Central Surrey Health Limited

Quality Report

Ewell Court Clinic, Ewell Court Avenue, Ewell KT19 0DZ
Tel:02083943860
Website: www.cshsurrey.co.uk

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Core services inspected	CQC registered location	CQC location ID
Community Children and Young People	Ewell Court Clinic	1-506761925
Community Adults	Ewell Court Clinic	1-506761925
Dorking Community Hospital	Dorking Community Hospital	1-506761958
The New Epsom and Ewell Community Hospital	The New Epsom and Ewell Community Hospital	1-506761974
Molesey Community Hospital	Molesey Community Hospital	1-506761990

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

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

Overall rating for community health services at this provider	Good 
Are services safe?	**Requires improvement** 
Are services effective?	**Good** 
Are services caring?	**Outstanding** 
Are services responsive?	**Good** 
Are services well-led?	**Good** 

Summary of findings

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Summary of findings

Our inspection team

Our inspection team was led by Shaun Marten and Elizabeth Kershaw, CQC inspection managers and comprised four inspectors and specialist advisors with expertise in community therapy 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 the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- Visited Dorking Community Hospital, Molesey Community Hospital, New Epsom and Ewell Community Hospital and looked at the quality of the care environment and observed how staff were caring for patients.
- Visited community health services for adults at the above hospitals plus Leatherhead Community Hospital and other community locations.
- Visited Children, Young People and Families services at the above hospitals and other community locations.
- Spoke with 48 patients and 25 relatives (including parents) who were using the service.
- Reviewed 107 feedback comment cards.
- Spoke with 125 co-owners including nurses, medical staff, occupational therapist, physiotherapist, therapy technicians and administrative staff.
- Attended multi-disciplinary meetings
- Looked at five care and treatment records of patients
- Reviewed a range of policies, procedures and other documents relating to the running of the services.

Information about the provider

Central Surrey Health Limited (CSH) is a profit-for- social purpose social enterprise set up by employees (called co-owners) in 2006. As the first of its type in the country, the organisation re-invested any financial surplus from activities back into the business and local community projects. Around 40 other providers have since followed this model of healthcare.

Central Surrey Health Limited is the registered provider.

Summary of findings

Dorking Community Hospital provides a community inpatient service on Ranmore ward which has 22 beds. On the day of inspection, an additional four beds had been opened in response to increased demand and 26 beds were in use. The services provided include palliative care and rehabilitation. Patients are admitted to community inpatient services from acute hospital or from their own home. At Dorking Community Hospital the medical services are provided by a local General Practitioner Practice.

The New Epsom and Ewell Community Hospital provides a community inpatient service on one ward which has 20 beds. Four of the beds are designated for neurological rehabilitation, the remaining 16 are for rehabilitation. Patients are admitted to community inpatient services from acute hospitals or their own home. Medical services for the hospital are provided by a local General Practitioner Practice.

Molesey Community Hospital provides a community inpatient service on one ward which has 12 beds. The services provided include palliative care and rehabilitation. Patients are admitted to community inpatient services from their own home or from acute hospitals. At Molesey Community Hospital the medical services are provided by a local General Practitioner Practice.

The services provided for Children and Young People (CYP) include health visiting, school nursing, community paediatric nursing, integrated therapies, community paediatrics, audiology, continuing care, and services for Looked After Children (LAC), speech and language, physiotherapy and occupational therapy.

CSH provides a range of nursing and therapeutic services to the adult population of mid Surrey. These services included district nursing, physiotherapy and podiatry. Local commissioning bodies purchased additional specialist nursing and therapy services, which included end of life care, frailty and falls, continence, respiratory, heart failure, tissue viability and integrated rehabilitation services.

CSH delivers these services in people's homes or clinics located in neighbourhood medical centres and community hospitals. Clinics in the community hospitals also accept outpatients discharged from the wards or from other hospitals in the area. In addition, a wheelchair service operates from one community hospital.

The delivery of care was divided into two main groups, called 'planned care' and 'unplanned care'. Planned care included musculoskeletal physiotherapy, hand therapy, podiatry, wheelchair and continence services. Planned care utilised waiting lists and had targets set in agreement with the commissioning bodies. Unplanned care services included district nursing and domiciliary physiotherapy, community matrons and specialist nursing teams that responded directly to referrals from GPs and local hospitals.

