Good

Sirona Care & Health C.I.C.

Community mental health services for people with learning disabilities or autism

Quality Report

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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 Martin's Hospital	B&NES Complex Health Needs Service	
1-297411781	St Martin's Hospital	South Gloucestershire Community Learning Disabilities team	

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

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 the service	Good
Are services safe?	Good
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

Sirona is a community interest company that provides community health and adult social care services and was established in October 2011. Sirona provides a number of services to people with a learning disability including health services and social care.

This inspection focussed on the health services that Sirona provided to people with learning disabilities. The complex health needs team in Bath and north east Somerset (B&NES) and the community learning disability service in south Gloucestershire both provide multidisciplinary services to work with people who have a learning disability who require support for complex health needs including mental health care.

The south Gloucestershire service has a hydrotherapy service attached to it.

The complex health needs team is commissioned by B&NES clinical commissioning group and the south Gloucestershire community learning difficulties team is commissioned by south Gloucestershire clinical commissioning group. Each service is commissioned separately with specific service requirements.

We rated Sirona community mental health services for people with learning disabilities as good because:

- Service users told us that staff were supportive and caring, treating them with dignity, respect and kindness. Service users felt that staff listened to them. Carers commented that staff were interested in them and the service users as people. Staff displayed warmth and genuine interest in people using the service. This was evident for all staff within the teams.
- The service used interventions in line with National Institute for Health and Care Excellence (NICE) guidance delivered by a diverse and skilled multidisciplinary team.
- Service users were seen within four weeks from referral to the service. Service users, their carers and social care providers all said that staff were accessible quickly when they needed them.
- There was clear leadership evident from team leaders and the divisional manager that was respected and valued by staff within the service. Staff we spoke with were very complimentary about the team managers and the support and direction they give the teams.

However,

- Care records were stored on multiple systems and this meant that important service user information was not easily available to staff. Although daily record entries were of a good standard, staff were not readily able to identify where risk assessments and care plans were kept.
- In B&NES there was a lack of oversight of each service user's care (other than for those receiving care under the care programme approach) as community nurses did not undertake the care coordination role as in south Gloucestershire. Staff told us that this provided some risk for service users and left staff feeling that they worked in isolation

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- All sites, including Ash House, were clean. The hydrotherapy pool was cleaned to a very high standard by the staff team. Both Church House and the Thornbury office sites were well maintained.
- There were systems in place to monitor incidents and share learning from investigations.
- There were good levels of staffing with a stable staff team.
- Safeguarding was managed well.

However,

- Building maintenance at Ash House was poor. There were delays in reported jobs being completed.

Risk assessments were present but difficult to find on the electronic care notes system. There was no consistent place for them and it relied on staff to highlight risks. The risk assessments varied in quality from basic risk assessment to detailed comprehensive understanding of risks.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Care records were stored on multiple systems and this meant that important service user information not easily available to staff. Although daily record entries were of a good standard, staff were not able to identify where assessments and care plans were kept.
- In B&NES there was a lack of oversight of each service user's care (other than for those receiving care under the care programme approach) as community nurses did not undertake the care coordination role as in south Gloucestershire. Staff told us that this provided some risk for service users and left staff feeling that they worked in isolation

However,

- The service used interventions in line with National Institute for Health and Care Excellence (NICE) guidance, delivered by a diverse and skilled multidisciplinary team.
- Support and training for staff was comprehensive with strong systems for supervision and appraisals.

Summary of findings

Are services caring?

Good

- Service users told us that staff were supportive and caring, treating them with dignity, respect and kindness. Service users felt that staff listened to them. Carers commented that staff were interested in them and the service users as people.
- Staff displayed warmth and genuine interest in people using the service. This was evident in all staff within the teams.
- Staff spoke about service users respectfully and in positive terms in team meetings and with other professionals. All staff displayed excellent knowledge of individual's needs.
- Service users were involved in setting out the care plan and where this was not possible, family members or carers acted on their behalf.
- Service users were involved in the recruitment of new staff for the service.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Service users were seen within four weeks from referral to the service. Service users, their carers and social care providers all said that staff were accessible quickly when they needed them.
- The service provided information in a variety of accessible ways to meet service users' needs.
- Complaints and compliments were monitored well and fed back to the teams.

