Sirona Care & Health C.I.C.

1-290660061

Community health services for children, young people and families

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-297411781	St Martins Hospital	Children young people and families	BA2 5RP
1-297411781	St Martins Hospital	Patchway Children's Hub	BS34 5PE
1-297411781	St Martins Hospital	Kingsway Children's Hub	BS2 8BJ
1-297411781	St Martins Hospital	Cadbury Health Centre	BS30 8HS
1-297411781	St Martins Hospital	Yate West Gate Centre,	BS37 4AX
1-297411781	St Martins Hospital	Thornbury Health Centre,	**BS35 1DP**
1-297411781	St Martins Hospital	Osprey House,	BS14 0BB.
1-297411781	St Martins Hospital	Eastgate House	BS5 6XX
1-297411781	St Martins Hospital	Westgate House.	**BS10 5LT**

This report describes our judgement of the quality of care provided within this core service by Sirona Care & Health C.I.C.. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by Sirona Care & Health C.I.C. and these are brought together to inform our overall judgement of Sirona Care & Health C.I.C.

Summary of findings

Ratings

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

Summary of findings

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Overall summary

We rated children young people and families services, overall, as good because:

- There was a positive culture around incident reporting which helped promote learning and service improvement for children and families. Staff said they received feedback from reported incidents when this was appropriate and were told what actions were taken.
- There were arrangements in place to safeguard children from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and were aware of the provider's policies and procedures.
- People's needs were assessed and care and treatment was delivered in line with legislation and evidence based guidance. We saw numerous examples of best practice being identified, shared with colleagues and delivered.
- There were some outstanding examples of the planning for transition being undertaken. This included the Lifetime service who undertook planning for transfer to adult services and the Bath & North East Somerset (B&NES) speech and language team who were providing transition reports for people with autism moving into further education or going on to university.
- The provider encouraged innovative practice. One of the school nurses had developed an app to help young people make informed choices regarding sexual health and contraception.
- We observed care, support and advice being delivered by a variety of staff in a compassionate and caring manner at all the locations we visited. We had feedback and comments from children and families that was positive about the staff they received a service from. People told us that staff took the time to explain and ensure they understood the care and treatment they were involved in providing.
- The services which Sirona were commissioned to provide were planned to meet the needs of the local population. For example Sirona, as part of the Community Children's Health Partnership, had worked with a charity in developing a participation strategy. This strategy outlined how children, young people and their families could be involved with service feedback, development and improvement.
- The Lifetime service provided specialised, highly valued care and support to approximately 250 children with life limiting conditions and their families over a wide geographical area. This included some outstanding practice around advance care planning for children and families.
- Sirona had a vision and set of core values that were well promoted and known to staff. Staff were proud of the organisation and the services they were involved in providing. Because the transfer of the Community Children's Health Partnership had only taken place on an interim basis, Sirona and the other partners had not introduced a new service vision and strategy. Instead, they were focusing on continuing to deliver the service while the contract tender process was being completed.
- There were numerous examples of staff engaging with the users of services to gain feedback and use this information to influence service development.
- We saw examples of teams and individuals engaged in improving their services and its delivery through research and the sharing of learning and participating in innovative projects.
- However:
- There were some shortfalls in the safeguarding training updates being completed by some teams.
- The support staff working within the Lifetime service were being trained to safeguarding level two when the national recommended level for staff lone working in this type of situation is level three.
- We saw examples where staff were not following the required infection control protocols.
- There were shortfalls in the systems for storing of medication used by the sexual health nurses working in the schools.

Summary of findings

- There were inconsistencies in the use of risk registers and the understanding of the process for escalating concerns.

Summary of findings

Background to the service

Sirona Care and Health CIC (community interest company) provided a range of community based services for children, young people and their families across the B&NES (Bath and North East Somerset) area, North and West Wiltshire and parts of Somerset and also, from April 2016 for twelve months, services in South Gloucestershire and Bristol. The two areas have separate teams for all the services with a registered manager, the Head of Childrens services, having overall management responsibility for all the services.

The services provided were health visiting, family nurse partnerships, 'looked after children' (LAC) services, community paediatrics, school nursing, speech and language therapy, safeguarding, paediatric audiology and children's health. There was also the Lifetime service which provides support, care and treatment for children with life limiting conditions. This was provided across the B&NES area the Mendip area of Somerset, South Gloucestershire, Bristol and North Somerset.

We also inspected sexual health services provided by Sirona in Bath and Keynsham. Under CQC methodology sexual health services under a certain size are reported on within the main report of the connected core service.The sexual health services sat within the healthy improvement division of the organisation. The service was registered to provide the following registered activities: diagnostic and screening procedures, treatment of disease, disorder and injury, termination of pregnancy and family planning. The registered location was at Riverside Health Centre. The school nurses provided a drop in service for young people at schools and colleges to receive contraceptive and sexual health services.

Our inspection team

Chair: Julie Blumgart, invited independent chair

Team Leader: Amanda Eddington, inspection manager

The team included a CQC inspectors and three specialist health professionals with experience in children and family services and also sexual health services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting the services, we reviewed a range of information we hold about the organisation, asked the provider to send us a wide-range of evidence, and asked other stakeholder organisations to share what they knew. We carried out announced visits on 19, 20, 21 and 22 October 2016.

During this inspection, we visited a number of locations across the Bath and North East Somerset area, (B&NES) and the South Gloucestershire and Bristol areas. We

Summary of findings

spoke with approximately 55 staff including senior managers, nurses, therapists, administrators, psychologists, doctors and health visitors. We spoke with 10 parents and 5 young people. We also held focus groups for Sirona staff.

We observed staff practice in clinics and with the consent of patients, in patient homes. We looked at 35 sets of clinical records and also other records relating to staff training, the auditing of services and various service specific reports.

What people who use the provider say

People who used the services reported on in the children's and young people's report told us they were treated with respect and that services were responsive to their needs. People told us they were involved in planning and discussing their care and treatment and that confidentiality was respected. We were told that sufficient information was provided by the services being accessed. Parents and children we spoke with were positive about the approach of staff and the way they were treated.

Good practice

We found two examples of outstanding practice. This was the transition planning for young people being undertaken by staff in the Lifetime service and the planning of advance care plans and the support of families in completing these by the Lifetime staff.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider must take to improve:

- The provider must ensure that staff complete their adult safeguarding updates within the required timescales.
- The provider must ensure that care staff working in the Lifetime service complete level 3 children's safeguarding training as per national guidance.
- **Action the provider should take to improve:**
- The provider should review the system and practices in place within the school nursing service to ensure medicines are stored securely at all times.
- The provider should review the use of abbreviations within patient records in the sexual health service to ensure that all staff understand the meaning of the records.
- The provider should review the completion of medical records within the sexual health service to ensure they are all maintained appropriately.
- The provider should ensure that staff are aware of their infection control procedures and that these are followed. They should ensure that all equipment being used is cleaned in line with guidance. The provider should review the guidance provided to staff on how to clean reusable equipment, specifically when washing tourniquets.
- The provider should review the opening and access times of sexual health clinics to ensure they meet the needs of local people.
- The provider should review the environment in the waiting room for the sexual health clinic at the Riverside Clinic.
- The provider should ensure there is consistent understanding of the process for getting issues or concerns reported onto the provider risk register.

Good

Are services safe?

- The provider should review the systems in place to ensure all staff know how to respond to emergency alarm bells within the sexual health clinic setting.
- The provider should consider monitoring patients who attended a CASH clinic and were not able to be seen and how this equated to the outcome for the patient.

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of the children and young people's services as good. This was because;

- We judged that overall harm free care was being provided. There was a positive culture around incident reporting which helped promote learning and service improvement for children and families.

  Staff said they received feedback from reported incidents when this was appropriate and were told what actions were taken.
- There were arrangements in place to safeguard children from abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and were aware of the provider's policies and procedures. Staff were completing training that was being audited and monitored. The providers safeguarding children's policy had been reviewed in April 2016 and during induction all staff members received safeguarding children training at level 1.
- At the clinics we visited we saw that safe and child friendly environments were maintained. Rooms being used for baby feeding hubs and drop in sessions for parents were clean and comfortable.
- Records were written and managed in a way that kept people safe and protected confidentiality and were regularly audited and where required improvements made.
- There were systems in place in the different teams and services to manage and plan caseloads. Whilst there was an increased demand for many services staffing levels were maintained with the minimal use of agency staff. Staff we spoke across the services told us their workloads were generally manageable apart from in the Community Children's Health Partnership (CCHP). Staff there told us they felt their workloads were becoming difficult to manage. This was particularly the case with health visitors and the family nursing partnership team.
- The various services and teams had business contingency plans in place to respond to emergencies and other major incidents.

  However:
- There were some shortfalls in the safeguarding training updates being completed by some teams.
- The support staff working within the Lifetime service were being trained to safeguarding level two when the national recommended level for staff lone working in this type of situation is level three.
- We saw examples where staff were not following the required infection control protocols.
- There were shortfalls in the systems for storing of medication used by the sexual health nurses working in the schools.
- Abbreviations were being used within patient records in the sexual health service which were not all understood by staff.
- Not all medical records within the sexual health service were maintained appropriately.

Good

Are services safe?

- The infection control policy and procedure in use in the sexual health clinics did not provide guidance or advice for staff on how to ensure the washing procedure for reusable tourniquets was of a sufficient standard to promote the control of infection.
- In the sexual health clinics there had not been a training drill for staff to ensure they would know the correct action to take in the event of a panic button being activated, meaning there was a risk that the appropriate course of action would not be taken.

Safety performance

- The services were monitoring safety effectively and we saw evidence that learning occurred when things went wrong. A range of safety information was being monitored and fed into service improvement.
- There had been no serious incidents (SIRI) reported in respect of the children and young people's services during the twelve months prior to our inspection. SIRI events are serious incidents requiring investigation. There had also been no never events reported. Never events are incidents determined by the Department of Health (DoH) as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.
- The provider had an electronic adverse incident reporting in place and all staff, we spoke with, were aware of how to use this system and report incidents. Managers and staff told us how reported incidents were discussed at team meetings and that feedback was generally provided.
- The health visitors working for Sirona as part of CCHP received regular feedback on serious case reviews through team meetings and safeguarding training.
- Not all managers responsible for undertaking root cause analysis investigations had received training. One manager we spoke with said they would be responsible for undertaking root cause analysis investigations, however they had not received any training to ensure this was completed to a good standard. A toolkit was available to assist staff, but there did not appear to be any training available.

Incident reporting, learning and improvement

- There was a positive culture around incident reporting which helped promote learning and service improvement for children and families.
- Staff we spoke with said they received feedback from reported incidents when this was appropriate and were told what actions were taken. One health visiting team had a number of reported incidents around communication shortfalls with community midwife teams. Meetings were arranged between the two services and an action plan put into place to improve. On-going liaison meetings were also planned to monitor the situation. Learning from incidents was shared across the service with reported incidents being discussed at managers meetings and information being disseminated throughout the different services. Several staff commented that the sharing of this information was one of the positive aspects of the multi-disciplinary links there were in the children's services.
- Within the sexual health service learning from incidents was shared at team meetings and recorded in the minutes of those meetings. We were provided with examples of when learning from an incident had changed practice. For example, additional time had been provided to clinicians for the checking of results together with more support from the administrators to follow up on delayed results.
- A new PGD had been developed and presented to the medication management group of the organisation for approval. This was to ensure that recommended first choice medication could be provided to patients. There had been an incidence when a patient had attended the clinic and not been able to be provided with the recommended treatment for their needs and had received the second line treatment.

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 a provider 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 provider had a policy in place in respect of this regulation.

