day, seven days a week. When referrals arrived, they were triaged and allocated to staff with the correct skills.
- The falls service would see people in their own homes or within a number of clinics throughout the local area. People were able to move between these clinics as appropriate to their needs at the time. Clinics were available Monday to Friday
- Access to treatment and care for end of life was available 24 hours a day, seven days per week. End of life care in the community within patients' homes was provided by community and district nurses, other community teams and end of life care coordination centre staff. There was also access to care and advice through two local hospices who worked with North Somerset Community partnership.
- Patients being able to die in their preferred place of care varied, with data demonstrating during the period April and October 2016 between 25% and 69% of patients referred for end of life care had received care in their home. In October 88% of patients died in their preferred place. However for other months figures were lower 39% in June 2016. Figures were often influenced by availability of care, speed of referral or quality of discharge planning by other organisations.
- The MIU consistently exceeded the national standard, which requires that 95% of patients are discharged or transferred within four hours of arrival at urgent care (MIU) and emergency departments. The unit had achieved 99% against the national standard.
- All children that presented at MIU with a minor injury were initially observed on arrival by an emergency nurse practitioner (ENP) and assessed (triaged) within fifteen minutes of arrival. If the wait to be seen by an ENP exceeded one hour then children took priority over adults waiting, but this was dependent on clinical need.
- X-ray results were immediately reviewed by ENPs who had undertaken the appropriate training. This reduced delays in accurate diagnosis and appropriate treatment.
- Staff used processes of assessment to ensure children and families had timely access to services. Senior health visiting staff reviewed referrals by discussing them as a team. Children and families were prioritised and allocated visits according to their need. This included child development checks, safeguarding and visits for children new to the area.
- Health visiting teams provided access for parents by operating a 'duty rota'. This meant that a Health Visitor was available in each base from Monday to Friday, within office hours to answer any queries.
- School nursing staff prioritised needs of children using a system of triage. Information from referrals were reviewed by a senior member of the team and children were allocated to a team member for action depending on the urgency. There was a four month waiting list for children who were assessed as needing a routine appointment although staff would reassess need if further contact was made by the parent or referrer.

Good

Are services responsive to people's needs?

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

- Staff had reviewed how they offered their services to improve health outcomes. As an example, immunisation sessions were offered to children in schools during school hours but some children found these difficult to attend. New sessions in the evening were being offered for those children who found day time sessions difficult to attend.
- The No Worries service recorded the number of monthly contacts with young people and the reason. Over the three most recent months there were between 80 and 138 contacts recorded for each month. In the most recent month for example it was recorded there were 17 new contacts, 23 re-visits and 98 outreach contacts.
- Young people were able to approach school nurses for sexual health advice. Cascaded training was provided to them by the lead nurse form the No Worries service. The school nurse could signpost people to other services if required.
- Access to urgent referrals for the learning disability service were at 100% against the in the year before October 2016. The average wait for assessment after referral was 11 weeks in that time period and the service reported meeting the two week target for completing a formulation of the persons care needs after the initial assessment. However, there were 20 service users (correct as of the beginning of November 2016) that had been waiting longer than their target wait. Waiting times were recorded as a risk on the risk register and they were trying to recruit more staff, as well as re-organise in order to help address this.

Complaints handling and learning from feedback

- People's concerns and complaints were listened and responded to in a timely manner and learning from these were used to improve quality of care, however there was a lack of training for investigators and some responses lacked compassion and individuality.
- A structure for monitoring and management of complaints was in place. However, there had been no training for investigators for over two years and no template or checklist for what needs to be covered to both guide the investigator and provide consistency. The investigator is not required to provide an investigation report.
- The complaints governance arrangements as described in the policy are not embedded in practice. Learning and actions from complaints are considered at the quality committee with a plan to review this as part of the governance review. Staff we spoke with in services were aware of learning and feedback from complaints.
- There were 31 complaints between August 2015 and August 2016. Nine of these complaints were upheld, two were partly upheld.
- In the seven files we reviewed, outcomes and learning were not clear in the final response letter to the complainant as required by the policy. The complainant was not told if their complaint was upheld or not which was a requirement in the company policy.
- Final letters demonstrated variances of compassion and concern in the language used and there is no standard format for the final letter or the acknowledgement letter.
- Complaints were discussed in different meetings at different levels from board meeting to team meetings; this meant that staff across the organisation was aware of people's complaints and any changes that was made as a result of patient's complaints. For example, the development of the tissue viability service demonstrated where the organisation had learned from complaints
- Staff told us complaints or concerns about their service were shared with them and any learning from them discussed at team meetings. It was unclear if there was a system to monitor, if any new practice put into place following a complaint, was embedded in practice.
- Patients were provided with information about how to make a complaint or raise a concern and information was available on the organisation website. Contact details were available and located on the front page of the patient care record, kept within patient's homes. Where clinics were held in GP practices, we did not see clear information about how patients could make a complaint about the care and treatment they received from staff from the organisation.
- In one example the provider had received a complaint about end of life care. We saw evidence of discussion about the identified service gaps the complaint had brought to light and outlined the actions taken to improve the service. Changes included: the appointment of a lead nurse for end of life and palliative care, improved pain management policy and