However

- The waiting areas were not comfortable or accessible to people in wheel chairs (although were very rarely used by services users). Service users and carers could overhear staff phone calls at Church House and Thornbury. Despite having a large amount of easy read information, this was not made available in the waiting areas.

Are services well-led?

Good

We rated responsive as good because:

- Staff felt valued by the organisation. Staff told us that Sirona recognised what people have to offer.
- There was clear leadership evident from team leaders and the divisional manager that was respected and valued by staff within the service. Staff we spoke with were very complimentary about the team managers and the support and direction they give the teams.

Summary of findings

- Effective governance systems were in place with administrative support to support managers.
- Staff worked well together and there was clear respect between all members of the team.

However

- The provider had a central risk register and risks were discussed in learning disability division meetings with other team leaders and the divisional manager. However as there was no service specific risk register there was a risk that staff did not have a clear view of the risks in their specific service.

Summary of findings

Information about the service

Sirona is a community interest company that provides community health and adult social care services and was established in October 2011. Sirona provides a number of services to people with a learning disability including health services and social care.

This inspection focussed on the health services that Sirona provided to people with learning disabilities. The complex health needs team in Bath and north east Somerset (B&NES) and the community learning disability service in south Gloucestershire both provide multidisciplinary services to work with people who have a learning disability who require support for complex health needs including mental health care.

The south Gloucestershire service has a hydrotherapy service attached to it.

The complex health needs team is commissioned by B&NES clinical commissioning group and the south Gloucestershire community learning difficulties team is commissioned by south Gloucestershire clinical commissioning group. Each service is commissioned separately with specific service requirements.

Our inspection team

The team that inspected community mental health services for people with learning disabilities was led by Gary Risdale, Inspection Manager, CQC.

The team was comprised of two CQC inspection managers, a CQC assistant inspector and a specialist advisor with experience of working in services for people with learning disabilities.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

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

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- Visited four locations where staff were based and services delivered from, looked at the quality of the environments, and observed how staff were interacting with service users.
- Spoke with 14 service users.
- Spoke with nine family members/carers.
- Spoke with three managers of the services.
- Spoke with 40 other staff members; including doctors, nurses and social workers.
- Held three focus groups for staff and service users.
- Interviewed the divisional manager with responsibility for these services.
- Spoke with six external stakeholders.

Summary of findings

- Attended and observed four multi-disciplinary meetings.
- Observed 10 episodes of care.
- Looked at 27 treatment records of service users.
- Reviewed 11 supervision and appraisal records.

Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

Service users told us that staff were supportive and caring, treating them with dignity, respect and kindness. Service users felt that staff listened to them. Carers commented that staff were interested in them and the service users as people.

The service regularly collected feedback from service users, which was always positive. The service had received 91 compliments from service users and carers in the previous 12 months and no complaints.

Good practice

The provider was proactive in having an employment inclusion scheme for service users. Sirona provided placements for people with disability or autism (often previous service users). People were offered a place in the administrative team for a period of time to help them to gain skills in the job market and to boost their confidence. For example, one service user worked as an administrative staff member at Church House for three months on the scheme before gaining a full-time position in Sirona's finance department.

The service proactively managed risks for service users who could be detained under the Mental Health Act with other agencies. This had resulted in no admissions to hospital in four years.

In B&NES staff had a communication passport in a grab bag that they carried with them to all new assessments. It had an introduction section with "my name is…." and a photograph. The bag also contained photographs of other team members, locations and photographs of common emotions and other key words. For example, happy, angry or sad. There were also symbol cards and a wipeable board with a marker pen. The communication passports were designed to ensure that staff communicated with service users when they first met them before they had the opportunity to assess any communication needs.

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that the care records system/s it has in place do not pose unnecessary risk for staff and service users.

Action the provider SHOULD take to improve

The provider should ensure that maintenance at Ash House is completed in a timely manner and that jobs reported to estates are monitored for completion in agreed timescales.

The provider should consider developing local risk registers for each service.

The provider should ensure care is coordinated effectively in B&NES and that staff don't work in isolation.

The provider should consider how it could make the waiting areas in each environment more accessible to people in wheelchairs that might have cause to use these.