- The managers of the different services we spoke with were aware of this regulation and could explain their responsibilities in relation to it. Staff spoke of their practice of being open and transparent with the families they worked with. We saw evidence from team meetings that the Duty of Candour legislation had been discussed with staff, though no specific training had been undertaken. A team leader from a health visiting team gave two examples of how they had contacted families to explain and apologise, once for a late appointment and once for an issue around communication.
- We saw that two complaints had been made by patients regarding the sexual health service within the last year. Records showed that the complaints had been investigated and apologies made to the patients concerned. One patient had declined the offer of the apology in writing and had been satisfied to hear the outcome of the investigation into their complaint verbally.
- Staff were knowledgeable and aware of the requirements of the Duty of Candour legislation and we saw posters containing information regarding this in offices used by staff. The Sirona intranet site also had a page dedicated to the Duty of Candour and 'saying sorry', which gave staff a quick reference source.

Safeguarding

- There were arrangements in place to safeguard children form abuse that reflected the relevant legislation and local requirements. Staff understood their responsibilities and were aware of the provider's policies and procedures.
- Staff were completing training that was being audited and monitored. We found high levels of training being completed in some teams but not all. For example in the B&NES health visiting and administration team there was 100% completion of safeguarding training. However, the support staff working within the Lifetime service were being trained to safeguarding level two. The national recommended level for staff lone working in this type of situation is level three.
- The Sirona safeguarding children's policy had been reviewed in April 2016. During induction all staff members received children's safeguarding training at level 1. This provided them with a range of information including how to access the South West child protection procedures. Level 1 is provided face to face at induction and subsequently by e-learning. Level 2 training was delivered as part of a 3 yearly mandatory training cycle. The latest figures for level 3 training showed that 79% had completed the training at the current stage of the training cycle. The previous year showed the completion rate for all services at the end of the year had between 98% and 100%.
- Not all staff were up to date with children's safeguarding training. Only two members of staff in the family nursing partnership were required to complete safeguarding children level one training. Neither had completed this since 2014. However, the remaining six members of the team were up-to-date with their safeguarding training, including level three children's. Only 37 of the 52 (51%) staff in the CCHP community paediatrics team had completed level one, although 16 out of 21 (76%) had completed level two and 75 out of 81 (93%) had completed level three. In the South Gloucestershire school nursing team, only two out of seven (29%) staff had completed level one training, but four out of five (80%) had completed level two, and 14 out of 17 (82%) had completed level three. All six of the South Gloucestershire health visiting team had completed level three training, and none were required to complete levels one or two.
- Not all staff were up-to-date with adult safeguarding training. Three members of the family nurse partnership team in the South Gloucestershire team (33%) had not received adult safeguarding training since 2014. Only 50 out of 121 (41%) staff in the CCHP community paediatrics team had completed level one and only 16 out of 53 (30%) had completed level two. For school nursing in South Gloucestershire only seven out of 22 staff (32%) had completed level one,

and three out of seven staff (43%) had completed level two. In the South Gloucestershire health visiting team, three out of five staff (60%) had completed level one, but the only person requiring level two had not completed it.

- Staff were supported through a structured approach to safeguarding supervision. This was provided regularly and from appropriately qualified professionals. In the B&NES health visiting and family nurse partnership teams safeguarding supervision was provided every four to six weeks. The managers were also provided with the same frequency of supervision. We saw the records that showed over 90% of sessions were being completed. A new prescriptive formula had been introduced in 2015 that ensured that the supervision was included as part of the line management arrangements.
- The school nurses working in the B&NES area were given one to one safeguarding supervision with the lead nurse three times a year and group sessions four times a year. The Sirona lead safeguarding nurse also provided group supervision session for nurses working in the family nurse partnership teams.
- Staff in the health visiting teams and the family nurse partnership teams had completed training on FGM (female genital mutilation). Input on this had also been provided by the community paediatric team.
- The provider had produced, in January 2106, a written communication process for primary care and the health visiting and family nurse partnerships. This provided guidance around the responsibilities of GPs and health visitors and provided clarity over roles in relation to safeguarding reporting. Health visiting teams had a named linked safeguarding person for each GP practice. There were designated responsibilities for this role. One health visitor we spoke with explained how this had helped the team feel more confident that information was being communicated and that liaison meetings with GP practices were more productive and efficient. It also supported staff to follow national guidance.
- Staff we spoke with described how safeguarding was regularly discussed at team meetings and learning from serious case reviews could be discussed. For example at the family nurse partnership group supervision session, the named nurse updated the team with topical national or local information. Staff gave examples of topics discussed and these included child sexual exploitation, parental mental health difficulties, and liaison with drug and alcohol services.
- The B&NES speech and language team explained how they discussed the learning from case reviews at team meetings and that the lead for safeguarding within their team could lead a discussion on different aspects of the learning.
- The health visitors in CCHP received regular supervision and had regular meetings with the provider's safeguarding team. This ensured they were up-to-date with any developments and able to respond to concerns promptly and correctly.
- Within the sexual health service team staff were provided with policies and procedures regarding the safeguarding of vulnerable adults and children. Guidance included the recognising and reporting of abuse, female genital mutilation (FGM), child sex exploitation (CSE) and trafficking. Safeguarding training at level 3 was completed by clinicians working within the sexual health service. This was provided through face to face classroom based training or electronically at the choice of the staff member. The staff who worked within the sexual health service were up to date with their safeguarding training. Information was displayed within the waiting rooms in the form of leaflets and posters to alert patients to recognising trafficking, rape and sexual abuse support, sexual consent and inform patients of a chaperone during their appointments chaperoning.
- However, an audit had been conducted of medical records of patients who were under the age of 18 and attended the sexual health service between April and December 2015. This audit had found that risk assessments had not been maintained appropriately for three patients which had not safeguarded them from the risk of abuse being identified. It was planned to re-audit the records in December 2016 following discussion with the staff team on the importance of detailing any safeguarding signs and

triggers. The risk assessment template used by staff did not follow the latest national proforma for spotting signs of CSE. It was planned to develop the proforma template for recording this information.

Medicines

- There were safe arrangements in place for the managing, administering and storing of medicines when this was required.
- School health nurses used patient group directives (PGD) when administering vaccines. A PGD provides a legal framework that allows registered nurses who had completed appropriate additional training and signed the PGD to supply and administer a specified medicine to a pre-defined group of patients. School nurses we spoke with confirmed they had completed the required training and any updates. Staff were able to explain the guidelines they were to follow to ensure the safety of children receiving vaccines.
- Should additional medical advice be required by the nurses regarding the medication for a young person their point of contact was the persons GP.
- We looked at the storage of medication in two locations and found this kept securely with the appropriate recording being completed.
- No medicines were being stored by the CCHP. Some staff were prescribers and could produce a prescription for the service user to take to a chemist. Other staff would refer the service user to their GP if prescription medicines were needed.
- At the locations of the sexual health clinics medicines were stored securely within the clinic in locked cupboards in a locked clinical room. Medicines which required cool storage were stored in a locked fridge of which the temperature was recorded daily to ensure it was within the required limits.
- The PGDs in use were all in date and had been updated and signed off by the contraception and sexual health consultant prior to them leaving the service in June 2016.
- The school nurses transported medicines from their office to run the drop in contraception and sexual health clinics at schools and colleges. However, the medicines were not transported in locked bags or boxes and on occasions were stored at the nurses home overnight. This did not ensure the safe storage of medicines at all times.
- Medicines featured on the risk register. A risk had been highlighted on the organisations risk register regarding the system for labelling tablets that patients took home with them (TTOs). The labelling had not been in line with the national PGD guidelines. This had subsequently been rectified and appropriate procedures had been put into place to ensure the service was now compliant when providing medicines to patients.

Environment and equipment

- At the clinics we visited we saw that safe and child friendly environments were maintained. Rooms being used for baby feeding hubs and drop in sessions for parents were clean and comfortable. Where possible staff would book an additional room so that more private conversations could be facilitated if required. There were appropriate arrangements for the management of waste and sharps including clinical waste. Health visitors told us that the equipment they used was well maintained.
- We found both baby weighing scales in the Cadbury Heath Health Clinic had been calibrated within the last 12 months. However, in the Kingswood Hub we found a scope that was overdue a service by two years and the chair scales in the same clinic room were over a year out-of-date for their next service. We reported this to the operational manager before we left and they told us they would check all the clinic rooms and ensure service requests were made for any equipment that was out-of-date.
- The Kingswood Hub building was owned by the local authority and they took responsibility for fire and portable appliance testing (PAT). All equipment we looked at had received a recent PAT.
- All audiology new born baby screening equipment had been calibrated in 2014 and did not require re-calibration until the end of 2017. The equipment for the on-going screening was on a service contract and calibrated yearly as part of this contract, the last calibration was during 2016.

Good

Are services safe?

- The waiting room at Riverside Health Centre for patients attending the contraception and sexual health service (CASH) was large and airy but did not have access to external windows. This was because it was surrounded on three sides by offices or consulting rooms and the reception on the remaining side. It was not lit well and a number of the ceiling light bulbs required replacement. The staff told us these had been reported but had experienced delays in the bulbs being changed. Estates management was provided by the private company who owned the building. We saw the estates team come to the building during our inspection to carry out a survey of some external building faults which had been reported to them.
- At Riverside Health Centre, staff had access to emergency resuscitation equipment in the form of a defibrillator, suction, oxygen and masks. This was placed in the locked clinical room and all of the staff we spoke with knew where to locate this. Checks were made on this equipment, and recorded, to ensure it was ready and fit for use in an emergency. At the Keynsham clinic we were told the emergency equipment provided by the GP practice would be used if necessary and staff knew where to locate this.

Quality of records

- Records were written and managed in a way that kept people safe and protected confidentiality. Records were regularly audited and where required improvements made. However we found some shortfalls in the record keeping within the sexual health service.
- We looked at a sample of records across the full range of services. We found that records were up to date, detailed and provided healthcare professionals with a wide range of information. A mixture of electronic and paper records were in use depending on the service. Paper records we saw were stored securely.
- An audit of the B&NES health visiting records had shown some inconsistences in the quality of care plans and also around the recording of consent. An action plan was put into place to improve this which included introducing a new format for the care plan. This was now being used consistently across the teams. We looked at a sample of six of these. They were consistently filled in with information about professional involvement, meetings attended and actions that had been agreed. We saw examples were the views of the families were recorded, with quotes from parents being documented. All entries were dated and signed. There were clear journal recordings of the chronology of events and the involvement of professionals. There was clear recording of the completion of the mandatory visits that were undertaken.
- An audit of a sample of family nurse partnership records was completed in January 2016. The audit showed that they were meeting the standard in 100% apart from a shortfall in recording of consent. We saw that action had been taken to address this by sharing results with staff and discussing at team meetings.
- School nurses maintained electronic patient records to detail each contact with a young person. The organisation provided them with lap tops for this purpose. However, staff had experienced problems with connectivity and WIFI access. In these instances staff told us they either updated the electronic records when they returned either to an office or at home in the evenings or completed paper records at the time.
- Paper records were scanned into the patient's electronic records from the office base and we were told were then shredded to ensure patient confidentiality.
- No records were stored at the schools or colleges to ensure patient confidentiality.
- The electronic records used by Sirona enabled the school nurses to access some of the young people's GP records.. School nurses made positive comments about the effectiveness of the joint access which assisted with the provision of joined up and seamless care for the young person. However, not all GPs used the same system which could mean some young people received less of a joined up service.

Good

Are services safe?