Good practice

- We saw that there was an imaginative approach on managing the risk of patient falls at Dorking Community Hospital with the desktop mapping of the ward using Lego enabling co-owners to identify where falls had occurred and where there might be increased risk for the patients. This heightened the awareness of all the co-owners to patient falls and not only enhanced the safety of the patients it was a learning tool for staff that had a good practical application.
- In community hospitals, the introduction of the 'blue moon' project enabled staff to identify patients with cognitive impairment such as dementia, which meant that by the wearing of a blue wristband co-owners could easily identify that certain patients needed additional support to be safe in their surroundings. We saw this as enhancing safety for particularly vulnerable patients.
- The Special Educational Needs Team (SEND) team went beyond their roles to ensure that the children in their care, their families, and siblings received a consistent, high quality holistic service.

Requires improvement

Are services safe?

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

Areas for improvement

Action the provider MUST or SHOULD take to improve

CSH should ensure the tongue tie service can meet the needs of the local population in a timely manner.

CSH should improve management over sight of the SEND service and effectively manage any risks in the service in a responsive way.

CSH should improve its staffing levels across the entire children and young people's service.

CSH should improve the appraisal rates across all staff groups in the service.

CSH should review its current local and national audit activity with a view to strengthening the service and empowering co-owners to embrace a positive audit culture.

CSH should review its governance oversight within children and young people's services of incident handling and complaints management to ensure quality.

CSH should review the way it manages data in the organisation to ensure it can demonstrate quality outcomes for all its services.

Requires improvement

Are services safe?

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

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

Summary of findings

The provider was rated as requires improvement for safe. This was because:

- The quality of investigation of incidents was variable across the services provided.
- Co-owners in children and young people's services had not been suitably trained to investigate incidents.
- Staffing levels within children and young people's services were at a low level and impacted on co-owner wellbeing and patient care.
- Hand hygiene audits in children and young people's services lacked senior oversight and the service was unable to provide evidence of medicines audit activity.

However,

- Despite a challenging environment all areas were seen as visibly clean and staff followed infection control guidelines.
- There were robust processes for the management of safeguarding issues.
- A strong portfolio of mandatory training was available to co-owners although overall compliance was not meeting the trust stretch target of 95%.

Requires improvement

Are services safe?

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

Our findings

Duty of Candour

- Co-owners across the provider were aware of their responsibilities in discharging duty of candour.
- There were policies to inform co-owners of actions required to meet the duty of candour and incident systems supported the identification of cases requiring a duty of candour response.
- We saw the duty of candour was being appropriately applied.

Safeguarding

- The provider had up to date policies relating to both adult and child safeguarding that were based on best practice.
- Co-owners received appropriate levels of safeguarding training and staff attendance at training was compliant with targets.
- A safeguarding team was in place and co-owners were aware of the processes for reporting and escalating safeguarding issues to the team.
- Safeguarding incidents were monitored with appropriate senior oversight. Opportunities for learning from such incidents were taken.
- Provider processes allowed for the identification of risk such as Looked After Children (LAC) and also provided alerts if at risk children missed planned outpatients appointments.
- The provider internet site gave the public the route for reporting safeguarding concerns

Incidents

- There was an incident reporting system. Co- owners were aware of the system and had received training on its use.
- The provider had not reported any Never Events in the last twelve months.
- Incident reporting in adult settings was of the expected level, however in children and young people's services incidents were under reported and opportunities for learning were not being maximised.
- In both adult and children and young people's services the standard of report investigation was inconsistent. Co-owners with responsibility for investigating incidents, notably in children and young people's services, had not received comprehensive training and were not skilled to perform the task.
- Incident reporting practice and process was robust across all community hospitals. Co-owners were fully aware of systems, had access to feedback and opportunities to learn from incidents. The desk top modelling to identify environmental risk and hazard at Dorking Community Hospital was particularly impressive.
- The provider undertook thematic review and analysis of incidents.
- The provider used a core brief process to disseminate learning from incidents but in some areas co-owners reported that workforce levels prevented this from being a fully effective process.