The provider should consider how it can maintain confidentiality more effectively in Thornbury. Patient confidentiality was compromised due to poor soundproofing in the waiting area.

Sirona Care & Health C.I.C.

Community mental health services for people with learning disabilities or autism

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
South Gloucestershire community learning disability team, Church House, Kingswood.	St. Martin's Hospital, Bath
South Gloucestershire community learning disability team, Thornbury office, Thornbury.	St. Martin's Hospital, Bath
Hydrotherapy, Kingswood	St. Martin's Hospital, Bath
B&NES complex health needs team, ash house, St Martin's hospital, Bath.	St. Martin's Hospital, Bath

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The service rarely used the Mental Health Act. However, staff displayed a good understanding appropriate to their roles. Both services worked actively to avoid admissions under the Mental Health act and no one had been detained to a learning disability hospital for four years.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood the principles of the Mental Capacity Act and demonstrated good knowledge of how it should be used.

Consent and capacity were considered by staff in all their interventions with service users, many of whom had no verbal communication. In observations of care staff took time to ascertain service users understanding and agreement to care where possible.

Recording of capacity and consent was variable due to the problems with the records system discussed in this report.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- There were issues with maintenance of the building at Ash House at St Martin's Hospital in Bath including delays in issues being rectified. For example, there was no working door bell. Our inspectors were waiting some time before staff arriving for meetings opened the door. Staff within the building had not heard our knocking. Managers told us that a team administrator normally sat in the room by the door. However, we observed that due to their duties they were not always present in that room which left the potential for service users to be left waiting. The doorbell had not been working for 20 days at the time of our inspection. Other issues included paint peeling from walls in toilets, stains on the carpets and the ceiling in the manager's office collapsing. The ceiling had collapsed six weeks prior to our inspection but work to rectify it had yet to start. There was also a delay in responding to an overflowing sanitary bin of five days. Although the service kept a log of maintenance jobs it had reported to the provider`s estates department, there was no monitoring of whether any jobs had been completed or how long the jobs had been waiting. Some of the delays were beyond the providers control and due to the buildings landlords.
- All sites, including Ash House, were clean. The hydrotherapy pool was cleaned to a very high standard by the staff team. Both Church House and the Thornbury office sites were well maintained.
- Interview rooms did not have alarms at any of the sites. Staff relied on administrative staff being aware that they were using rooms and for them to call for help if needed. At Church House, staff had a system for monitoring and code words for staff to use to indicate the need for help. The provider told us there was a formal system in place in Ash House but staff were not aware of it at our inspection. However, the service did consider the risks of service users who visited the sites and we were informed by the provider that there had not been any adverse incidents.

Safe staffing

- There was sufficient staffing for the commissioned model, however in B&NES the community learning disability nurses were not in the complex health needs service. There was a separate commissioned model for them to provide support with physical health needs to GPs.
- Caseloads varied depending on the professional group. All caseloads were allocated according to the intervention and professional and closely monitored by managers.
- In B&NES the service had a sickness rate of 2.3% and a staff turnover of 3.9%. South Gloucestershire had a sickness rate of 4.8% and staff turnover of 5.6%. This meant that both services had a stable staff team.
- The provider did not provide us with mandatory training rates for staff due to transferring to a new training program that provided all mandatory training in one day. We saw that all staff were booked into the new program or had already completed it.

Assessing and managing risk to patients and staff

- Risk assessments were present but difficult to find on the electronic care notes system. There was no consistent place for them and it relied on staff to highlight risks. The risk assessments varied in quality from basic risk assessment screens to detailed comprehensive understanding of risks. We reviewed three records with the support of service managers, who also could not easily find risk assessments. They attributed this to their own lack of knowledge about the new records system rather than a lack of them . Once located we did find good examples of risk assessments which highlighted specific approaches to be used, such as preventing risk of choking. In south Gloucestershire there was no easily identifiable way to save risk assessments. The documents had to be manually created and scanned into the system. These were then uploaded. However, as the electronic care records were shared records also used by other health services including GPs they could be hard to identify amongst the other documents that had been uploaded by those services.
- Seven service users were assessed as high risk and had appropriate crisis plans in place out of the 27 records reviewed. For example, a service user going in to crisis at

Good

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the time of our inspection had a plan which included liaison with the local mental health crisis team and the option of admission to a local acute mental health ward if needed. The service would instigate a care and treatment review with other agencies if a service user was considered at risk of inpatient admission or current placement breaking down.