- The health visiting service used a paper based recording system which were left in families' homes. This enabled the next health professional who visited the family access to information should the electronic system not be working.
- South Gloucestershire teams only had access to paper records and funding was being sought to implement an electronic system. Records were indexed and organised so information could be easily located, and included clinic or visit notes, follow-up letters and referrals, and continuous historical notes from pre-Sirona involvement with the CCHP.
- Patient records in the CCHP were paper-based. Although other areas of Sirona were using electronic records, because the contract for CCHP was only for one year while re-tendering took place no investment had been made to move to electronic records. Staff told us they were able to access records when needed, including those stored off-site once archived. However, they did feel vulnerable carrying paper-based notes and felt they had to be extra careful to ensure data protection and confidentiality was maintained. Paper records that were not being used were stored securely at all times.
- The sexual health service maintained patient records in an electronic format. Access to the patient record electronic system was password protected and staff were not able to log onto more than one computer at a time. This promoted the confidentiality of patient records as it meant computers could not be left on in error and then staff continuing to access records elsewhere. During our inspection we reviewed the electronic records for 14 patients. We saw that abbreviations were used in the electronic patient records. We did not understand all of the abbreviations and asked staff to explain them. The staff on duty were unable to provide an explanation. The clinical lead had identified this as being an issue when carrying out a review of patient records prior to our visit and had spoken with staff about this practice. They had seen an abbreviation 'ONS' and were not aware this meant 'one night stand'. We were told that some abbreviations were acceptable as everyone was aware of their meaning. However, there was no recognised list of accepted abbreviations.
- The sexual health electronic records consisted of assessment, risk and care and treatment proformas which served as a prompt to staff during the consultation with the patient and following treatment. We found inconsistencies and gaps regarding the information gathered and contained within the electronic patient records. Out of the 14 records reviewed there were seven issues identified.
- We reviewed the records for one patient. Information recorded identified there had been significant risk to warrant the recommendation of a HIV test. The electronic record identified that no HIV test had been offered. In a section where the nurse added a narrative there was a suggestion the HIV test had been offered. We discussed the record with a member of staff who could not clarify whether or not the test had been undertaken. They offered no alternative method of clarifying this information. This did not provide assurances that adequate testing had taken place for this patient. We followed this up with the clinical lead and were told that this was an error in recording and the HIV test had been carried out.
- Within the sexual health service the assessment for some patients was not fully completed. For example, there was a lack of detail regarding the risk experienced by men who had sex with men. There was insufficient detail consistently recorded regarding the methods of sex and whether the patient gave or received anal sex or both.
- Within the narrative of one patient record the member of staff had identified the risk the patient had been exposed to from a sexually transmitted infection (STI). However, the proforma indicated there had been no exposure to the risk of a STI.
- The prompt regarding pregnancy testing was not completed in three sets of notes we looked at. The proforma for the pre assessment prior to IUD fit did not reflect if the pregnancy test had been done or not.

Good

Are services safe?

- The electronic records used a system of coding which followed nationally recognised codes. However we saw coding errors within some patient records. For example, we saw there were no records of 'T4' codes which meant syphilis or HIV test even though they had been carried out. We saw another code of T2 which means a test for chlamydia and/or gonorrhoea and other GUM test recorded under T6 which could not have been correct as no blood test had been carried out.
- The clinical lead told us an additional check of code reporting was carried out by administrative staff but acknowledged that this would not identify all of the errors.
- An audit of patient records which had been completed in January 2016 identified that a pertinent information leaflet had not been given to three out of ten patients. Staff had been reminded of this following the audit.
- Within the sexual health service, the electronic records system was not set to print electronic patient labels. This meant staff were required to handwrite patient details on swabs and blood tests and associated forms. This increased risk for error and rejection of the sample by the laboratory which delayed treatment for some patients. There had been no auditing completed of the numbers of patients this had affected. Staff told us that tests had been returned by the laboratory.
- The electronic records system had the facility to send an automatic text to patients when required but this was not in action at the time of our inspection.

Cleanliness, infection control and hygiene

- At the clinics and home visits in the B&NES area we attended we observed staff following infection control procedures. These included using antibacterial hand gels before and after care, wearing the appropriate protective clothing and aprons when required. All staff followed the bare below the elbow policy.
- In clinics we observed scales and equipment being cleaned between patients.
- However, in the Bristol and South Gloucestershire area staff did not always observe the 'bare below the elbow' policy or observe good hand hygiene procedures. We observed two health visitors in a baby clinic and a paediatrician in a community paediatric clinic who all had long sleeve tops on. Two of those staff members also wore a wristwatch. This was against company policy and increased the risk of spreading infections. The two health visitors did not clean their hands between babies, although did clean the equipment the babies had been in contact with. One school nurse was wearing coloured nail varnish, again against company policy.
- The Kingswood Hub building was owned by the local authority and they took responsibility for cleaning the clinic rooms. However, the clinic assistants also completed a daily clean and cleaned the toys. A cleaning log was maintained, however this did not record which clinic rooms had been cleaned, only that cleaning had taking place generally.
- We checked one clinic room at the Kingswood Hub and found that although the floor and main desk surfaces were clean, other areas of the room were dirty. The shelf above the desk had a thick layer of dust, as did the frames of the scope and chair scales. The blue clinical curtains did not have the date they were last changed filled in and the bottom quarter of the curtain had heavy dark staining. We reported this to the operational manager before we left and they told us they would check all the clinic rooms and ensure they were cleaned sufficiently.
- We saw that the clinic used by the sexual health service was visibly clean during our inspection visit. All areas of the clinic were tidy and clutter free. The service employed a member of staff to clean the clinic from 6am to 12.30pm six days a week. There were cleaning schedules in place and these included the frequency the privacy curtains within the consultation and treatment rooms were changed.
- We observed there were plentiful supplies of personal protective equipment (PPE) available to staff such as gloves and aprons. Staff told us they used PPE when necessary. We did not observe this as we did not observe any patient consultation or treatments. There were hand washing facilities and antibacterial gel for sanitising hands in each consulting / treatment room.

- There was a mixture of single use and reusable equipment in the department. Single use speculums for cervical examinations and procedures were an example of disposable equipment. Staff had access to disposable tourniquets for use when taking blood samples. We were told that the staff preferred to use reusable tourniquets as they considered they were more efficient. Staff washed the tourniquet at least once a week and if stained or marked with body fluids. However, the infection control policy and procedure did not provide guidance or advice for staff on how to ensure the washing procedure was of a sufficient standard to promote the control of infection.
- Staff checked the room prior to starting a clinic to ensure it was stocked with sufficient equipment and clean. The treatment and consulting rooms were cleaned thoroughly at the end of each clinic. The patient examination couch was covered with disposable paper towel and was replaced between each patient.
- Infection control training was part of the provider's mandatory training programme.

Mandatory training

- Training was provided for all staff to ensure they were competent to perform in their roles. There were systems in place to monitor and remind staff when training was due. There was a designated list of mandatory training. The training included fire safety, health and safety, infection control, defibrillation, equality and diversity, lone working and dementia awareness.
- A new system of providing mandatory training had been started since April 2016 which involved staff completing all the training in single day. At the time of the inspection the overall figure for the provider was 82% completion for the training. In several of the services we visited the completion rate was 100%. These included the B&NES health visiting team and the school nursing team.
- In the Bristol and South Gloucestershire teams most staff were up-to-date with their mandatory training. Six of the nine (66%) staff in the family nurse partnership team were up-to-date with their mandatory training, 153 of the 168 (91%) community children's health partnership community paediatrics team were up-to-date, and all 28 members of staff in the South Gloucestershire school nursing team were up-to-date. However, four of the five (80%) health visitors in South Gloucestershire required an update.

Assessing and responding to patient risk

- Risk assessments were completed as part of the assessment process for children receiving a service. This would include the environment and any associated risks depending on the service being delivered. For example the risk template that was completed for staff working in the Lifetime service included information about parking, flooring, lighting and the space that was available for equipment and manual handling In the Lifetime service staff supported families with children with life limiting conditions. Staff spent time supporting families to understand the conditions and the actions to be taken if a concern was identified.
- There were mechanisms in place to identify patients at risk. In the B&NES area details were recorded in the electronic records which all clinical staff had access to. The provider used the healthy child programme to identify and support children, young people and families according to their level of need. The levels of service used depended on need and the risk of harm. Electronic records identified which level of service children were receiving and described their specific needs and risks. Alerts could be added to the system to indicate specific risks such as domestic abuse, which ensured staff, were aware of and had speedy access to individual needs and risks. There were pathways for staff to use when certain risks were identified, for example, domestic abuse and child sexual exploitation.
- At the school nurses' team meeting we observed that a set agenda was followed. One agenda item was the discussion amongst the team of any areas of risk or concern that individual staff members had identified. We observed that one school nurse spoke of the care and treatment provided to a young person who had presented to them at a recent school visit. A group discussion took place regarding the action taken and suggestions were made of alternatives for the young person.

- An assessment template was completed by the school nursing service when meeting young people at the schools and colleges. The template provided prompts to assist the clinician when exploring potential risks to the child or young person.

Staffing levels and caseload

- There were systems in place in the different teams and services to manage and plan caseloads. Whilst there was an increased demand for many services staffing levels were maintained with the minimal use of agency staff. Staff we spoke with across the services told us their workloads were generally manageable. The B&NES health visiting service had implemented a new caseload weighting tool which was being used to manage and plan services. 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. The B&NES area teams had caseload at the time of our inspection of between 313 and 403.
- In the B&NES speech and language team the caseloads were managed on a group basis. Staff told us this ensured that workloads were evenly distributed. Whilst there had been an increase in referrals for some conditions, which had resulted in longer referral to treatment times, the distributing of work made caseloads manageable. The demand for the pre-school language and the pre-school complex needs services for example had increased by 50% in the previous 18 months.
- The school nurses acknowledged their main concern was the emergent mental health illness of children and young people in the schools they supported. At times they felt the staffing levels were stretched to reach the children and young people who required support.
- Although there were no significant vacancies in the provider's staffing as part of the CCHP, all staff we spoke with felt their workloads were becoming difficult to manage. This was particularly the case with health visitors and the family nursing partnership team. At the time of our inspection there was no plan to reassess workloads due to the short length of the interim contract.
- We were told clinic assistant absences in community paediatric clinics as part of CCHP were not always covered. If a clinic assistant was off sick or had taken annual leave bank staff were no longer used to cover them. We were told this placed additional pressure on the staff who were running the clinics because they had to take on additional tasks and still keep the clinics running to time.
- The sexual health service did not have any registered nurse vacancies. Any gaps in the duty rota due to holiday or sick leave were covered by permanent staff or bank staff. No agency staff were used within the service. Registered nurses were required to be a member of the Faculty of Sexual and Reproductive Healthcare (FSRH).

Managing anticipated risks

- Potential risks were taken into account when services were being planned. Staff we spoke with were aware of the plans to be put into pace in the event of adverse conditions.
- Within the sexual health clinic panic alarms were installed within the reception area and consulting and treatment rooms. Staff were provided with guidance on the use of the panic alarms. Staff we spoke with were all aware of the location of the panic alarms and that they would sound in the reception if set off. They knew what the alarm sounded like and how they would respond appropriately in an emergency. However, there had not been a training drill for staff to ensure they would know the correct action to take in the event of an emergency. This meant there was a risk that the appropriate course of action would not be taken should a member of staff need to sound the alarm. There was also an alarm that linked directly to the police. This had been installed on behalf of another service which previously operated from the building.
- The receptionist at Keynsham clinic showed us where the panic alarm was situated in reception and advised that there were also alarms in the clinic rooms should staff need to summons help in an emergency.
- Emergency equipment was available within the department to enable staff to respond to patients

who became unwell. Staff told us they would summon an ambulance for an acutely unwell patient or liaise with the emergency gynaecology staff to refer a patient to the acute hospital.

Major incident awareness and training

- The various services and teams in the B&NES area children's and young people's services had business contingency plans in place to respond to emergencies and other major incidents. The plans were specific to the individual services but were all written in conjunction with the Sirona emergency planning officer. We looked at a sample of two plans and found they were up to date and had been reviewed within the previous twelve months.
- For example the plan of the Lifetime service was written in accordance with the Civil Contingency 2012 Act and the practice guidelines from the Business Continuity Institute. It detailed a summary of the functions to be recovered and identified these services as critical, essential, important, desirable or other, which meant to be recovered within a month. Each eventuality provided a list of immediate actions, interim and subsequent actions and who was responsible for overseeing these.
- Business continuity plans existed for the CCHP. These detailed possible interruptions to the service, for example from the loss of power or water, and identified key actions to be taken. However plans did not detail the impact of adverse weather on the service's ability to attend service users in the community. The impact on staff being able to arrive at work and get home from work was recognised, with actions including redeployment to another location. But there was no mention of how vulnerable people in the community with priority visits would be reached.