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assessment tools approved by the clinical cabinet, a programme of staff training, and the provision of the syringe drivers directly within teams rather than contracted from another provider.

Are services well-led?

Good

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Summary of findings

We rated well led as good because:

- Staff were proud to work for the organisation and liked their roles. They felt they could feed issues up to senior managers and executives and they were listened to at board level.
- The challenges of changes at executive level were recognised and much work was underway to ensure a cohesive team which was visible and accessible.
- Public opinions were sought in a variety of ways which was suitable for the service they offered and where possible changes were made in response to comments.
- Staff were keen to improve services and acted on ideas for improvement.
- Staff engagement was recognised as key in the employee owned organisation with the staff council being at the heart of plans going forward.
- Staff had good practice recognised in the organisation's quarterly magazine and by receiving awards for specific achievements.
- Staff felt supported by their managers and team leaders and felt positive about the new executive managers in place, which they hoped would create stability, and support innovation.

However:

- Some areas were working long hours to provide a safe service and were gaining support from their immediate team but could see no way of the situation improving.
- The No Worries service did not have a formal strategy for the development of the service over the term of the newly acquired contract.
- The No Worries service was commissioned as level one service and meetings were held with the commissioners but the service specification had limited detail. The size of the service, and the level of service and the frequency and location of clinics did not appear to be based on an evaluation of the needs of the population it served.

Our findings

Leadership

- 2016 was a time of change for the leadership of the organisation. Whilst the non-executive directors and chair had been with the organisation since it came into place in 2011, the last year saw various changes to the executive team. The most long standing executive being the director of finance (5 years) with the director of nursing and therapies being appointed in April 2016 and the chief executive in September 2016. Interim positons for the director of operations and company secretary were currently in place at the time of our inspection. There was recognition that the changes in the executive team and a high number of interim posts had meant a lack of decision making from senior management team and the risk of lack of organisational memory. This is clearly recognised by the executive team with the chief executive taking steps to ensure a cohesive approach. The board members described good open relationships between the new and existing members with challenge and support being key to forming the relationships.
- The timing of the new contract in April 2016 placed a challenge on the executives and board in forming a unified team, getting to know the organisation and its staff while delivering against the new contract and implementing new ways of working. The team are sighted on the challenges and are 'getting on' with the next steps in stabilising the organisation to deliver.
- All leaders were described by staff as visible and approachable and encouraged appreciative supportive relationships within teams. Community staff we spoke with felt part of the overall end of life and palliative care service.
- Staff felt positive about the new executive team and many services had had a recent visit from members of the executive team. The executive leaders had demonstrated a real interest in staff's jobs and the challenges within the different roles.
- There was recognition that the changes in the executive team and a high number of interim posts had meant a lack of decision making from senior management team.

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Staff told us that although the services had carried on providing care, there had not been as many new projects or initiatives as these depended on 'sign off' by senior management.

- Managers and leaders of services had the skills and knowledge to carry out their role. Many of them had worked within, or at similar services and so had a working knowledge of the practices of staff.
- Staff said their immediate managers were supportive, approachable and accessible and they felt they were represented at board level. Information was cascaded to and from the executive team through managers at team meetings and by e mail for those who could not attend the meetings. Staff were clear about how and when they could seek advice from their managers.