Out of hours cover was provided by the psychiatrists on call from the local mental health trust under a service level agreement between the providers. They would also provide cover for annual leave, training and sickness as necessary.

- The psychiatrists from the mental health trust did not have access to the records of service users; the psychiatrists in Sirona provided regular briefings on service users considered high risk and crisis plans for the on call doctors to follow. Staff displayed good knowledge of safeguarding. The service referred appropriately to the local authority safeguarding team and kept a log of all issues. When we raised a potential concern following comments by a service user in a focus group, staff responded swiftly and sensitively and explored the issue privately with the service user. Although following this it did not result in a safeguarding being raised, staff listened to the service user and explored all concerns with them appropriately and then took action to support the individual appropriately.
- Good personal safety protocols were operated in both teams with whiteboards used to highlight staff whereabouts. Administrative staff monitored staff whereabouts. There were code words agreed for emergency in the event that a staff member needed assistance. In south Gloucestershire, the electronic clinical record system had the capability of using a flag system on individual service user records to indicate known and/or increased risks.

Track record on safety

- There had been no reported serious incidents in the last 12 months.

Reporting incidents and learning from when things go wrong

- Staff understood how to report incidents and what was expected. Incident reports we reviewed were completed with an appropriate level of detail. There were 116 incidents in south Gloucestershire in the previous 12 months and 19 incidents in B&NES.
- Incidents were discussed in team meetings with lessons learnt shared with the team. Teams discussed how they would apply these in a meeting we observed. This included feedback from an investigation undertaken by another service in the learning disabilities division.
- Managers monitored incidents and received regular reports from the provider's health and safety team to identify any trends. For example, managers were able to explain that a spike in incidents one month was attributable to multiple safeguarding concerns the service had raised about a service user.
- Staff told us that they received debrief after incidents that affected them, and that managers were supportive in identifying these.

Are services effective?

Requires improvement

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.

Our findings

Assessment of needs and planning of care

- Comprehensive assessments were undertaken for all new referrals. These were stored on both electronic systems and were available for staff to access.
- Staff understood the needs of service users and were able to explain their current needs and histories in detail. Managers also demonstrated an understanding of individual service users currently using the service.
- Care records were kept on different electronic systems depending on the local authority area. Bath and North East Somerset staff were using a new electronic notes system which was different from the South Gloucestershire service. This had only been introduced three weeks prior to our inspection and staff we spoke with were still learning how to use and navigate their way around it. In addition to these electronic systems was a provider wide system, which also housed assessments, clinical letters and progress notes. The medical staff in both services also used a separate paper based system of medical records. For all service users who were subject to the care programme approach (CPA), a further paper based system of care records existed. We reviewed three of the CPA based records and found these to be comprehensive, up to date, personalised and with good quality care plans and risk assessments. We also found four examples where service users had duplicate entries. Staff told us this was a legacy of the previous system where records had been copied from. They told us that the information technology department were aware of this issue and working towards deleting these, although no completion date was known. Paper based records used under the previous system were also still in use and had been stored within offices, awaiting assimilation into the new system. The managers we spoke with told us no agreement had been reached on how and when this would occur. Although daily record entries were of a good standard, staff were not able to readily identify where assessments and care plans were kept and multiple systems added to this risk.
- However all 14 service users, nine carers and six social care providers said that they received copies of their care plans. In the 10 episodes of care that we observed staff giving copies to service users or their carers.