Good

Are services effective?

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

Summary

We rated the effectiveness of the children and young people's services as good. This was because;

- Peoples needs were assessed and care and treatment was delivered in line with legislation and evidence based guidance. We saw examples of best practice being identified, shared with colleagues and delivered. Staff across the services had processes for seeking out the guidance and information from associated professional research.
- The provider monitored patient outcomes and undertook range of audits to promote best practice though this was more limited in the Community Children's Health Partnership (CCHP).
- The service was meeting national targets and had action plans in place to identify shortfalls highlighted by audits. Outstanding results were achieved by the Newborn Hearing Screening Programme (NHSP) being delivered by the paediatric audiology division across the area of Bath and North East Somerset (B&NES) and West and North Wiltshire. Audits showed that 100% of eligible population were offered screens. The service was identified as a top performing national programme and been described as an "exemplar programme".
- Staff had the right qualifications, experience and knowledge to undertake their roles and were regularly supervised and appraised.
- We saw evidence of positive and proactive working across teams and with other professionals and organisations. We saw that care was delivered in a co-ordinated manner and the required services were involved in assessing and planning care and treatment.
- Staff worked together to assess and plan on-going care and treatment when families or children moved between teams or services. There were clear protocols for referrals and for the discharge of children and young people. There were some outstanding examples of the planning for the transfer to adult services being undertaken. This included the Lifetime service and the B&NES speech and language team who were providing transition reports for people with autism moving into further education or going on to university. They also provided "communication passports" which were documents for children to use to help themselves integrate themselves into their new environment.
- One of the school nurses had developed an app to help young people make informed choices regarding sexual health and contraception.
- Staff had the right qualifications, experience and knowledge to undertake their roles and were supported to undertake further training. For example the clinical lead for sexual health services was a qualified trainer for the faculty of sexual reproductive health (FRSH) and other staff were also members of FRSH.
- Consent to care and treatment was sought in line with legislation and guidance. We saw that consent was clearly recorded.

Evidence based care and treatment

- People's needs were assessed and care and treatment was delivered in line with legislation and evidence based guidance. We saw various examples of best practice being identified, shared with colleagues and then delivered. We saw that staff across the services had processes for seeking out the latest NICE (National Institute for Care and Excellence) guidance and information from associated professional research. Some of the staff were also contributing to research which was being undertaken locally in conjunction with universities and health trusts.
- The B&NES speech and language team had care pathways that were all evidence based and reviewed every year. Members of the team were involved in contributing to research carried out by a local university and were providing feedback to their colleagues. During team training days, staff provided feedback to their colleagues on the training they had done and shared any information about new practice or initiatives. An example we were told of involved the key working of staff with children with elective mutism.

Good

Are services effective?

- Health visiting teams were provided with a 'Care and Health Infant Feeding' newsletter every month. This highlighted any new practice or on-going issues. One example of this was recent advice from the Department of Health on vitamin D deficiency. We also observed staff offering advice based on recent training and shared learning, for example explaining the use of paracetamol for infant pain relief and also the latest guidance on clusters of sneezing and yawning in babies. We also observed staff giving evidence based advice on the leaving of weaning to six months to reduce allergy risk.
- The family nurse partnership produced an annual report that provided data collected covering a range of outcomes. This produced action plans to support the increase of breastfeeding, increase smoking cessation, decrease alcohol and drug use and increase awareness of contraception to decrease the chances of future unplanned pregnancies.
- Sirona had achieved accreditation to Unicef Baby Feeding initiative in 2014. The accreditation lasts for three years and was due for reassessment in 2017. Sirona was planning to aim for accreditation to the new "advanced awareness level" that that was being developed nationally. There were 16 baby feeding hubs across the B&NES area and to support these there was an antenatal parent education programme called 'Hello Baby'. An average of 15 courses were run annually. Feedback surveys showed that 100% participants said the courses had improved their readiness for caring for their baby and 77% said it helped them be more connected to other parents in their local area.
- The designated nurse for 'looked after children' (LAC) attended the South West LAC Nurse regional meetings which were held every six months. An aim of these was to promote the sharing of service developments and best practice across the region. The annual report produced by the LAC service provided details of the latest guidance which helped inform service development. This included 'Promoting the Health of Children in Public Care' (year) published by the British Association for Fostering and Adoption.
- The Lifetime service had a group of staff who worked as an "in-house" research group and reported back to the larger team on developments and initiatives. The team had also been involved in work with a local university completing research into Duchenne muscular dystrophy and end of life planning.
- Children with complex needs and long term conditions receiving care and support from the Lifetime service, had clear personalised care plans in place which were up to date. The plans reflected the latest guidance around the condition or illness the family and child were being supported to manage.
- The school nurses used national health promotion guidance and literature to promote healthier lifestyles for children and young people they spoke with in schools and colleges. For example regarding ceasing smoking.
- The sexual health service followed the Faculty of Reproductive and Sexual Health (FRSH) guidelines. New guidelines were discussed at team meeting and then changed if appropriate. The service was involved in a consultation process with the FRSH regarding the insertion and siting of implants. The final outcomes from the consultation were awaited prior to changing local guidelines if necessary. Staff were aware of the guidelines produced by the FRSH and used these as a resource when reviewing policies and procedures.

Pain relief

- In the sexual health clinics patients were provided with advice regarding taking analgesia prior to attending for specific procedures that could cause pain. We observed during our inspection that one patient attended to have such a procedure but due to the criteria for the procedure to go ahead not being met, they had to return. This meant that they had taken analgesia for no reason.

Technology and telemedicine

- Community staff were provided with laptops to record their records on. However several staff commented that were connectivity problems in certain parts of the locality that could make using the devices difficult at times. This resulted at times in staff having to complete work in their own homes.
- Within the sexual health service patients were provided with the option of receiving notification of their test results by text. If the result was negative the text

message informed them of this. If the test was positive they were asked to contact the clinic for information. The reception staff answered the telephone to patients who requested test results. We observed that the test results were written in a folder and if negative the outcome was provided to the patient. If the results were positive the receptionist obtained contact telephone details and advised the patient the nurse would telephone them with their results.

- One of the school nurses had developed an app to help young people make informed choices regarding sexual health and contraception. An app is a software application designed to run on mobile devices such as smartphones and tablet computers. The app was available to down load and had received positive comments from young people who had trialled it. The app promoted consent to treatment for sexual health and contraception and enabled young people to process and remember important information regarding contraception.

Patient outcomes

- The provider monitored patient outcomes and undertook range of audits to promote best practice. Information was collected and disseminated to the teams. There was limited auditing in place in the CCHP. Sirona had only been providing services as part of this partnership for six months, and this was only as part of a 12-month interim contract. The main focus had been on ensuring a smooth transition of the service and continued delivery of services to the service users.
- The national 'Healthy Child Programme' stipulates various targets for services to meet. For example a new baby review should take place within 14 days with mother and father in order to assess maternal mental health and discuss issues such as infant feeding. Evidence provided by Sirona showed they were meeting all the set targets for this programme. For example the B&NES health visiting service were delivering face to face visits within 14 days of birth at 82 % and the required reviews at 6 to 8 weeks were averaging at 92%. Children receiving a two year review was recorded as being at 96%.The most recent records for mothers breastfeeding recorded at 96% with 55% being recorded as breastfeeding after a six to eight week review.
- Sirona had developed a project to provide a health and development review, using a developmental screening tool, for all children between the age of 2 and 2.5. An audit had been undertaken of this work. The records of children resident in B&NES, who were eligible for 2-year review in September 2015, were accessed and audited to review the information which had been added about the 2 year review to the individual child's record. The audit showed that a health review was completed for 100% of the children and that 97% had a developmental screening completed. It also showed that 98% of the reviews were completed within 6 months of the child's 2 year birthday. It produced information about the level of service provided to individual families, and the development screening produced information about areas such as fine motor skills and communication abilities. There was also information about referral rates to other services. The audit produced a range of recommendations for improving how the information was recorded and how it could be used to flag up issues which would support staff to provide the appropriate interventions for families and children.
- An audit of the vaccination rates in the Bristol and South Gloucestershire area for HPV (human papilloma virus) for girls was recorded at 68 % and 49% respectively in June 2016. An action plan was put in place which involved additional support for the school nursing teams to vaccinate as many remaining children as possible. This included contacting parents and children and offering clinic appointments. The latest audit showed that the percentages had risen to 81 % and 85 %, though still missing a provider target of 90%.
- The ACWY meningitis vaccination for boys being delivered in 63 schools across Bristol and South Gloucestershire area was audited at 79% and 77% in August 2016, which was a 12 % increase from last year. An immunisation team had been put into place which was intended to improve these rates.
- In the B&NES area vaccination and immunisation rates for the first quarter of the year were recorded at 99 % for 2 year olds and for aged 5 it was 92%.
- The new-born hearing screening programme (NHSP) was delivered by the paediatric audiology division across the area of B&NES and West and North Wiltshire. Well babies were screened at home around day 10-14 by 110 trained Health Visitor Screeners. Babies in a

neonatal intensive care unit (NICU) were screened by trained NHSP screeners and received two screens in line with national protocol. The audits showed that 100% of eligible population were offered screens. The service was identified as a top performing national programme and during a Public Health Quality Assessment in June 2015 the service was described as an "exemplar programme" and had no recommendations for improvement.

- It was identified by managers that in some of the B&NES health visiting teams there was potentially inconsistency in the levels of medication prescribing. The leads undertook an audit which included looking at training rates as well as discussing prescribing with staff in supervision and team meetings. The initial report had identified potential barriers that were due to be discussed at the next health visiting leads meeting.
- The speech and language service had undertaken an audit of the effectiveness of their 'advice line' service. This audit was looking at how effective referrals were and also ensuring they were serving as an effective first point of contact for parents to get advice about a child's language development.
- The school nursing service had used the feedback from an audit of consent forms to make improvements to the form and ensure that clearer information was being recorded.
- The school nursing service had audited the results for children being vision screened in schools and who were referred onto a hospital ophthalmic department. The audit identified that a number of referrals failed to reach the ophthalmic department and as a result, a new system was put into place. An additional audit was carried out that showed that all children who were referred on were offered an appointment.
- The sexual health service reported data through the NHS sexual and reproductive health activity data system (SHRAD) which came into effect in 2010. This consisted of anonymised patient level data which was submitted annually providing a rich source of contraceptive and sexual health data for a range of uses from commissioning to national reporting. Whilst the data was submitted annually, the service collated the data monthly which identified themes and trends in patient outcomes.
- The SHRAD data was set out in a table which was RAG rated. This showed that where there was a risk to the service or the service target was not achieved, the data was highlighted in red or amber. Where the target was met the data was green. Data collected by the service identified that high numbers of patients had requested removal of implants sooner than the recommended length of insertion time. The service was monitoring the effect of changed information sharing with patients where they were told to keep in for minimum of six months following insertion before deciding it did not suit them.
- The sexual health service was commissioned to provide a block contract of certain intrauterine devices (IUDs). For example they were able to provide 9 Marina coils per month. The number of patients requesting this type of IUD outnumbered the numbers available so were put on a waiting list. At the time of our inspection there was a four week wait period for appointments for this procedure. There was no audit of average waiting times. Staff told us patients could be signposted to Wiltshire or Bristol for earlier treatment.
- A number of clinical audits had been completed within the sexual health service. We reviewed the outcomes from the audits and found there had been learning taken from the audit to improve patient care and treatment. For example, an audit regarding the PGDs for Medroxy progesterone acetate

Competent staff

- Staff had the right qualifications, experience and knowledge to undertake their roles and were supported to undertake further training. Staff were regularly supervised and appraised by their managers. Staff told us they were encouraged to develop their skills and share their learning with colleagues.
- In the B&NES area Sirona had introduced a standard operating procedure for staff supervision. This provided clear guidance, and a structure, that was to be followed by managers delivering supervision. The process included peer supervision, safeguarding supervision and line management. Additional guidance was provided for the safeguarding supervision process. The procedures included guidance on how to maintain and enhance clinical practice, how to facilitate reflective

practice and how to ensure the meetings had a restorative function. Supervision was also tasked with highlighting any issues with multi-agency working that may need escalating and addressing.