Infection control, equipment and environment

- Areas inspected were largely visibly clean and supported by cleaning programmes.
- The provider had an up to date evidence based prevention of infection policy.
- Co-owners had access to the policy and also to personal protective equipment and cleansing agents. Observed practice met expected standards.
- The environment and co-owner practice was subject to audit, however in children and young people's services audit was not robust, lacked review and did not have suitable senior oversight.
- Co-owners had access to equipment that had been maintained and cleaned. Emergency resuscitation equipment was subject to regular checks.
- Co-owners reported a number of estates related concerns that had not been addressed within a suitable timescale. The Molesey Community Hospital in particular was of outdated design and poor repair. Estates issues were managed by a separate organisation and lack of response was a source of concern to the senior management team.
- At the Molesey Community Hospital site the fire risk assessment action plan had not been fully acted upon.

Requires improvement

Are services safe?

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

Training

- An extensive portfolio of mandatory and other training was available to co-owners and was delivered via on line and class room based training.
- The provider monitored attendance and compliance was generally good across the workforce. However some co-owners reported difficulties in attendance due to workforce shortages.
- The provider had prioritised aspects of co-owner training and in order to facilitate delivery had arranged events such as the training 'big day'.

Medicines and health records

- Medicines were largely stored in a secure manner with storage conditions monitored. However, we did observe an unlocked medicines cabinet and a lack of temperature monitoring at weekends.
- Patient Group Directives (PGD's) were up to date and subject to review.
- We were advised that medicines were subject to audit but when following up a planned audit in SEND services the provider could not satisfy our request for audit evidence.
- Medicines at all community hospital sites were stored and monitored in an appropriate manner although on one site ambient room temperatures were not being monitored,
- Wards in community hospital locations had appropriate levels of pharmacist support.

Staffing

- Nursing co-owners at all community hospital sites was at appropriate levels, albeit supported by temporary bank and agency staff at times. Medical support was maintained by visiting general practitioners with ward rounds occurring at regular intervals.
- In children and young people's services co-ownership levels were described as stretched with less success in covering vacancies with bank and agency staff. This resulted in increased risk of delays in service delivery and had impacted on the delivery of care to SEND patients and the wellbeing of co-owners.
- In Community Adults the increasing caseload per member co-owner was detailed on the provider risk register. The resulting workload pressure was impacting on co-owner wellbeing but at this stage had not affected safe patient care or service delivery.

Major incident awareness and training

- Business continuity plans were in place across the provider services. However, it was noted that scenario testing for cardiac arrest had not taken place at Dorking Community Hospital as recently as would be expected.

Are services effective?

Good

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

Summary of findings

The provider was rated as good for provision of effective care. This was because:-

- There was structure in place to ensure staff competence and this was supported by up to date, evidence based policies and procedures.
- The provider used a range of patient outcome measures to benchmark, monitor and drive service improvement.
- Pain relief was well supported with suitable techniques applied for patients with complex needs.

Our findings

Evidence based care and treatment

- The provider had up to date policies that were based on best practice and national guidance, including those required to support the management of end of life care.
- Community hospitals had participated in national benchmarking exercises and performed favourably with respect to length of stay and readmission rates.
- We saw evidence of local audit activity within services and the analysis of audit results to further service improvement. However, in children and young people's services there was no clear audit plan and limited audit activity.

Patient outcomes

- In community hospitals outcomes from catheter audits had been reviewed and used to inform training and enhance patient care.
- In addition, tools such as Modified Barthel index (MBI), functional independence measure (FIM) and elderly mobility scale (EMS) were all in use to measure patient outcomes.
- In children and young people's services good outcomes were being obtained in the measurement of maternal mood, post birth visits and twelve month reviews.
- However, in adult community services we noted some audit data was incomplete and out dated.

Pain relief and use of telemedicine

- Although there was no formal pain team available in community hospitals all patients indicated that they were happy with the level of pain relief they received.
- In children and young people's services discussions with patients regarding pain relief were facilitated with appropriate age related tools.
- The needs of complex patients with SEND were also well supported using a variety of pain assessment methods.
- During the inspection we saw examples of the use of telemedicine including movement monitors to manage the risk of falls, GP communication via text and hand held electronic devices to support reminiscence in patients living with dementia.