Best practice in treatment and care

- The service used National Institute for Health and Care Excellence guidance to develop care pathways. For example, the recently appointed epilepsy nurse in B&NES had reduced the caseload of the epilepsy monitoring service from 90 to 62. This had been achieved by working with GPs to take over the monitoring of service users who had not had a seizure in over two years. This allowed more in-depth reviews for service users who had more complex presentations and for the service to be more responsive to changes in presentation.
- The south Gloucestershire team had practitioners who were trained in positive behaviour support and used this model to work with people who presented complex behavioural issues. This had been successful in preventing people being placed out of area. There was clear evidence of effective working with other agencies and the service was linked in to the national transforming care program. The psychiatrist pro-actively considered risk positively in managing people's needs. Positive behaviour support was also used effectively by the complex health team in B&NES, a service user who had previously been removed from their support centre was now engaging well with no further removals following creation of an accessible support plan. The plan was developed with photographs of the service user, their surroundings and people important to them.
- The service considered service users' social needs as well as their clinical needs. This included a focus on employment, training and housing. The provider was proactive in this having an employment inclusion scheme. Sirona provided placements for people with disability or autism (often previous service users). People were offered a place in the administrative team for a period of time to help them to gain skills in the job market and to boost their confidence. One service user worked as an administrative staff member at the Church House for three months on the scheme before gaining a full-time position in Sirona's finance department.
- Following requests from service users, the psychologists in south Gloucestershire developed a relationship group aimed to help service users understand how to be safe and fulfilled in relationships with people who were not their carers.
- Staff worked to enable service users to do things for themselves. A service user gave an example of how a

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physiotherapist had worked with them in the hydrotherapy pool and had then enabled them to access public swimming pools. The service user was clear that the physiotherapist had not liaised with the swimming pools, but had encouraged the service user to address the accessibility issues at the local pool including support with a hoist from their wheelchair by themselves with the swimming pool's management.

- Hydrotherapy had comprehensive assessments of people's needs and used sensory equipment in the pool to aid service users in engaging with the treatment.
- The speech and language service provided bespoke training to service users and the people around them to meet their communication needs. This included training in signs and the use of cards, pictures and other methods such as talking mats to support service user's communication needs.
- Occupational therapists completed work with people on sensory processing, aiding service users with autism who had difficulty with the amount of stimulation that their senses provided.
- The services had an "information exchange" in team meetings where staff shared evidence of best practice and recent NICE updates.
- A separate team provided by Sirona worked to support local GP's in B&NES completing annual health checks. However, clinicians in the complex health needs service were unable to demonstrate where they were recorded on the electronic record system. There were no facilities for the consultant psychiatrist in B&NES to complete physical health checks or for other staff to complete them before medication reviews. The consultant had to ask the service users to visit their GP before the medication review to get basic observations such as height and weight completed. In south Gloucestershire the GP's completed health checks which were completed on the shared clinical record system, resulting in the consultant being able to access all the GP's records and the GP's able to view the services entries.

Skilled staff to deliver care

- Both services had a range of disciplines working within the teams. Professionals were highly knowledgeable and understood current practice. In B&NES community nurses provided physical health support to GPs and did not undertake the care coordination role as in south Gloucestershire. Staff told us that this provided some risk for service users who were not cared for under the care programme approach as no one had an overview of all the care being delivered and also left staff feeling they worked in isolation. The service had attempted to mitigate this by having a clinical case manager in the team. However, they only managed 16 high level cases identified through a traffic light risk register and not everyone receiving a service. However, two nurses in the team provided specialist support on epilepsy and behaviour management. The providers 'learning disabilities division performance monitoring report' for April 2016 to June 2016 recognised this as a risk. It stated that there was "a concern regarding the loss of the community nurse role and impact on managing dementia care effectively."
- In south Gloucestershire, the community nurses were an integral part of the team and conducted the role of care coordinator, as did other professionals. There was no evidence of professionals working in isolation within the South Gloucestershire team.
- Staff had regular supervision and appraisals. Nine records reviewed showed staff that a standard format was followed. This included both clinical supervision and individuals support and development. Supervision contracts were in place between staff and their managers that were renewed annually. Positive feedback about individuals was also recorded. All records were signed by the staff member and their supervisor. Team managers monitored frequency of management and clinical supervision to ensure that this occurred every four to six weeks. Supervision records were completed and stored securely on the electronic system. Staff reported feeling supported by the supervision process.
- Additional clinical supervision from a professional of the same discipline was available if required. In addition, staff attended monthly reflective practice from a clinical psychologist.
- Appraisals focussed on staff development. Staff had access to training and support for professional development. This included non-registered staff, for example, a support worker receiving professional training appropriate to their role and training for an NVQ level five. Staff said that training was readily available and supported by managers.