- The B&NES school nurses were receiving regular supervision and also had formal peer supervision and also occasional group supervision meetings. We were told the team leader was available for additional meetings when required and had an open door policy for the nurses. All the team had appraisals completed in the previous twelve months. Across all children services there was a 91% completion of staff appraisals.
- Staff across all the services had undertaken additional training to develop their skills and we saw evidence that this was shared amongst colleagues and other services. Additional learning and training undertaken included family nurse partnership nurses exploring 'Boundaries' within the work of their service, which involved skills practice and also 'Domestic Abuse in Teenaged Relationships' provided by a local safeguarding children's board. The family nurse partnership team had provided learning sets for student nurses, student health visitors and student social workers about their work. It was planned to provide these regularly.
- In March 2016 thirty-six health visitors had attended a one day training designed to facilitate better understanding of mental health issues. This reflected the move from a medical to a more holistic social model of health visiting service delivery.
- In the B&NES area health visiting service all the teams had completed the UNICEF baby friendly training at the end of last quarter.
- School nurses reported they had the scope to be autonomous practitioners which was possible due to the abundant training they were able to attend. The school nurses had attended an eight week mindfulness training course which they had found useful and the principles of which were used in their daily work.
- The school nurses had completed a specialist community public health qualification regarding personal, health and social education (PHSE) which we were told assisted when supporting young people. For example offering support regarding consent, safer sex, relationships and healthy relationships.
- The school nurse team meeting concluded with a multiple choice answer style quiz about an aspect of their practice. The correct answers were discussed on completion of the quiz. We observed that on the day of our inspection the quiz was about contraceptive pills.
- The family nurses undertook initial national training regarding the family nurse programme. Training was provided every other month nationally and in addition the family nurse team accessed local relevant training. For example, the nurses had attended a training session held at the local prison which explored the effect on children of having a parent who was in prison. Additional training had been provided locally through an external organisation regarding child sex exploitation.
- Staff working for the CCHP were planned to receive yearly appraisals. We were told about 85% of all staff in CCHP had received an appraisal within the last 12 months, although were not assured this was the case. All nine members of the family nursing partnership team had received an appraisal in the previous 12 months. Of the medical staff, 23 out of 26 (88%) had received an appraisal. The remaining three were only a matter of weeks overdue, and two of these had dates booked. We asked for compliance data for the health visiting, school nursing and non-clinical teams but these were not provided.
- **Multi-disciplinary working and coordinated care pathways**
- We saw evidence of positive and proactive working across teams and with other professionals and organisations. We saw that care was delivered in a co-ordinated manner and the required services were involved in assessing and planning care and treatment.
- The B&NES health visiting managers had regular six weekly liaison meetings with local GPs, and also the community midwifery service.
- The B&NES speech and language therapists explained how they worked with other professionals and we were told the size of the locality helped them to build good working relationships. They had regular contact with the children's hub at the local NHS hospital and contributed to children SEND (special educational needs and disabilities) plans. Staff told us that the sharing of the electronic systems helped with the liaison between

services with the sharing of information being efficient and effective. They could see the notes on the records from meetings and entries from other professionals. This also helped families, who did not have the need to repeat their history every time they met someone from a different service.

- The designated doctor and the designated nurse for 'looked after children' met every three months with social services leads and every six weeks with the local child and adolescent mental health services (CAMHS) lead. Links were made with CAMHS to refer young people for specialist mental health support.
- The school nursing teams could link in with the school pastoral care teams to share information and coordinate support and advice for children.
- The school nurses worked closely with multi-disciplinary teams both within and outside of the organisation. For example, within social services, school improvement teams, public health and personal, social, health and economic educators (PSHE) leads within the schools. PSHE has, in various forms, been part of the National Curriculum for schools since 2000.
- Patient records from the community children's health partnership showed good multidisciplinary involvement with all aspects of a patient's care. This included evidence of communications and reports from GPs, community specialist teams, hospital specialist teams, schools and local authorities.
- The contraception and sexual health (CASH) service worked closely with the school nursing service. The school nurses provided a CASH service to young people in schools and colleges who may also attend CASH clinics. Sirona, the school nurses and CASH staff, worked with schools where referrals to external agencies were required. For example, where there were safeguarding concerns.
- The sexual health service liaised closely with the acute hospital regarding joint care for patients who required the services from the genitourinary medicine department (GUM) and emergency gynaecology services. Contact and working relationships had been built and staff were able to telephone the external services for advice and guidance regarding the care of patients who presented at the clinic.
- The school nurses worked with external agencies in the support of young people who attended a substance misuse service, providing sex and relationship education. In addition a service had been developed to which young people attending this organisation could attend a drop in CASH clinic or be visited at home by the school nurse.
- **Referral, transfer, discharge and transition**
- We saw that staff worked together to assess and plan on-going care and treatment when families or children moved between teams or services. There were clear protocols for referrals and for the discharge of children and young people. Staff were clear about the referral process and how they could advise families to access the different services that were available. The provider had a network of staff from the different services who met as a transition group every few months.
- Families could access the speech and language service through GP referral single point of access system. All referrals were triaged according to clear priorities.
- The 'looked after children' (LAC) nurses worked with young people up to the age of 21 years. The nurse had regular contact with the designated leaving care worker. Contact could be around a range of health issues and also they would provide support and advice about accessing adult health services. A "health passport" had been developed in conjunction with Barnardos and been approved by the Children in Care Council. This had been introduced in 2015/16 and was to be audited against its effectiveness in 2017.
- The health visiting teams were using a referral process, called the C2, to refer safeguarding concerns to the local authority.
- The B&NES speech and language team provided transition reports for people with autism who were moving into further education or going on to university. They also provided "communication passports" documents for children to use to help themselves integrate themselves into their new environment.
- The Lifetime service had a structured formal process for preparing children to transfer into adult services that began at fourteen. The format used was called Ready Steady Go and was based on the National Service Framework for children transition guidance produced by

the Department of Health. The documents were completed in three stages usually from the age of 14, though this could be started earlier if required. We saw a sample of these that had been completed. We saw the service had fully involved the child in the planning and recording. It was also clearly recorded that a goal was to support children to take as much responsibility as they could for their own health needs as they moved into adulthood. We saw that these transition plans were also regularly reviewed and updated.

- The B&NES school nurses could respond to referrals within a week but would also encourage children to call in at drop in sessions so that they could be seen sooner.
- The family nurse liaised with the health visiting teams when a young person was due to complete and leave the programme. Detailed records were prepared to transfer with the young person so that the health visiting team were appraised of the feedback and content of the programme for the individual.
- When young people dropped out of the family nurse programme, contact was made with the relevant health visiting team to advise them. This meant professional support would be made available to the family.
- The sexual health service worked closely with the department of genitourinary medicine at the local acute NHS trust. They referred patients to the department if they were not able to be treated at the clinic. We observed one patient turn up to a walk-in clinic who did not meet the criteria. The receptionist provided the patient with details regarding times and location of clinics which could meet their needs. They did not keep a record of the patient's name or inform the clinician this person had attended as agreed with the service lead. This meant there was no way of tracing whether the patient attended any other sexual health clinic in the area for treatment of their symptoms. We discussed this with the clinical lead who stated as the patient was an adult they had responsibility for their own health. However, this did enable additional support to the patient to seek the treatment they may have required in order to protect themselves and or others from the risk of a sexually transmitted infection.
- Referrals could be made and advice received from the emergency gynaecology team at the local acute hospital for patients who were experiencing gynaecology complications.
- Staff referred patients back to their GP when necessary. We saw evidence of where one patient had been referred back to their GP following an unusual smear test. The nurse liaised with the GP and patient regarding the test.
- The sexual health service referred patients to external organisations when requiring termination of pregnancies.
- **Access to information**
- Staff were provided with the information they needed to deliver effective care in a timely way. The electronic records system enabled the easy accessing of information and enable staff to keep up to date with the input a child or family may be receiving.
- Sirona provided information online that was available to all staff. This provided information about guidelines, policies and standard operating procedures. Staff we spoke with told they could access information easily. Staff were also provided with team brief that came electronically and some of the individual services produced their own newsletters which distributed information.
- At the Riverside and Keynsham sexual health clinics, staff had access to electronic patient records which provided an additional record of the care, treatment and medical and social history of the patient. Staff did not have access to an electronic system to view test results. All of the laboratory results were returned to the clinic in paper format. The nurses had allocated time each week to review test results and enter them onto the patient's electronic records and also into a paper based system. Reception staff referred to the paper based results file when responding to patients who telephoned for the their results
- At the various locations we visited printed leaflets were available for parents about the various services and also about Sirona as an organisation.
- **Consent**

Good

Are services effective?

- Consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the needs to ask for consent and for this to be appropriately recorded.
- We saw care plans where consent was clearly recorded. For example in the Lifetime service. The original nursing assessments were agreed and signed by staff and parents. Consent had also been recorded for interventions which were unexpected and outside the agreed plan of care. These were clearly separated in the plans.
- As a result of an audit of the consent forms used by the Sirona employed school nurses for the HPV vaccine using a Patient Group Direction (PGD) the form was redesigned. Action was also taken to ensure that the allergy status of the children was recorded.
- An audit of the family nurse programme records was undertaken in January 2016 by the organisation. This audit found that verbal consent from the young person to engage with the programme was obtained with staff recording this. Following the audit a consent form was developed for young people to sign. This showed that staff had explained the programme, outlined the expectation of participation and identified that the young person had understood and agreed.
- Within the sexual health service written consent was obtained from patients regarding the maintaining of electronic and paper medical records and sharing their electronic records with the genitourinary department at the acute NHS trust. Written consent was also obtained prior to making contact with the patient's GP. We observed and were told by staff and patients that verbal consent was obtained prior to the delivery of care and treatment.
- Patients using the sexual health service we spoke with commented that they were given sufficient information about their care and treatment needs meaning they were able to make an informed decision about their treatment.
- Staff were knowledgeable about the Fraser Guidelines and Gillick competence. Fraser guidelines refer to a legal case which found that doctors and nurses are able to give contraceptive advice or treatment to under 16 year olds without parental consent. The Gillick competence is used in medical law to establish whether a child (16 years or younger) is able to consent to his or her own medical treatment without the need for parental permission or knowledge.
- Assessments regarding capacity were completed at the first visit to the service by a patient under the age of 16 and reviewed at each subsequent visit. We saw this process had been completed within the notes we inspected.
- Opportunities for personal development were limited because there was no budget for personal development. However, managers would try to accommodate personal development requests using the in-house training department or by finding money from another budget. Alternatively, managers told us that if no money was available they would be able to support staff with travel costs and study time.
- In the sexual health service the clinical lead provided support, training and guidance to the clinicians working within the service. The clinical lead was a qualified trainer for the faculty of sexual reproductive health (FSRH) and in this role was able to deliver training to visitors to the service such as trainee GPs.
- Staff were members of FSRH and attended training sessions relevant to their roles put on by the organisation
- The clinical lead in the sexual health service sought clinical supervision from a sexual health consultant in a nearby NHS trust. This person had also provided support and guidance when the clinical lead was finalising her portfolio submission to become a faculty trainer for the FSRH
- Staff working in the sexual health service we spoke with said their appraisals were up to date although we did not see evidence to support the appraisal process or the content of the appraisals.

Good

Are services caring?