Competent staff and multidisciplinary working

- We saw use of induction, competency frameworks, appraisal and personal development plans to maintain competence across all services. However, in some co-owner groups appraisal rates were not meeting the trust standard, notably in school nurses.
- There was a high degree of multidisciplinary working across the services provided. Regular MDT review occurred across all services.
- Services had ready access to specialist services including social workers, dieticians and speech and language therapists.
- Occupational therapists in community hospital settings had a clear focus on safe discharge and there was links between services and local authority nurses.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Co-owners across all services were aware of the MCA and its implications for patients.
- Likewise, DoLS was well understood and where applied assessment, documentation and review met national guidance.
- Processes for consent were well managed with appropriate arrangements in place for children and young people.

Outstanding ☆

Are services caring?

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

Summary of findings

The provider was rated as outstanding for caring. This was because:-

- Children and young people's services were rated as outstanding, whilst community adult services and all community inpatient services were rated as good.
- Our observations and feedback from patients and carers indicated that co-owners placed privacy and dignity as a priority. Feedback from patients and carers using the children and young people's service was overwhelmingly positive and we saw numerous examples of co-owners going the extra mile to provide support and meet patients' needs.
- Co-owners across all the services demonstrated an understanding of holistic care and the need to provide emotional support to patients and carers.

Our findings

Compassionate care

- The patients and carers we spoke to in all services were highly complimentary of the care they received.
- Our observations of co-owners interacting with patients and carers indicated a high degree of patient focus with co-owners showing clear empathy for patients.
- Co-owners took immediate and effective action in the event of any issue arising that may compromise patient dignity, comfort or experience.
- Patient privacy and dignity was a priority for co-owners and was supported by the development of designated dignity champions and meetings that facilitated discussions relating to patient and care feedback.
- In the children and young people's service we found a strong belief in the "patient first ethos" which extended into a very high degree of compassionate support to parents and carers.
- However, Patient Led Assessment of the Care Environment (PLACE) scores relating to privacy and dignity at all community hospital sites were below the national average. A corporate action plan had been implemented and was close to completion.

Understanding and involvement of patients and those close to them

- Co-owners in all services successfully endeavoured to ensure that patients and carers were both informed and involved in the design and delivery of care.
- Comments from patients and carers supported our observations of involvement and spoke positively of accessibility of co-owners and information.
- Co-owners worked with patients to develop and attain personal goals in both the home and hospital environment, enhancing recovery and rehabilitation.
- Hospital discharge was planned with due regard to and with the involvement of patients and carers.
- The SEND service was exceptionally highly regarded by carers for its holistic approach. In addition there were numerous examples of co-owners making a commitment to patient support and care beyond that routinely seen.

Emotional support

- Co-owners in all services were aware of the emotional needs of patients and carers. This included the issue of an anxiety management plan.
- During the inspection we saw interactions between co-owners and patients that supported emotional need and we also saw that such requirements were documented.
- Patients had access to spiritual advisors and chaplaincy as required and in addition to a number of advocacy services.

Good

Are services responsive to people's needs?

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

Summary of findings

The provider was rated as good for being responsive. This was because:-

- Services were planned in conjunction with commissioners to meet the needs of the local population with appropriate consideration of seasonal pressures.
- The design of facilities and use of communication techniques took account of the needs of vulnerable people.
- Generally services could be accessed in a timely manner.

Our findings

Service planning and delivery to meet the needs of local people

- Services were planned in conjunction with local commissioners and with a view to serving the local population.
- In community hospitals, facilities had been designed and planned to meet patient needs and support rehabilitation. This included access to kitchens and outdoor recreational spaces. However, signage and colour coding of toilets could be improved to support patients living with dementia.
- Other key stakeholders including social workers and local authority nurses were engaged with the provider to assist in achieving smooth and supportive transition for patients, particularly for those with complex needs.
- Additional bed capacity had been planned in response to activity surges in demand and winter pressures.
- The provider had given due consideration to the diversity of the population it served in its design and had taken steps to ensure equitable access to services. This included initiatives to promote access for hard to reach groups including asylum seekers, travellers and ethnic minority groups. However, we noted a lack of access to information in foreign languages.