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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.

- The provider supported apprenticeships with regular support and training for administration roles. Senior administrative staff felt that this valued their skills and junior staff found this a supportive way to develop them into the role.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings reviewed people's needs appropriately and discussed referrals. One of the two meetings observed included a regular session of learning sign language. Staff we spoke with said they felt their contributions to multi-disciplinary discussions were important and that they felt listened to and valued by colleagues and managers.
- Staff from other agencies spoke positively about the relationships with the service. They felt it met service users' needs and provided them with appropriate support and specialist knowledge.
- Staff worked well in partnership with other agencies. For example, psychology in B&NES worked with social workers on parenting programs for parents who had a learning disability.

Adherence to the MHA and the MHA Code of Practice

- Psychiatrists were employed by the local mental health trust and received appropriate support and training to maintain their section 12 status. One psychiatrist who had recently been employed by Sirona received their training and support from the mental health trust as well.
- Staff had an appropriate understanding of the Mental Health Act. However, it was rarely used in the service.
- Staff worked actively to avoid admissions with clear multiagency agreement through "blue light meetings" under the transforming care agenda. Monthly transforming care meetings were held with commissioners and partner agencies that considered service users who had a potential risk of admission. There were currently no service users from south Gloucestershire detained under the Mental Health Act and there had been no admissions in four years from B&NES, although there were a small number of service users detained in hospital due to an offending history who had been admitted before this. There were active plans to repatriate those service users where possible.
- When people were in crisis, the service would work with colleagues in the local mental health trust to provide short term admissions to acute mental health wards whilst community placement issues were addressed. The learning disability psychiatrist visited service users in the wards and worked with the mental health staff on care plans and interventions. The positive behaviour support workers also supported the ward staff.

Good practice in applying the MCA

- Staff understood the principles of the Mental Capacity Act and demonstrated good knowledge of how it should be used.
- Consent and capacity were considered by staff in all their interventions with service users, many of whom had no verbal communication. We observed that staff took time to ascertain service users' understanding and agreement to care where possible.
- Recording of capacity and consent was variable due to the problems with the records system discussed in this report.
- In south Gloucestershire, a statement on the consideration of capacity and consent of the service user was given at the start of every clinical letter.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- Service users told us that staff were supportive and caring treating them with dignity, respect and kindness. Feedback was very positive. Service users felt that staff listened to them. Carers commented that staff were interested in them and the service users as people.
- Carers told us that staff supported them holistically not just for the presenting need that had led them to use the service. For example, one carer reported staff providing emotional support and letters to help with their housing situation.
- Professionals in social care said that staff from the service were always calm and kind towards service users they worked with.
- Staff displayed warmth and genuine interest in people using the service. This was evident in all staff within the teams. For example, administrative staff greeted service users in a friendly manner and asked if they wanted hot drinks on arrival that they would then prepare.
- Staff spoke about service users respectfully and in positive terms in team meetings and with other professionals. In clinical sessions, staff showed empathy and compassion to service users' needs and situations.
- All staff displayed excellent knowledge of individual's needs. This included managers who knew and greeted service users and were able to explain their needs and clarify any issues to our inspectors despite not working individually with them.
- Staff respected service users' views. In one group session we observed the clinician checked individually with all eight service users whether the inspector could sit in the session.