Vision and strategy

- The North Somerset Community Partnership CIC five year strategy for 2016-2021 was 'Together we can do more….' which sets out the vision to provide healthy communities where people are cared for close to home and supported to maintain their independence and promote peoples wellbeing. The strategy is aligned to the five year contract awarded to the organisation in April 2016 and has a focus of working with partners and the voluntary sector in North Somerset, moving from illness management to early intervention and prevention keeping people healthy in their own environment. Key to the strategy are the aims of developing quality care through a trained and supported workforce who are employed by an organisation which has financial resilience and, delivers services efficiently through partnership working to identify opportunities for new or changed services.
- There were clear organisational values, which included quality care, respect, working in partnership, effectiveness and with integrity. Staff were aware of the values of the organisation and some staff we met with had been involved with project work, where the values were developed. We saw these values in action when we observed staff caring for patients. The values were also embedded in the recruitment process, the aim being to recruit staff with the same values. These values promoted quality of care, delivered in a compassionate way.
- The new executive team was in the process of introducing a new model of care which focussed on a whole system approach. Staff in leadership roles were aware of the new model of care, whereas the majority of staff, although aware, did not engage much as they 'just carried on doing their job' and did not feel that it had an impact on the way they were working. Many specialist services already supported the new model of care for example, the patient groups for Parkinson's, the pulmonary rehabilitation group and the leg club.
- The organisation had six clear quality priorities to develop services. These priorities arose from previous serious incidents and complaints and from a commitment to meet the health and care needs of the local population, through working with local NHS hospitals and meeting targets set by the local clinical commissioning group.
- There were quality improvement priorities and staff engagement to achieve this was clear. For example, the work of the tissue viability service to reduce the prevalence of pressure ulcers and the innovative ways of working by the outreach team to reach out to 'hard to reach' groups in the local area.

Governance, risk management and quality measurement

- The governance framework supported the delivery of safe and effective care by measuring progress of key indicators. An electronic system was being introduced to measure effectiveness but there had been some discrepancies between electronic and manually held data. The manual data was being used as the accurate measure and electronic data collection was being analysed to ensure it could be collected accurately. This data was presented to executive teams and commissioners every three months.
- The governance and quality committee was chaired by a non-executive director and oversaw the quality and safety agenda for the provider. There were sub committees that fed into the overarching committee. The quality and governance team monitored and reported through the relevant groups to the governance and quality committee. Information such as current performance, learning from complaints and patient stories where case studies were discussed to highlight good practice and areas for improvement. Assurance and review of risk was scrutinised through regular reports on safeguarding, infection control, complaints, clinical audits and the quality report. With these reports

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being supported by the quality dashboard for monitoring of trends. Some further work on quality of data captured in the dashboard was recognised although improvements in this were evident from earlier versions. Serious incident investigation and associated action plans were reviewed at the quality and governance committee.

- The clinical cabinet, which is chaired by the director of nursing and therapies, provides approval and support for clinical policies and standard operating procedures (SOPs, review of root cause analysis investigations ensuring learning is implemented and review of the corporate risk register. Attendance by clinical leads across the services ensures a focus on clinical issues and enables feedback and sharing of learning.
- The quality priorities are clearly articulated in the 2015/16 quality account and were reflected in the services.
- The clinical audit programme set out a schedule of different audits including audits to measure compliance with national guidelines, infection control and documentation. Outcomes from audits were discussed in relevant meeting such as 'clinical cabinet' meetings and quality committee meetings. However, we reviewed minutes of clinical cabinet meetings and found audit compliance was not a set agenda item although it was noted in the minutes of the meeting held in October 2016 that the results of the NEWS audit was noted and areas for improvement was highlighted.
- An annual complaints report is produced however changes made as a result of complaints and lessons learnt is not clear or specific.
- A corporate review of committees was underway with the recognition that frequency of board meetings should increase from three monthly to monthly.
- The board assurance framework reflected the high level risks which were: services for children and young people where changes to the Public Health funding were having an impact across staffing numbers, recruitment and retention, lack of mobile working and risk of the transformation programme not proceeding at required pace and scale affecting efficient and effective service delivery. In response to the staffing risk an additional £385K had been invested in staffing budgets and the board were maintaining oversight through staffing and recruitment being on the risk register and board assurance framework. Further data for analysis of team capacity was due in early 2017.
- The clinical services reported via locality leads to the director of operations with data contributing to the regular performance report. The integrated performance report provided oversight of services and assurance of meeting the contract CQUINs.
- There was lack of a robust system to flag when compliance with mandatory training was below the target to ensure staff were reminded and able to complete training. Some managers were not aware of when staff required training despite the flagging system being in place.
- The move towards more mobile working was at times hampering staff in being able to access information in a timely way and adding additional hours to the working day. The board recognised the need for this to be resolved as being key to the transformation and new ways of working.
- There was not a designated risk register for the No Worries service. However there were identified risks that had been discussed with the line management and also the business manager for the service.
- The organisation was unaware of some governance issues in relation to medicines in the minor injury service.
- Leaders in services were clear about their roles and they understood what they were accountable for.
- There was a clear process for the reporting of, feeding back and learning from adverse incidents. We spoke to staff with varying levels of responsibility within this process. It was clear that the system was embedded and staff were confident in its use. We saw evidence that learning was discussed and shared at board level. We also reviewed minutes of meetings and found that patients' experiences – both good and bad experiences – were discussed and evidence that the outcomes were shared with members of teams. We reviewed minutes of staff meetings in relevant services and we were able to corroborate the evidence and we were assured that learning from patient experience was shared at all levels and across the organisation.
- Governance of complaints requires some improvement for a review of the policy, training for investigators, implementation of a learning tool, template and protocol for investigations and a change in written style of the final response letter. Meetings with complainants were not actively sought from an early point, only if the complainant was not happy with the written response.