Meeting needs of people in vulnerable circumstances

- The provider had developed services to support patients living with dementia in both in patient and out patient settings. Co -owners had received specific training to support this group of patients. A dementia navigator role had been developed to support patients and carers.
- Facilities were well designed to support access by disabled patients and visitors including access to toilets and bathrooms.
- The provider had developed a learning disability team and co-workers had access to a file and tools to aid communication with patients with learning disabilities.
- The provider used indicators to identify vulnerable patients and to ensure that care was suitably tailored. These included colour coded and pictorial bedside markers and colour coded wrist bands.
- There was an alert system to ensure that co-owners were aware when vulnerable children failed to attend appointments. There was also a clear plan for transition when a young person moved into care provided by adult services.

Access to right care at the right time

- The provider collated and reviewed performance data relating to access to services on a regular basis. However, although planning to do so, the provider was not collecting data relating to delayed discharge from community hospital beds.
- In children and young people's services the time to first appointment from referral was being met by all therapy services. However, patients were experiencing extended waits for the tongue tie service.
- Did not attend (DNA) rates in children and young persons services had come under scrutiny and the provider was planning to address this with the implementation of a text messaging service.
- Adult therapy services met referral to treatment standards with the exception of hand therapy services for which 16% patients waited longer than 18 weeks.
- Bed occupancy rates in all community hospitals exceeded 90%, however the provider was achieving an average admission from time of referral of one day which was better than the national average for community services.

Good

Are services responsive to people's needs?

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

Learning from complaints and concerns

- All services received low levels of complaints and there was a process that supported shared learning. However, our review of complaints indicated that the quality of response was inconsistent in both children and young people's and adult community services and this may have impeded the opportunities to learn from complaints.

Are services well-led?

Good

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

Summary of findings

The provider was rated good for well led. This was because:-

- Leadership was visible throughout the organisation and provided vision, demonstrable values and clarity of strategy.
- Co-owners were highly engaged and the culture of the organisation was exceptionally positive.
- Governance was largely robust, although understanding of process was less comprehensive in children and young people's services.
- Although some elements of well led in children and young people's services required improvement, the overall standard of leadership provided outweighed those concerns. We have deviated from our usual aggregation of key ratings to rate this service in a way that properly reflects our findings and avoids unfairness.

Our findings

Leadership of the provider

- The provider was founded as a profit-for- social purpose social enterprise in 2006. This was the first such initiative in healthcare. The CEO was central in the initiation and development of this model of healthcare and has been nationally recognised and awarded for this work.
- During the inspection we interviewed all executive team members, the chair and three non executive directors.
- The executive and non-executive teams were stable and at full establishment at the time of inspection, with only the director of quality position being occupied by an interim.
- The CEO had founded the provider in its revised business structure in 2006 and has consequently been in post for 10 years. This continuity of leadership and vision had been a major benefit in the provider's growth and development.
- The chair had been in post since 2014 following extensive experience as a non-executive director. The chair demonstrated understanding of broader healthcare strategies and his role in engagement. The chair also described the developmental needs of the board and modes of accountability for non-executive directors.
- Non-executive directors possessed appropriate experience for the role and chaired sub - board committees. A continuous programme of clinical walkabouts was conducted by non-executive directors.
- The provider had a human resource strategy that maximised the benefits and opportunities afforded by the social enterprise model.
- There was a model of financial control and oversight that took due account and diligence of clinical service risk and opportunities for business growth.
- All members of the leadership team showed a very strong commitment to the ethos of the provider as a social enterprise and eloquently described its link to organisational success, high standards of patient care and co-owner satisfaction. As well as clearly shared values there was also a shared and consistent understanding of strategic plans, priorities of the organisation and strategic risk.
- There was a clear management structure below the executive team that facilitated direction throughout the organisation and provided clear accountability.
- Co-owners reported that the executive team was both visible and responsive and expressed a high degree of confidence in their leadership. Similarly service level leadership was also well regarded. However, some co-owners within children and young people's services expressed the view that senior leaders had not been responsive to their concerns when raised.
- The provider had developed a comprehensive leadership programme for both aspiring and new managers. In addition a series of individual skills based modules had been developed that was aimed at enhancing leadership capability.
- It was apparent within the organisation that the status of co-ownership elicited a strong sense that all individuals had a leadership role within the organisation. This was facilitated by the provider via co-owner forums and the board level co-owner meeting called The Voice. However, the provider reported that it was currently struggling to recruit co-owners into key positions on The Voice.