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

Summary

We rated caring in the children's and young people's service as good. This was because:

- We observed care, support and advice being delivered by a variety of staff in a compassionate and caring manner at all the locations we visited. We had feedback and comments from children and families that was positive about the staff they received a service from. People told us that staff took the time to explain and ensure they understood the care and treatment they were involved in providing.
- Staff took the time to explain and involve parents in all the discussion around care and support that were available. The family nurses had a range of tools to share with young people on the programme to assist with information sharing.

Compassionate care

- We observed health visiting staff interacting with expectant mothers using a respectful and compassionate approach. Staff were able to discuss a range of subjects sensitively, including the mental health world health organisation (WHO) questions. Staff explained why the questions were asked and how these would be asked at every visit. Staff took time to explain clearly the role of the health visitor and the service and support that was provided.
- All staff we observed at the Cadbury Heath Health Centre and Kingswood Hub were courteous and sensitive to the children they were seeing, as well as their parents. Staff took the time to communicate and interact with the children they were seeing, and provided reassurance and support to children and their parents.
- In the Cadbury Heath baby clinic we saw staff took the time to listen and engage with the baby and mother they were with, not being distracted by the noise and busyness from the waiting area.
- In the Kingswood Hub we saw a clinic assistant and community paediatrician show patience with a young child who was nervous. They took time to reassure the child and allowed them to get to know them before they completed any observations.
- One service user at the Cadbury Heath Health Centre told us they had been made to feel comfortable and welcome when they arrived for their appointment.
- The family nursing partnership nurses had received 'compassionate minds' training from an external psychologist. This enabled them to have a greater understanding of compassion and how to introduce this into a clinical relationship.
- At the sexual health clinics the doors to the consulting and treatment rooms at the main clinic all locked from the inside so that no other patient could enter. Staff could enter with a key fob but we observed they always knocked at the door and said their name prior to entering. The windows to the treatment rooms were occluded. There was a curtain drawn around the examination couch during any procedure to further provide confidence of privacy and dignity. This ensured young people felt safe and that their dignity and privacy was respected.
- The confidentiality of patients attending the clinic was promoted by the reception staff asking patients to identify their name and reason for visit on a brief questionnaire. This meant that personal information was not discussed as this could have been overheard by other patients.
- We observed in the sexual health clinic that if the receptionist needed further information they asked the patient to move to the other end of the reception area for a discreet and quiet conversation. The waiting area was located away from the reception desk and music was playing in this area. This meant that conversations were less likely to be overheard. Patients we spoke with commented that this area was quiet but they felt their confidentiality was respected.
- Chaperoning was available for all patients attending the sexual health clinics. Another clinician working in the

clinic provided this service. Very occasionally, a receptionist had been required to provide this service if there was no clinician available. Three patients we spoke with did not know about chaperoning but confirmed no intimate examination had been performed and that they had not needed a chaperone.

- Patients made positive comments about the kindness shown to them by the receptionist in the sexual health clinics and the way in which the clinicians treated them. All of the patients we spoke with had had a positive experience at the clinic.

Understanding and involvement of patients and those close to them

- Staff took the time to explain and involve parents in all the discussion around care and support that were available.
- The family nurses had a range of tools to share with young people on the programme to assist with information sharing. We saw there were activities, games, diagrams, animations and models which showed the development of the foetus. When using the tools the nurse engaged with the young person to deliver the information and ensure their understanding.
- We observed a community paediatric clinic at the Kingswood Hub and saw a clinic assistant and community paediatrician take the time to involve a child as much as they could in their assessments. They took time to explain to the child what they were doing and why, and checked the child understood and was happy for them to proceed.
- We observed another community paediatrician involving a young person with their care plan and checking they understood. The paediatrician then explained they would also write to the patient's father and checked this was ok with them.
- In the sexual health clinics the staff provided information to patients in the written format and verbally during their clinic visit. This information included treatment options and patients were encouraged to share their views and opinions on their preferences. This was in accordance with national recommendations contained within the NICE QS 15. This quality standard covers improving the quality of the patient experience for people who use adult NHS services.
- We saw that following the visit to the clinic for the fitting of an intrauterine device (IUD), one patient was provided with additional information by the reception staff. The patient had not been able to have the IUD fitted during their appointment and made an appointment to return for this procedure. The receptionist ensured the patient had access to the information they needed regarding pre procedure preparation and that they were aware of the leaflets and why they were important.
- We observed that patients were able to be accompanied on their appointment by a friend, partner or relative if that was their choice. We spoke with two patients following their appointment and they told us this had been appreciated by them. They commented it had been useful as they could discuss the information provided with their friend after they left the clinic. Another patient told us they had been nervous about attending the clinic and having a friend with them provided them with confidence.

Emotional support

- People received the support to help them cope emotionally with their care and treatment. We observed interaction between staff and parents and staff that demonstrated staff had empathy for the experiences of parents, children and expectant mothers.
- At one baby feeding hub we saw staff supporting a distressed parent. They ensured they had privacy to talk through their concerns and also arranged to contact the parent at a later time to see how they were.
- One parent we spoke with told us the staff were "brilliant I'm really lucky to have this help and advice from the nurses" and another told us "the nurse are great and being able to meet other mothers has been really helpful to me and my partner".
- The school nurses supported young people with mental health issues and were able to refer or signpost them to relevant specialist services when needed. We observed one young person attended a school clinic in a distressed state and the school nurse was calm, kind and showed empathy for the young person.

Good

Are services caring?

- The school nurses had introduced a cognitive behaviour therapy model into primary schools which had included working with whole classes to reduce anxiety amongst the children.
- Links were made with the child and adolescent mental health teams (CAMHS) to refer young people for specialist mental health support.
- We observed good emotional support being provided by a community paediatrician at the Kingswood Hub when a child's mother became upset. The staff member was calm, reassuring and gave the mother time to recover before they checked she was ok to continue.
- Within the sexual health service the school nurses had liaised with school staff, with the permission of one young person, to be seen by the nurse outside of the usual clinic time. This enabled them to support the young person in a more effective way. We observed one school nurse supported a distressed young person who had attended the drop in clinic and spent time with them until they felt able to leave the clinic and return to school.
- The school nurses maintained strong and positive links with the local child and adolescent mental health service (CAMHS) when they identified young people with suspected mental health issues. Staff also were able to discuss the action they would take to support young people who arrived at the school / college drop in clinic with acute mental health issues and the action that would be taken.
- The contraception and sexual health service (CASH) had appointed a psychosexual counsellor in 2016. This service provided psychosexual therapy for patients usually referred by their GP or other health professional for many sexually related issues. The service used a recognised counselling model to assist patients with treatments including psychodynamic, cognitive behavioural and systemic counselling approaches.

Good

Are services responsive to people's needs?

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

Summary

We rated the responsiveness of the children and young people's service as being good. This was because;

- The services, which the provider were commissioned to provide, were planned to meet the needs of the local population. For example the B&NES Health visiting service moved from a GP based caseload to a new locality based caseload in 2015 which better served the needs of the local community with eight locality teams.
- The provider, as part of the community children's health partnership (CCHP), had worked with a charity in developing a participation strategy. This strategy outlined how children, young people and their families could be involved with service feedback, development and improvement.
- The Lifetime service, run over a wide geographical area to approximately 302 families with children with life limiting conditions, provided specialised, highly valued care and support.
- In the B&NES area children and their families were able to access services in a timely way for assessment and treatment. Services were appropriate were within national referral to treatment time targets for appointments. Services were also able to accommodate urgent appointments when these were assessed as being required.
- At the sexual health clinics there was no monitoring or auditing of the numbers of patients turned away from the clinic or tracking to see if they attended another clinic in the area.
- In CCHP, not all service users were receiving care at the right time. Access to community paediatricians within 18 weeks, completion of new born visits within 14 days, health visitor reviews, family nurse partnership visits during pregnancy, infancy and toddlerhood all had poor compliance.

Planning and delivering services which meet people's needs

- Commissioned services were planned to meet the needs of the local population. Services reflected local needs and were flexible in providing continuity of care and choice
- The B&NES health visiting service provided the nationally prescribed four levels of care including the "universal provision" and "universal partnership plus". These provide additional packages of care and support to families. Within these there were nine different care packages that a family could be provided with. The type of package was agreed between the family and the service following an assessment of needs. Each had agreed specific content and objectives.
- Sirona had a family nurse partnership scheme in both the B&NES and the South Gloucestershire area. The B&NES service had allocated funding for 80 places. The service, which was voluntary, monitored the level of enrolment, the level of completion of the programme and the number of visits completed. In the B&NES area 82% of people offered the programme enrolled and 44 % completed more than 80% of the expected visits. There had been an increased uptake during the previous twelve months, with the expected overall caseload going from 54 to 72.
- An "Early Days Baby Feeding Circle" pilot which was jointly run with the community midwife service had been set up to provide extra support for women experiencing breastfeeding problems. They aimed to develop a service that met the UNICEF Baby Friendly requirements. The project had an initial review after six weeks which produced positive feedback from staff and the mothers using the service. The report recommended that the services were reviewed again in six months when more evaluative data would be collected. We spoke with parents attending this service and they were very positive about the advice and the support provided. One mother told us, "it's been great to get such helpful and expert advice and meeting other mums with similar issues has been helpful as well".
- Sirona, which had provided services since 2011, had moved the B&NES Health visiting service from a GP based caseload to a new locality based caseload in

2015. There were now eight locality teams. The most recent records showed that the response to urgent referrals within 1 day to the referrer and 2 days to the family, was at 90 %. Sirona had a target of 95% for all referrals within 5 days and the most recent record for this was 90%. Mothers receiving a "mood assessment" at the required weeks in relation to mental health support being possibly required were recorded at 97% in last quarter against a target of 90%.

- The speech and language service gave an example of the service responding when there was reduction in the service for pre-school children with complex needs due to maternity leave. The team notified all the families affected and organised some additional input for children from other members of the team over the preceding summer holiday period. This ensured that the families affected by the reduction in service had as much input as could be provided over the preceding period.
- The Lifetime service provided support, care and advice to children and their families with life limiting illnesses and conditions. We saw evidence that the service planned to effectively meet as comprehensively as possible the needs of the families and children that accessed the service. At the time of our inspection there were approximately 250 children, and their families, receiving some form of service from the Lifetime team. The service had a team of nurses and psychologists who worked with the children and families and also a team of care assistants who provided direct care and support in the child's home. Staff we spoke with were positive about the unique joint working aspect of psychology and clinical input which the service provided to children and their families.
- We looked at samples of the recording and care planning completed by staff and also spoke with nurses and psychologists working for the Lifetime service. We saw that comprehensive assessments were competed and that detailed recorded was completed about visits. The views of parents and the child were recorded when appropriate. The staff aimed to provide as comprehensive a plan as possible to support families with the care of the child. As well as direct advice and information, guidance and support around the accessing of other medical services was provided. We spoke with one family who received a service. They told us the advice and support from the nurses was invaluable and the support workers were excellent and reliable.
- The service covered a wide area, reaching into five different clinical commissioning groups areas. The service also provided support groups for siblings and additional activities during school holidays and provided transition arrangements for children who were moving into adult services. The service had developed its skills in providing, were appropriate, advance care planning for children and their families. A medical discussion around a child's prognosis could result in the offer of advance care planning. Documentation had been developed that could be used to record final wishes, preferred place of care and a record of any discussions that took place with the families and the child. Written guidance was provided for staff in the managing of these situations and support was available from colleagues with the team. Guidance was provided for working with children and families experiencing grief and there was written material available for staff to share with families dealing with bereavement. The service continued to provide bereavement support to families for a period of eighteen months if this was asked for. There were clear written guidelines around this support and it also ensured that the family were provided additional information around any other support services they needed. Staff also ensured that the families had prompt practical help with the removing of equipment from the family home. We saw two examples of completed advance care plans and also care plans where families had declined the offer of this. This was sensitively and accurately recorded.
- The provider, as part CCHP, had worked with a charity in developing a participation strategy. This strategy outlined how children, young people and their families could be involved with service feedback, development and improvement. Regular meetings took place between Sirona's leadership and service users. These meetings provided a forum for feedback and learning so Sirona could develop their services with the service user's voice included.
- The reception area at the Kingswood Hub had numerous posters and leaflets providing information to children, young people and their families. Information

available included fostering, breast feeding, continence, bullying, septicaemia/meningitis, parent support, drug/alcohol support, childcare, young carers, baby clinics and service feedback forms. However, there were no alternative formats readily available (for example different languages or braille).