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Culture across the provider

- There was an open and supportive culture within the organisation and staff were keen to learn from colleague's experiences.
- Candour, openness and honesty was expressed in all services and teams and demonstrated through response to complaints and incidents for example. Incidents were discussed at team meetings and actions for learning were shared.
- There was an emphasis on promoting the safety and well-being of staff. Staff had access to an employee assistance scheme (a partnership service with staff employed by healthcare organisations) which offered different kind of support, such as counselling, to staff free of charge.
- The services had embedded 'lone working' practices supported by the organisations 'lone worker policy'. Staff said they felt safe and if they had concerns about visits, these concerns would be listened to and would be actions taken to ensure their ongoing safety. Staff were required to phone a designated member of staff each morning, at the end of the shift and following a visit to a difficult patient or family. Also a process was in place to ensure contact was made with staff if they had not phoned. Electronic recording systems showed alerts, for example the need for two nurses to visit, if there were any safeguarding incidents, dogs at a property or there was a key safe. There were processes in place if a member of staff needed immediate assistance and the service worked with 'Care link' for monitoring of staff's safety for those working evenings or overnight.
- The organisation had a staff council whose aim was to represent the views of staff in a forum that could be heard by the executive team. Staff were aware of the council and told us the council was in the process of being reinvigorated after having suffered a lull in recent times. There was also a drive to be more open at board level with it being available for staff to attend and ask questions.
- Responses from the staff survey demonstrated staff felt they worked well in teams. 63% and were 'extremely likely' (17%) or 'likely' (46%) to recommend the organisation as a place to work to friends and family.

Fit and proper person requirement

- The organisation was subject to Regulation 5 of the Health and Social Care Act 2008 which states that individuals in authority (board members) in organisations that deliver care are responsible for the overall quality and safety of that care. The regulation is about ensuring that board members are fit and proper to carry out their role.
- The organisation had a policy in place to ensure recruitment processes were in place that took account of the requirements of the regulation including checking of skills, knowledge experience and integrity of board members. We reviewed five personnel files for current directors and saw that this process had been completed.

Workforce Race Equality Scheme

- The Workforce Race Equality Standard requires NHS Trusts and independent acute healthcare providers where annual aggregated income from NHS-funded care is at least £200,000 to demonstrate progress against nine indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation. The Equality Delivery System 2 (known as EDS2), was designed to review and improve organisations performance for people with characteristics protected by the Equality Act 2010. Providers must collect, report, monitor and publish their WRES data and take action where needed to improve their workforce race equality.
- Reporting requirements as set out in the Workforce Race Equality Standard were met by the organisation with a report and action plan to ensure ongoing compliance with the workforce race equality standards. The report was available on the public website and held information about employment equality with the associated action plan being presented at the board meeting in July 2016.
- There were 680 full time and bank members of staff employed at the time of our inspection of which 1.8 %(15) were staff of black or minor ethnic origin (July 2016). The providers did not report WRES data per locality or service.
- We did not meet with any staff from ethnic minority groups during the inspection.