Are services well-led?

Good

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

Vision and strategy

- The provider had a vision for the organisation and co-owners to be recognised nationally for transforming health and care through pioneering, innovative and integrated services that deliver exceptional care for patients.
- The provider vision was underpinned by four values: people first, integrity, enterprising and exceptional delivery.
- Throughout the organisation there was a strong recognition by co-owners of both vision and values with a sense of association and contribution towards both their development and delivery.
- Appraisal systems implemented throughout the organisation incorporated values based assessments.
- The provider had developed a five year quality strategy.
- The provider had a four point annual business plan that focused on engaged employees, innovation, high quality care and growth. This strategy was reflected in service plans. The plan was well communicated through the organisation via a one page schematic. Co-owners felt fully involved in the development of plans.

Governance, risk management and quality measurement

- The provider board met monthly. Board meetings are not held in public and minutes are not available on the provider website and the quality of board papers was not included in this inspection.
- The Voice was an innovative bi-monthly meeting that was chaired by a co-owner and with non-executive attendance that then acted as representation at the provider board meeting. This provided opportunity for co-owners to receive progress reports and contribute towards strategic and quality themes, whilst also holding the board to account.
- Three committees provided assurance to the board on matters relating integrated governance, finance and appointments and remuneration.
- A broad and appropriate portfolio of committees reported to the quality and clinical governance committee. This included a professional congress which aimed to provide clinicians further opportunity to inform and influence professional development and quality of services.
- The trust utilised a 'house of quality' approach to reporting through to the integrated governance committee. This approach was aligned to the CQC key questions of safe, effective, caring, responsive and well led.
- For operational matters, the executive committee met monthly. Contract performance, health and safety, equality and diversity, emergency planning and business planning all reported to the executive committee.
- Risk registers were in place at both a corporate and service level and regularly reviewed for mitigation progress.
- Most services reported a clear link from service level to board and an understanding of the processes of governance and risk management. However, in children and young peoples service's we identified a lack of understanding of how the governance and risk systems worked. This correlated with an inability to identify key risks or maximise learning from incidents and complaints.
- The provider publishes an annual report, an annual quality report and an equality and diversity report. All reports were available on the provider web site.

Culture within the provider

- Across all services we found a very positive and engaged workforce. It was clear that co-ownership was of significant value and assisted in generating a feeling of inclusion, involvement and influence. A strong sense of pride existed within co-owners.
- A feature of the culture of the organisation was its ability to embrace change and address the challenges that change brings.
- Our interviews with co-owners indicated that co-ownership generated an enhanced level of accountability for quality of care and patient experience.

Co-owners engagement

- The provider had a strategy for maintaining co-owner engagement based on empowerment, involvement and information which was supported by The Voice and co-owner forums.
- Co-owners interviewed were highly engaged and this was further evidenced by high engagement scores in all areas in the 2016 co-owner survey. Co-owners were extremely likely to recommend the provider as a place to work.

Are services well-led?

Good

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

- Recognition of excellence was integral to the trust with annual awards ceremonies for both individuals and teams.
- The board recognised the contribution of co-owners at Christmas by providing a 'thank you' fruit basket.

Public engagement

- The provider utilised a number of methods to obtain public feedback and engagement including questionnaires and user view surveys.
- The provider website was informative and allowed for feedback to be provided electronically.
- The provider used some of its reserves, along with contributions made by co-owner fund-raising activities, to support local community projects. Co-owners were involved in the selection of projects to support.
- The provider regularly engaged in health promotion activities in the community.