The involvement of people in the care they receive

- Service users' and carers told us that they were involved in their care. Service users were involved in setting out the care plan and where this was not possible, family members or carers acted on their behalf.
- The majority of care plans considered what service users identified as their needs. However, five care plans viewed in B&NES were generic in nature and lacking a person centred approach.
- Service users were involved in the recruitment of new staff for the service. Service users who had been involved in that process were very clear that they felt listened to and valued by the organisation in that process. Other service users and carers described meet and greet sessions that gave them the opportunity to meet new staff.
- Although there were no formal participation groups, the service tried different methods of engaging with people to help shape the service. For example, in South Gloucestershire the provider had employed the services of a third sector organisation to provide an event explainingthe services provided to people and then to ask how they could be improved. These were led by people with a learning disability who felt supported and empowered to lead on this work. Further events were being planned.
- The service collected service user's views regularly and this was always positive.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- Both services had targets of referral to treatment of four weeks. The service met these timescales although some staff felt this resulted in higher caseloads. Staff within the service all viewed its ability to respond swiftly as one of the services strengths. This had been an improvement on the previous model where waiting times in October 2013 were 26 weeks.
- Different clinical approaches had resulted in the shorter access times. For example, psychology used more group work and had a full program of group interventions that had reduced waiting times considerably. Speech and language therapy had quick access for urgent assessments if required. Occupational therapy was the only part of the service that had a longer waiting time than the four weeks. This was 13 weeks for sensory processing work; however this was within national targets of 18 weeks. This was due to the specialist and complex nature of the assessments that took time.
- Service users and carers confirmed that Sirona staff had repeatedly reassured them that they are only 'at the end of a phone-call' – and that they can feel free to call them at any time if they are worried about something. All service users and carers said that they were seen swiftly.
- Social care providers described the service as very responsive, supporting people swiftly when needed.
- The service had procedures in place to take active steps to engage with people who find it difficult to engage with services. The services aimed to work with referrers to address the reasons why people did not engage rather than exclude following a number of non-attendances to appointments.
- The service did not offer appointments outside weekday hours of 9-5. The service was not commissioned for weekends or crisis care. Arrangements were in place with the local mental health trust for their crisis team to cover and the learning disability consultant psychiatrists took part in the on call rota.
- The service worked closely with children's services for transition to the adult service. Work had been completed to agree a pathway of care between children's services. In south Gloucestershire the service had held coffee mornings in the local special schools to explain to parents and young people the services they would be able to provide once they had reached 18.

The facilities promote recovery, comfort, dignity and confidentiality

- The majority of contact with people who used the service occurred in the community, whether in their own homes, supported living or other services they accessed. The services aimed to see people where they were most comfortable or where the need or behaviour was occurring.
- Church House had been refurbished two years prior to the inspection and had comfortable furniture. However, there was little evidence of service user involvement and the environment was sterile with no artwork. Ash House had tired decoration and stains on the carpet and mismatched furniture. However, there was art from service users displayed on the walls.
- The hydrotherapy pool had a welcoming environment for service users and a range of equipment to aid in the interventions provided. These included sensory equipment such as mirror balls, coloured spotlights and music systems.
- Church House had an art therapy room that contained the necessary materials.
- At Church House, a medical secretary was based in the large open plan reception area. A confidential call about a service user's medication was taking place as service users were being welcomed at the reception desk. The service manager moved the secretary to another office on the day of the inspection as soon as we raised our concern about confidentiality. In Thornbury office the waiting area was adjacent to administrative staff who were answering phone calls. However, interview rooms did appear to be adequately sound proofed.
- All sites had been adjusted for wheelchair access with accessible toilets. However, the waiting room at Church House was small and a service user with a wheelchair had difficulty getting in and out. This also impacted on others in the waiting room who were trying to move out of the way to allow the person access. There was no waiting room at Ash House and service users had to sit in a corridor on mismatched chairs with varying degrees of comfort.
- Information available to service users in the waiting rooms was not provided in accessible formats for people who use the service. In both Church House and Ash House there was only one easy read leaflet explaining how to complain available and this did not stand out from the other information. There was no easy

Are services responsive to people's needs?

Good

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

read information available at Thornbury office. However, the sign in book in both sites had symbols and easy read presentation for each section. Carers told us that accessing information on other services was hard.

Meeting the needs of all people who use the service

- The provider had information about the services provided in a range of well-presented easy read formats which it sent out to service users and carers on referral. However, these were not available in the waiting areas.
- In B&NES staff had a communication passport in a grab bag that they carried with them to all new assessments. It had an introduction with "my name is…." and a photograph. The bag also contained photographs of other team members, locations and photos of common emotions and other key words, for example, happy, angry or sad. There were also symbol cards and a white board with a marker pen. The communication passports were designed to ensure that staff communicated with service users when they first met them before they had the opportunity to assess any communication needs. Staff created care plans in easy read format or social stories when appropriate for service users.
- We observed staff using a variety of formats including sign language, pictures, symbols and other methods of engaging service users appropriate to their needs. Staff were able to access interpreters when required and were able to translate information into different languages on request. Neither service had large populations of people with other languages.
- Information for service users on the provider's website was not clear. The provider had 12 different learning disability services on the same webpage that were a mix of social care and health provision. A number of services had similar names. It was not obvious which services were provided for which geographical location or the type of provision the service provided. Our inspectors had to request clarification from the provider when planning the inspection. This meant it would also be hard for people who use the service to access the information.