Public engagement

- The views and experiences of patients and those close to them who used the service were gathered and acted

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upon to shape and improve services. Patient stories were used in board meetings to highlight particular issues and to encourage staff to be more aware of end of life and palliative care at all levels of the organisation.

- Results for friends and family tests were positive with community adults, MIU and children services obtaining 99% in patients recommending care from the organisation. Patients could provide feedback either at every contact, on discharge from a service via a mobile device, return of prepaid cards or using the link on the provider web site. Children were able to feedback using suitable evaluation forms which used a number scale and smiley faces and simple questions. One change put in place was for school entry health assessment appointments to increase from 15 to 20 minutes.
- A patient and public involvement strategy was in the process of being developed to underpin the ongoing work with a focus on reviewing how to use feedback obtained to engage with patients and review available patient information. Alongside this was an understanding of the patient groups which may be hard to reach such as teenage parents and feedback form bereaved families. A plan to engage with local stakeholders in early 2017 was being considered.
- Involvement of patients took several forms such as in recruitment of staff in the learning disability and health visiting teams and using patients from the pulmonary rehab programme to speak to new patients to the group.

Staff engagement

- Throughout the process of securing the contract in April 2016 the organisation was proactive in seeking views from staff with the transformation team leading on some activity to engage with staff through a range of groups and pilots. Staff were kept informed of changes and progress with the transformation agenda with weekly bulletins and some FAQs (frequently asked questions). There was a staff engagement strategy in place containing an action plan which was presented to the board in May 2016.
- As a social enterprise the company staff are able to become shareholders which entitles them to attend board meetings. This is seen as a positive and staff were described as 'having a buzz' about the reality that the executive team talk about things that are important to them.
- The staff survey 2015, published in May 2016 had a response rate of just 37% in comparison to the previous year. Improvements from the previous survey were seen through staff having the tools, equipment and facilities to carry out their job effectively, delivering value for money services and being treated fairly if staff were involved in an error, near miss or incident. Areas of lower scores were seen including being involved in making suggestions and making decisions where changes affected their work. The substantive changes in executive leadership roles was reflected with staff responding they did not always know who the new leaders were, communication was not always good between teams and leaders in the organisation did not always give a high priority to patient care and providing quality services.
- The staff council had seven staff representatives with a new chair elected recently. The council are planning a refocus on their purpose to represent staff at all levels. The council are clear on the need to ensure a focus on the values across the organisation and that staff understand their role as a shareholder and the strategy of the organisation. Work to re-energise the council was now underway, with an emphasis on ensuring representations across the localities.
- The organisation awarded individuals and teams for exceptional commitment, care, compassion, competence, courage and communications. An award ceremony was held and a booklet setting out the winners was widely available to enable sharing the achievements of individuals and teams achievements. The community outreach team won the 'partnership and patient and public involvement award' and the lead intravenous nurse won the clinical excellence award for receiving the most nominations from patients. The deteriorating patient's group' won the patient safety award for implementing an early warning score tool across the organisation to support staff in early assessment and treatment of patients at risk of clinical deterioration.
- Staff were kept update through the monthly managers newsletter which allows for communication of key workforce information to all line managers, including updates from Workforce Development Forum, JUMP and dissemination of information linking to key initiatives e.g. health & wellbeing CQUIN

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- Staff were involved in the interview process for the new chief executive to assess the presentations based on key areas/criteria. Other staff members were recruited to be part of focus group discussions.
- The importance of engaging with staff has been set out in a plan presented to the board in September 2016. This places the staff council at the heart of staff engagement with actions around a listening approach, communication, staff focus groups and the board visits to teams and developing existing forums such as the 'ideas factory' where staff can bring ideas and innovations for service redesign support.