- The design of some services meant confidentiality could not be guaranteed at times. We attended a baby clinic at the Cadbury Heath Health Centre. The clinic was staffed by two health visitors and held in a large room that incorporated the waiting area. The health visitors had separate work stations but conversations with mothers were not private and could be heard by other mothers waiting to be seen. However, the health visitors assured us they were aware of this and said if there was a confidential or sensitive matter to discuss they would arrange a home visit or telephone call and would not discuss the matter in the clinic. We also spoke with three mothers who all told us they were not concerned about confidentiality because they could telephone and discuss difficult issues and felt the staff would step outside the room with them if there were any issues during the clinic.
- Translation services were available to support patients who required speech or sign language translation. Both face-to -face and telephone translation services were available, and staff told us the service was easy to access.
- The sexual health clinic at the Riverside Health centre was located in the centre of Bath, near public transport routes and public car parks which enabled easy access for patients. The clinic was open five days each week closing on Wednesdays and Sundays. Times of the clinics varied providing both walk-in and booked appointments with one evening open until 7pm. On a Saturday morning the clinic was open in the morning only. The Keynsham clinic was run from the health centre in the town and again offered public transport and car parking close by. This clinic opened on a Wednesday evening from 6pm until 8pm for both walk in and booked appointments.
- It was not clear whether any consultation had taken place with the public to assist in the decision of the times and days of these clinics. Two staff members we spoke with said that teenagers had commented an earlier clinic would have been helpful for them following on from school and college finishing times. However, other staff commented that the school nursing service provided a service to patients who attended schools and colleges and they chose not to come to the clinics at the health centres. We noted that the school nurses did not fit contraceptive implants so any young person requesting this would need to attend an external clinic for this treatment.
- We observed the patient journey in both the Riverside clinic and at Keynsham clinic from when they arrived to entering the consultation and leaving the building. At Riverside clinic there were information leaflets scattered on tables in the waiting room. There was no other form of distraction for patients while waiting for their appointment. We observed that most patients sat in the waiting room looking at their mobile telephones. For patients who attended with young children there was a brick maze available, but no other form of distraction or entertainment for children. The clinic at Keynsham was run from a GP surgery and we observed there were magazines, books and toys in addition to a television in the waiting room.
- Patients were able to attend a walk-in clinic each day as well as booking appointments. Patients made positive comments about the convenience of attending a walk-in clinic and that they did not normally need to wait for longer than 20 minutes to see a nurse. Those that had made an appointment expressed there had been no problems in getting through to book the appointment and that they had been provided with a date and time promptly.
- The data collected by the sexual health service showed that patients were generally seen by clinicians within the target of 45 minutes of arrival at the clinic. In June 2016, at the Keynsham clinic, it had been identified that this had been achieved for 93% of patients which meant three patients had waited longer than 45 minutes. We were told this was due to the business of the clinic and one patient taking longer than expected during an appointment. There were times at booked clinics when the data showed patients did not always see the clinician within 20 minutes of their booked clinic time. However, overall patients who booked an appointment were seen within the target time of 20 minutes.
- The service had reviewed the clinics offered at Keynsham and to streamline the service for patients booked walk-in patients and those with appointments

with different nurses. This was in response to feedback which identified patients with booked appointments had experienced longer waits than usual due to the processing of walk-in patients. The change in clinic arrangements had reduced the wait for patients with booked appointments.

Equality and diversity

- Services were designed with the needs of vulnerable people in mind and all areas we visited were accessible for children and their families with a physical disability.
- Interpreter services were available via the telephone if needed for non-English speaking families. All staff we spoke were aware of this service.
- Leaflets were available in English only but could be ordered in other languages and formats if required. However this meant other formats were not readily available for use in the walk-in – clinics.
- Staff we spoke with were aware of the ethnic and religious make-up of the people who used their services and were able to describe how they ensured they were culturally sensitive. We observed two examples when staff gave advice that it took in to account cultural sensitivities, one was around nutritional advice and the other around appointment times.
- People who used the services told us that they were treated with respect by staff and as individuals.

Meeting the needs of people in vulnerable circumstances

- The family nurse partnership service was available to a commissioned number of families in the B&NES area and the South Gloucestershire area. This is a service for first time mothers aged 20 or younger and provided a greater level of intervention and support than the heath visiting service. An extended eligibility criterion to include mothers up to the age of 24 years who have ever been 'looked after' or with a Special Educational Need or Disability had been launched.
- The family nurse programme planned a visit to each individual patient once a fortnight. However, we saw that on occasions this was increased to weekly if the family nurse considered this was necessary to provide appropriate support to the young person.
- There was both a designated nurse and doctor for 'looked after children' in the South Gloucestershire area. The details of these leads were made available to patients and carers, and were also published on the community children's health partnership (CCHP) website. The designated leads had good working relationships with the health visitors and school nurses, as well as the local authority. They also worked closely with social workers and received regular updates about the 170 'looked after' children in the area.
- A small number of young asylum seekers were being cared for in the South Gloucestershire area. All had been initially assessed and were being seen on a regular basis by a community paediatrician. Interpreters were booked through the local authority in advance of any appointments.

Access to the right care at the right time

- Children and their families were able to access services in a timely way for assessment and treatment. Services were appropriate and were within national referral to treatment time targets for appointments. Services were also able to accommodate urgent appointments when these were assessed as being required.
- For example the records for the initial health assessments that are required to be completed on all children entering care showed that 92% were completed within 20 days. The delays were all for children who had been placed out of area and the service were waiting for another authority to complete these. All the assessments for children placed within the locality were completed within the 20 working day target. The records for health assessments completed on children in care for more than twelve months showed that 94% of children were up to date with their health checks, dental checks and immunisations were recorded at 96% and 92% respectively.
- The school nursing service was available Monday to Fridays. During the school holidays three school nurses were available across the region for young people to contact should they need to. Information was provided regarding accessing this service to young people through the use of texts and leaflets prior to the end of term.

Good

Are services responsive to people's needs?

- The family nurse programme followed a national curriculum which included the number of visits during the three stages of the programme. The stages of the programme covered pregnancy, infancy (once the young person's baby was born) and during toddlerhood.
- However, in the CCHP, not all service users were receiving care at the right time. Between April and August 2016 only 89% of service users accessing the community paediatricians were seen within 18 weeks, against a target of 95%. Only 70% of the health visitors 12-month reviews had been completed by 15 months, against a target of 90%. For the six to eight week health visitor reviews, 83% had been completed within eight weeks, slightly below the 90% target. Only 61% of the health visitor visits to two and two and a half year reviews had been completed by age two and a half, against a target of 70%. However, 92% of 'looked after children' were up-to-date with their health assessment, slightly better than the 90% target. In school nursing, 100% of the schools were holding drop-in-clinics run by appropriately trained nurses.
- During the opening hours of the sexual health clinics there were always a minimum of two clinicians and a receptionist on duty. The reception staff recorded the time a walk in patient arrived at the clinic, by entering them into a time slot on the electronic clinic list. For patients attending for a booked appointment the reception staff recorded the time they arrived. This enabled clinicians to know the order patients had arrived so they could be seen in turn and also indicated when their patients for booked appointment were present.
- The reception staff informed us that within a two hour clinic they would book in up to 15 patients only. Once that number had been reached patients would be asked to return to another clinic or advised of the opening times of the main sexual health clinic at the local acute hospital. The exception to this would be if a patient requested emergency contraception, a young person for example under the age of 16, or someone in distress. However, there was no monitoring or auditing of the numbers of patients turned away from the clinic or tracking to see if they attended another clinic in the area.
- The receptionists in the sexual health clinics identified on the clinic list if the patient required care and treatment from a specific clinician. This was to ensure the nurse had the correct competencies to meet the young person's needs. All of the receptionists were provided with information regarding the skills and competencies of each clinician to ensure patients did not wait unduly. Once the clinician had called the patient through to the consultation, they updated the system to reflect the time their consultation and/or treatment started and also the time the consultation concluded. This enabled monitoring to take place of the patient journey and to ensure the clinic did not mean patients were waiting for unreasonable amounts of time.
- Two patients who attended together did not wish to wait to see the clinician. The receptionist discussed this with them calmly and they agreed to stay. The clinician was made aware of the situation and after 20 minutes they were both able to see the same clinician and discuss their concerns.
- We spoke with one patient who told us they had attended the clinic, having booked an appointment, for an insertion of an intrauterine device (IUD). They had not had a pre fitting consultation appointment at the clinic or by telephone. The lead clinician told us this would be at the choice of the patient. The patient expressed anxieties about the procedure and wanted to 'get it over'. We saw the patient following their appointment and the procedure had not been carried out for routine reasons and the patient was required to book another appointment to return to the clinic.
- The sexual health service monitored the numbers of patients who did not attend for their appointments. The England national average for a service the similar size was 8.7% of people not attending. Sirona had less than the national average at 8%.

Learning from complaints and concerns

- At the locations attended by families, such as the baby feeding hubs, we saw that information was displayed about the complaints process available to families.
- In the B&NES health visiting teams staff explained how they tried to resolve issues locally if possible but would also offer people the chance to contact a manager to discuss an issue. The managers explained how this could resolve issues in the majority of cases but that would always offer people an explanation of the formal

Good

Are services responsive to people's needs?

process they could follow if they chose to. One manager we spoke with explained how they could also pass people onto the Sirona customer care team if they felt this was more appropriate.

- Although there were three different organisations involved with the CCHP the various complaints departments worked closely together to ensure coordinated investigations and responses. When a complaint was received it was the responsibility of the receiving partner organisation to oversee the investigation and response. This ensured the complainant was not passed between organisations.
- The national average number of complaints per year for a sexual health service, similar to the service provided by Sirona, was 3.1. Sirona had received two complaints in the past year. We looked at the documentation around the complaints made. We saw that action had been taken to address the concerns raised to the satisfaction of the complainants. Apologies had been offered to the complainants from the service.

Good

Are services well-led?

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

Summary

We rated the well-led domain of children and young people's services as good. This was because:

- Sirona had a vision and set of core values that were well promoted and known to staff. Staff were proud of the organisation and the services they were involved in providing. Because the transfer of the community children's health partnership (CCHP) had only taken place on an interim basis, Sirona and the other partners had not introduced a new service vision and strategy. Instead, they were focusing on continuing to deliver the service while the contract tender process was being completed.
- There was evidence of strong governance and lines of accountability through both the B&NES and the CCHP areas. However there were some inconsistencies in the use of risk registers, the understanding of how issues were put onto the register and then subsequently monitored.
- Staff and managers were aware of their responsibilities and their roles and who they were accountable to. However leadership in the CCHP was complex with three partnership organisations employing staff across Bristol and South Gloucestershire.
- Staff we spoke with across the different services and teams told us they worked in an open culture and could discuss any issues that concerned them. We were told that managers were approachable and responsive. We saw that different team worked together when required and there was evidence of effective communication across the service generally.
- There were numerous examples of staff engaging with the users of services to gain feedback and use this information to influence service development.
- We saw examples of teams and individuals engaged in improving their services and its delivery through research and sharing of learning and participating in innovative projects.

However:

- There were inconsistencies in the use of risk registers and the understanding of the process for escalating concerns.