Listening to and learning from concerns and complaints

- Service users and carers were all aware of how to raise concerns and felt confident that they would be listened to. Easy read versions of the complaints procedure were available.
- Neither service had received any complaints in the previous 12 months.
- The service in B&NES had received 39 compliments in the previous 12 months and the South Gloucestershire team had received 52. These were monitored by the service managers and fed back in team meetings.

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.

Our findings

Vision and values

- All staff were able to describe the providers core value of "taking it personally". Staff said that it was simple and easily applied to their daily practice.
- Staff felt valued by the organisation. Staff told us that Sirona recognised what people have to offer.
- Staff were aware of senior leadership in the organisation and said they were accessible.

Good governance

- The service actively sought feedback from service users in a variety of ways. For example, in B&NES there had recently been a drive to increase responses under Friends and Family over a week that had resulted in 19 responses. In south Gloucestershire the service had developed a new format called "taking it personally" which was an observation form on staff engagement with service users' and their carers. Example questions included: acknowledged with a smile, introduced themselves, warm and friendly. Staff within the service had peer reviewed each other and the results were being reviewed by the team leader. Once the peer review feedback had been given through supervision the forms were to be rolled out to service users to give feedback on staff.
- There was one central risk register that covered the whole organisation. There was no local risk register for either service. Although team leaders did not have access to this risk register, strategic risks were discussed regularly in learning disability division meetings with other team leaders and the divisional manager. Risks were then highlighted to the corporate risk register if required. The team leaders and divisional manager were able to describe risks to the service clearly. The B&NES service did hold a clinical risk register for service users that were considered high risk, but not one for service specific issues.
- Clinical pathways were agreed with the staff team and local partners. In south Gloucestershire the local partnership board had reviewed the pathways and engaged with the service design.
- The teams had sufficient administrative support to collate data to support the managers in their governance and oversight of the service. There was also specialist business support that assisted the divisional manager and team managers. This resulted in clear governance reports that were monitored monthly to identify any trends of concern and yearly reports to reflect the services performance. These reports were used to provide assurance to commissioners and in promoting learning in divisional and team meetings. Managers in the teams felt not having the role of collating the data gave them more time to focus on the quality of care for the service users and supporting the staff team.

Leadership, morale and staff engagement

- There was clear leadership evident from team leaders and the divisional manager that was respected and valued by staff within the service. Staff we spoke with were very complimentary about the team managers and the support and direction they give the teams. Managers were very knowledgeable about service user's needs. Managers were observed having good interactions with service users who visited the service, recognising them individually.
- Managers felt supported by the organisation and also peer support from other managers within the learning disability division.
- The provider supported managers in their development with both local courses and supporting them with further higher education. For example, one team manager was being supported to complete their masters. Another manager was supported to continue clinical practice in a split post.
- There was regular supervision that was monitored effectively by managers. Staff reported that there had been no significant impact with budget constraints, training was still readily available.
- Staff worked well together and there was clear respect between all members of the team. One administrative team member was nominated for "colleague of the year", that made them feel highly appreciated by the clinical staff.
- There were no issues of bullying or harassment in the teams and all staff felt they would be able to escalate concerns within the organisation if they needed to.
- However, staff felt the issue of future transfer of services to another provider was having a negative impact on staff morale but was not affecting service user's care.

Commitment to quality improvement and innovation

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.

- In B&NES there had been research on the effectiveness of mindfulness in people with learning disabilities by the psychology team which was about to be published.
- The service had provided training to other providers through the work of the "care home project – meeting the health needs of people with learning difficulties".

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Staff were using multiple records and information was not being recorded consistently in the same location/ format. This meant they were not accessible to authorised people as necessary in order to deliver people's care in a way that meets their needs and keeps them safe. Regulation 17 (2) (c)