Innovation, improvement and sustainability

- The staff awards recognised staff achievements and innovation across all services.
- The bladder and bowel service received an award for parent information evenings. This was an initiative that provided information for parents whose children were on the waiting list for the service and could prevent an unnecessary appointment. Health visiting staff in Weston Super Mare received an award to recognise their work in supporting vulnerable families.
- Support for children with medical needs in schools had been reviewed and was being delivered in a way that was more sustainable. Support to each of the schools on how to manage conditions such as asthma, epilepsy and severe allergies was being offered at an annual training day instead of at individual school locations. This had proved to be popular with school staff and well attended.
- A consultant nurse led a project aimed at leading innovation and quality improvement in care for older people and sought to develop a wider approach to diagnosing and managing frailty in specific area within the community.
- A specialist nurse was involved with a research project to detect hyperglycaemia (high blood sugar) in cancer patients receiving a specific medicine (Dexamethasone).
- The tissue viability service was trialling a new dressing system, which was an alternative to compression dressings. The device enabled nurses apply a more consistent approach to treatment, and had proved effective at healing leg ulcers. Although the device had a larger outlay at the start of treatment, the service had estimated savings at £17,000 on dressings per team where this device could be used. It also estimated a cost saving of £6000 in nurse's time per team.
- The Speech and Language Therapy (SALT) service intended to carry out a training programme in 2017 within care homes. The service recognised that staff frequently changes within care home settings so this training was to be delivered three times a year.
- Diabetes UK initiatives were followed by the tissue viability service in relation to identifying the need for foot care for people with diabetes. The team requested all staff use the 'check, protect and report' method as well using stickers in care records to highlight the need to check patient's feet. We observed nursing teams using this system during home visits.
- The end of life care coordination centre had established a library of books in each of the eight teams (for example learning disability, community nurses). This had been enabled by money raised by friends of a patient. They covered all children's age ranges who might be affected by a death in their life.
- The minor injuries unit had implemented intranasal pain control for children, which enable analgesia to be administered in a timely and painless way and with the minimum of disruption to an already distressed child. The medicines management committee had worked closely with the clinical leads to develop protocols and standard operating procedures (SOP) to ensure the appropriate administration of intranasal pain control.
- Making every contact count was a new model of care. Where previously the focus was to support a patient when they were unwell for the new approach of 'making every contact count' the focus was to be on 'when well-keep well'. This approach identified other points of contact, referral and advice which could be accessed to maintain patient independence in their own home and the community and avert admission to hospital. The outcomes would be evaluated over time as the non-occurrence of an event such as admission to hospital would be the measurement of success.
- At the time of inspection Clevedon Community hospital was closed for refurbishment. With plans for it to reopen in the spring of 2017 there would be a reduction in the number of beds from 17 to 11 and a focus on the rehabilitation pathway. The community hospital staff had in the meantime been transferred to be part of the discharge to assess team. The impact on this team once the community hospital reopened was not clear.
- An insulin passport had been introduced as a result of an incident. The passport enables an accurate record for

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staff and information acts as an indicator for further action by clinical staff. Reported incidents related to insulin have reduced from 21 to four since the passport was introduced.

- A joined up approach to medicines incidents to improve learning allowed GPs or pharmacists to report incidents and forward the detail to the relevant organisation.
- Clevedon hospital which was undergoing refurbishment was planned to reopen in the spring of 2017 with more of a focus on rehab beds which can move patients through the system quickly. This is part of the discharge to assess programme.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** **12 – (2) (a) Assessing the risks to the health and safety of service users of receiving the care or treatment:** • Staff did not always identify and responded appropriately to patient risks. We saw records of care where not all of the required assessments such as Waterlow score (a risk assessment tool to assess a patient's risk of developing pressure ulcers), malnutrition universal screening tool (MUST a tool used to assess patient's risks of malnutrition) and frailty assessment, had been recorded. **12 – (2) (h) Assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated:** • At the community leg club staff were using a disabled toilet as a preparation area for leg baths. We were told that staff cleaned this area using appropriate cleaning fluids at the end of the club. However, it was not cleaned prior to use. When not being used by the leg club, the facility was open to the public for various other functions. Therefore, the service could not be assured of the cleanliness of the facility prior to its use. The leg club had an infection control risk assessment that included the cleaning regime. However, this did not identify that the toilet should be cleaned prior to its use.

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Requirement notices

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18 Staffing 18 (2) (a) Persons employed by the service provider in the provision of a regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as necessary to enable them to carry out the duties they are employed to perform:

This section is primarily information for the provider

Requirement notices

18 (1) Sufficient numbers of suitable qualified, competent, skilled and experienced persons must be deployed.

- Health visiting teams had higher numbers of children on their caseloads than recommended by the Community Practitioners and Health Visitors Association. Some localities had very high numbers of children who needed additional support. This meant there were insufficient staff and led to health visiting staff working beyond their contracted hours to provide a safe service and there was little capacity for unexpected and sudden staff absence. The impact was that not all children received the universal service as outlined in the health child programme to ensure healthy outcomes.