Detailed findings

Service vision and strategy

- Sirona had developed a set of service values based around a plan called 'Taking it Personally'. These had been developed with the involvement of various staff across the organization. The plan had been recognized and given a Health and Wellbeing award by the Royal Society for Public Health in 2015. We found that the core values were well known and understood by the majority of staff we spoke with. Staff were aware of the Sirona vision and values and able to describe them. Staff were proud of the organization and the services the teams they worked in were providing for children, young people and their families. Because the transfer of the CCHP had only taken place on an interim basis, Sirona and the other partners had not introduced a new service vision and strategy. Instead, they were focusing on continuing to deliver the service while the contract tender process was being completed.
- Individual services had a variety of business plans and action plans in place outlining their objectives and plans for the coming year. For example the B&NES family nurse partnership service had an action plan containing a wide range of objectives all with designated staff and target completion dates. These included strategic as well as practical aims, for example to review the service safeguarding model and also understand and discuss the service unborn baby protocol. The latest copy of the plan detailed the work that had been completed and was circulated to the services involved. 26 actions were identified on the improvement plan, and by the end of the first quarter 21 actions have either been commenced or completed.
- The sexual health services sat within the Health Improvement Division of the organisation. The clinical lead was provided with management support from the head of the division. A "safer services" monthly review

was completed to inform the monthly division report which went to the senior leadership team and ultimately to the Sirona board. The review included performance information as well as RAG rated risks and concerns.

Governance, risk management and quality measurement

- There were strong governance arrangements in place in both the B&NES services and the CCHP. Within the CCHP services an operational delivery group met monthly to discuss HR, performance, finance and risk across CCHP. This group included representation from all three partner organisations, including operational managers and heads of service. Within B&NES there was a clear structure of accountability and meetings of managers at various levels reporting into the registered manager and the board.
- Within CCHP a partnership executive group met regularly to review similar topics at a high-level, including any issues escalated to them and any issues which needed to be communicated downwards. As well as the chief executives of the partner organisations, the heads of service also attended these meetings.
- Reporting structures and communication threads were closely managed in CCHP to ensure a single message was received by all staff, service users, members of the public and other stakeholders. This ensured there was no confusion caused by multiple versions of the same communication.
- An overarching clinical governance steering group also met quarterly, with representatives from each organisation within CCHP.
- There were some inconsistencies in the keeping and monitoring of risk registers. Some services held a local register which was part of the provider wide register and some had their own. A single Sirona-wide risk register recorded any large corporate risks. In some services we were not assured that local risks triggering a high enough score to be placed on the corporate risk register were being adequately recorded and monitored. However in other services managers were clear about how they reported issues to be placed onto the risk register.
- The sexual health service completed risk assessments at a local level. Any identified risks were escalated to the corporate risk register. The sexual health service had two risks identified on the risk register and appropriate action had been taken to address the issues.
- The family nurse partnership team met every three months at a meeting attended by representatives from the national programme and external organisations who were involved in the programme. We attended a meeting and saw that actions from the previous meetings were reviewed and new actions implemented. A summary report was prepared and presented to this meeting which included quality measurements of the service provided.

Leadership of this service

- There was an effective governance structure in place to support the delivery of good quality care. Staff and managers were aware of their responsibilities and their roles and who they were accountable to. However leadership in the CCHP was complex. There were three partnership organisations who employed staff across Bristol and South Gloucestershire. Staff were organised by geographical boundaries and were not always managed by leaders from the organisation by whom they were employed. For example, the community paediatrician teams in Bristol were employed by Sirona but were line-managed operationally by managers from one of the partner organisations. Likewise, the Sirona operational service manager for community paediatricians in South Gloucestershire line-managed staff from one of the partner organisations. Although this arrangement required the operational service managers to understand and use different policies, procedures and systems to manage their staff, there did not appear to be any impact on their ability to effectively lead their teams.
- Regardless of the employing organisation, staff told us their leaders were approachable, considerate and fair.
- Staff who transferred to the provider as part of the CCHP contract felt well-supported by managers. Although the contract was only for one year while re-tendering took place, staff told us they received regular communications and felt they knew what was happening as soon as Sirona did. They also told us staff welfare was a priority for their managers during this period of unease.
- The registered manager for children's services chaired monthly health leads meetings for the B&NES area and also for the South Gloucestershire and Bristol teams.

Good

Are services well-led?

The minutes from the meetings showed a full range of issues being discussed, including complaints incidents, feedback on training and the progress of staff appraisals.

- All the B&NES health visiting managers of the eight locality teams met every week. Team managers would deputise for the service manager at meetings if they could not attend. The managers said they were kept well informed through line management and also had regular contact with the registered manager for children's services. A team brief was distributed every week and if required would be discussed at team meetings.
- The school nurses reported that their immediate line manager and head of division were accessible and approachable.
- Staff were confident that the school nursing service was represented at a board level, through the head of division, raising any issues or concerns through meetings which informed the board.
- The family nurses were supported by a family nurse programme supervisor who was available to them and provided regular formal supervision sessions to the nurses.
- Staff were positive about the local leadership of the sexual health service. All of the staff were fully aware of who their line manager was and that the service was now a nurse led service. Staff made positive comments regarding the clinical lead for the sexual health service. This had been a relatively new position which had been put into place since the retirement of the consultant from the service. They said they could contact them at any time by telephone or email, even when they were not on duty. They spoke of an open door policy and could approach them for help and guidance at any time.

Culture within this service

- Staff we spoke with across the different services and teams told us they worked in an open culture and could discuss any issues that concerned them. We were told that managers were approachable and responsive. We saw that different teams worked together when required and there was evidence of effective communication across the service generally.
- The school nurses reported that they considered their team and the wider organisation to be open and transparent which enabled concerns to be raised. When concerns were raised they felt listened to and not judged by peers or their managers.
- Staff in the sexual health service spoke of feeling proud of the service they delivered and that they worked well as a cohesive team.
- Staff spoke of a 'no blame' culture within the organisation which provided the confidence to raise any concerns, report untoward incidents and enable shared learning to take place.
- Positive comments were made regarding the cultural changes that had taken place within the health visiting service moving from a medical model to a psychosocial model of care when working with families. This model relates to the interrelation of social factors and individual thought and behaviour. Staff were able to describe how they formed partnerships with people and their families and were child focussed.
- Staff working for Sirona as part of the CCHP felt valued and respected. All the staff we spoke with spoke of a positive culture in which they were able to be open and honest and felt supported by their managers and peers.
- Staff told us they enjoyed working for the provider because it truly had a community focus. There was a real sense of pride from staff in their ability to meet the needs of children and young people.
- The lone working policy was applied across Sirona, with local amendments as required depending on team size, location and geographical differences. Staff working remotely ensured team members knew where they were and what time they would be expected back. All staff were issued with mobile telephones so they could call for advice or assistance if required. Clear procedures were in place to ensure the safety of staff in the event they did not return or make contact when expected.

Public engagement

- Sirona had various processes and arrangements in place in the different service to collect the views of people using their services. This included children and families. Information was used to develop and improve services and feedback was provided to the users of services.
- The school nurses engaged with children and young people when developing the service they provided. For example, we were told a focus group consisting of four

'looked after' children and young people, who were leaving the care service, were included in discussions about the questions asked on an assessment tool. Their views and feedback were discussed and plans made to include their suggestions in the redesigned template.

- The school nursing service provided information for children and young people on the school and college websites. Recent feedback from young people had been that they preferred information to be available on an app as opposed to a website. The school nursing team had listened to this feedback were in the discussion and planning stage of building a service app to provide information.
- There was a programme of engagement with children, young people and their families. The provider worked closely with a charity as part of the CCHP to ensure service users were engaged with service provision and development.
- The charity's HYPE programme (Helping Young People (and children and families) to Engage) was created for CCHP and the provider was actively involved with the programme. HYPE supported children and families to have a say, recognising them as experts in their own lives who could influence how their health services were delivered. One example of the work completed was the production of a young people's charter as part of the participation strategy, which was written following input from service users.
- In CCHP a regular paper-based survey called 'How to be Heard' was being used and all areas participated for three months a year. Information from this survey was used to help identify areas for development. One example included the decoration of waiting rooms to be less 'clinical' with artwork that was created in children's workshops.
- The reception area at the Kingswood Hub had a 'You Said, We Did' board, displaying feedback they had received and the actions they had taken in response. If they had been unable to take any action, an explanation was provided.
- An audit was carried out by community paediatricians and children community nurses of 'all looked' after children over a three month period. Questions were included about the appropriateness of where and when they were seen, the friendliness of the staff and whether they had been given the option to be seen without a carer. This had produced positive feedback generally and it was planned to carry out the audit on an annual basis.
- The B&NES looked after children team had completed a survey of children who had health checks completed asking for feedback on the process and their thoughts on their health and well-being.
- In March 2015 an audit was carried out at all the baby feeding hubs, to obtain feedback from volunteers and families. Another audit was carried on 18 families who did not attend the hubs. Feedback was taken about the environment, and the facilities and the quality of service provided generally. Actions were taken up and included in service action plans by health visiting teams and recommendations made to the service managers.
- The Wiltshire clinical commissioning group had requested that the provider develop a tool within its specialist children's services to obtain and measure children's feedback on the quality of the care they had experienced. This was undertaken and completed and a report was completed in February 2016. This looked at three age ranges: 6-10, 11-15, 16-19 and had age specific questions for each group.
- The provider encouraged feedback through a 'Voice of the Child' survey for 30% of each service they provided. The overall return rate was 24% though some services had a 50% return rate. Overall feedback was positive with 78% of children saying their appointment had gone well and 88% saying they were listened to.
- The Lifetime service ran a children's group and as part of the evaluation asked those attending to complete a survey about their experience. Key feedback was 71% saying they would like to attend another session and 26% saying they thought the meeting was too much like school.
- The Contraception and Sexual Health Service (CASH) had surveyed patients attending the service over the year 2015 to 2016. Patients responded positively regarding the opening times of the clinic, the friendly and courteous reception staff, the promotion of their privacy and dignity and responses by the staff to the questions they asked.
- Consultation with young people had taken place during the development of the CASH information app that was

in operation within the school nursing service. Young people had been consulted on what they would like included in the app and the information, support and guidance they required.

- The school nurses had consulted with young people who used the school or college drop in for the contraception and sexual health service. As a result of feedback from young people a change had been made to where the clinic was run within the school. This was due to a perceived lack of privacy and confidentiality felt by the young people.

Staff engagement

- The provider staff working as part of the CCHP and B&NES told us they were given lots of opportunities to provide feedback and question how things were done. They felt engaged by their managers and believed their contributions to service developments were valued. For example, when the geographical boundaries were reorganised staff were asked for their thoughts and the final changes reflected the contributions made by staff.
- There was a monthly team briefing for all staff, and an additional separate update for CCHP staff. These ensured staff received regular messages with updates, and learning from incidents and complaints. Staff were also kept up to date through the provider intranet site, which included board bulletins, team and manager briefings, as well as copies of the staff newsletters.

Innovation, improvement and sustainability

- We saw examples of teams and individuals engaged in improving their services and its delivery through research and sharing of learning and participating in innovative projects.
- A project has been approved and was awaiting implementation to develop a cerebral palsy integrated pathway across the south west of England. This is intended to improve the lives of children with cerebral palsy by implementing a standardised surveillance and assessment process of the musculoskeletal system. The project aims to provide a database for the integrated care for children with cerebral palsy in the south west.
- Children and young people were involved with the recruitment process for new staff. Working with a charity as part of the CCHP, the provider had prepared a number of children and young people to sit on interview panels and score interviews. Children and young people had sat on 70% of the interview panels since April 2016, including interviews for receptionists, nurses and managers. The scoring system used to inform the recruitment decisions took into account the scores awarded by the children and young people.
- In the sexual health service staff we spoke with told us they were encouraged to share thoughts for practice improvements. For example the reception staff had developed a form to enable patients to share personal and confidential information by a simple tick list rather than being overheard by other patients.
- One school nurse had developed an app to be used on smart phones and tablets in order to provide information and a prompt to young people about contraception.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **18**(2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The provider must ensure that all staff are up to date with their safeguarding training and that this is completed to the required level as per national guidance

This section is primarily information for the provider

Enforcement actions

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.