Sirona Care & Health C.I.C.

1-290660061

Community health services for adults

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 Martin's Hospital		BA2 5RP
1-297412138	Paulton Memorial Hospital		BS39 7SB
1-1663905943	Keynsham Health Centre		BS31 1AF
1-1333619241	Westgate Centre, Yate		BS37 4AX

This report describes our judgement of the quality of care provided within this core service by Sirona care and & 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 and& health C.I.C. and these are brought together to inform our overall judgement of Sirona care and& health C.I.C.

Summary of findings

Ratings

Overall rating for the service	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

Overall summary

Overall rating for this core service

We rated community health services for adults as good because:

- There were effective incident reporting systems in place and staff reported they received feedback and learning from these.
- Staff had good knowledge of safeguarding procedures and felt supported in raising any safeguarding concerns
- Good medicines management protocols were in place to keep patients and staff safe.
- Equipment was available, had been checked and was serviced regularly.
- The needs of patients were assessed, planned and delivered in line with best evidence based practice using recognised assessment tools in most cases.
- Multidisciplinary team working was embedded throughout the service and referrals to different healthcare professionals were coordinated and efficient.
- Feedback from patients was consistently positive, patients went to great lengths to tell us about their positive experiences.
- We saw patients who were active partners in their care, and were encouraged to speak about their opinions of their planned treatment.
- Care that we observed was truly person centred, with patient's wellbeing at the heart of care.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff were fully committed to working in partnership with people and made this a reality for each person.
- Patients were given information about how to make a complaint or raise a concern. There were systems in place to evaluate and investigate complaints.
- There was strong local leadership in place. Staff felt able to approach their managers.
- There were governance and risk management systems in place.
- There was a very positive, supportive culture across all staff groups we spoke with.
- The organisation listened to staff and looked to ways to improve and be innovative across their services.

However:

- Individual care records did not always have risk assessments reviewed and electronic records did not always match with information kept in the patient's home.
- Staff did not always update records contemporaneously due to connectivity and confidentiality issues.
- Not all staff were compliant with mandatory training in safe systems, processes and practices.
- In some teams staffing levels were below established numbers which meant substantive staff had to work extra hours to cover the workload. The organisation was continuing to advertise and recruit to posts. In some clinic based services, despite being staffed to commissioned levels, there were long waiting lists. The lists were triaged to ensure patients with urgent needs were prioritised.
- The service did not always monitor the completion of timely assessment of risks to patients.
- Some bespoke services that needed specialist staff to run them were not able to be offered if that person was on leave or off sick. Although patients were offered another appointment with an alternative appropriate service.
- There was inconsistency across the two local authority patches in which Sirona worked. This meant different systems were in place in different areas making it difficult to provide consistent and meaningful audit data and an overview of risks across the services.

Summary of findings

Background to the service

Sirona Care & Health is an independent social enterprise organisation that provides community physical and mental health and social care services to the people of Bath and North East Somerset (B&NES) and South Gloucestershire.

The community adults' teams provide care and support in people's own homes, care homes, local health centres and clinics and community hospitals. Community nursing is provided 24 hours a day seven days a week. Rehabilitation and reablement services are provided seven days a week.

We spent two and a half days and one evening meeting staff members of the community based teams. We also met with and visited some patients and their carers and relatives. We spoke with 80 members of staff, 32 patients and three relatives and carers. We reviewed 14 sets of notes – four paper records and ten electronic records.

During the course of this inspection we spoke with:

- Five locality managers or assistant locality managers
- Four allied health professionals managers
- Two registered managers
- Seven specialist nurses
- Three community matrons
- Six district nurse team leaders
- Eight community nurses
- Three emergency care practitioners
- Two Health Visitors
- One assistant practitioner
- One clinical psychologist
- Two specialist team leaders
- One Extended Scope Practitioner
- Seven Physiotherapists
- Seven Occupational Therapists
- Four community healthcare assistants
- Six support workers
- One administrative team leader
- Ten administrative staff

We visited or spoke with staff in the following services: community nursing teams (including twilight and night staff), community matrons who managed patients with long term conditions, rehabilitation and reablement teams, tissue viability staff, community respiratory service, Parkinson's Disease clinic, community blood transfusion and intravenous therapy (IV) team, emergency care practitioners, the active ageing service, falls team, community bladder and bowel service, outpatient clinics including musculoskeletal services and the orthopaedic interface service.

We attended three multi-disciplinary meetings in GP surgeries and three handover meetings (community nursing and therapists).

Prior to and following the inspection visit we reviewed information requested by CQC and sent to us by the organisation. During the inspection we looked at patient records and associated documentation and observed some care and support provided in patients' own homes.

Our inspection team

Chair: Julie Blumgart, invited independent chair

Team Leader: Mandy Eddington, Inspection Manager, Care Quality Commission

The community adult's team included three CQC inspectors and a variety of specialists: community nurse manager (2), tissue viability nurse and physiotherapist.

Why we carried out this inspection

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

Summary of findings

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 Sirona care and health, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. We carried out an announced visit on 18, 19, 20 October 2016 and an unannounced visit on 1 November 2016. During the inspection we held focus groups and drop in sessions with a range of staff who worked within the service, such as nurses, therapists and support workers. We observed how people were being cared for and talked with carers and/ or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During the inspection we spoke to a number of patients who had used community services. They told us:

"It's more than nursing care – it's a nice friendly face, smiles and a bit of banter – very refreshing."

"They go the extra mile – person centred, treat me like an individual."

"I'm fully included – they never treat me with disrespect."

"They are always talking to and reassuring my mum as they treat her."

"They give us hints and insights into how to manage our care."

"They are people and are experts in putting you at ease."

"[the service] couldn't be better, I have improved since having the service", "there is nothing that could make it [the service] better."

Prior to the inspection we left comment cards at adult community services bases for people to complete. These are some of the comments from the 43 completed cards:

"I cannot fault the care and attention my xxxx has received" and "now the centre comes to us at home, including Dr xxx and all his staff, dentistry and the OT."

"I have always found the staff here to be very helpful and caring."

"The treatment is first class (10 out of 10)."

"I think the staff are great."

"Excellent care, listening, helpful treatment, efficient and caring."

"Brilliant service, very friendly and helpful staff, exactly what you need."

"The staff were caring and listened to all I had to say."

"I have always been treated with dignity and respect."

Good practice

- The service demonstrated outstanding multidisciplinary working across services, with GPs and other external health care providers.
- Feedback from patients was consistently positive; patients went to great lengths to tell us about their positive experiences.

Summary of findings

- We saw patients who were active partners in their care, and were encouraged to speak about their opinions of their planned treatment.
- Care that we observed was truly person centred, with patient's wellbeing at the heart of care.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff were fully committed to working in partnership with people and made this a reality for each person.
- The organisation provided bespoke services across their adult community services such as the Active Ageing Service, falls service, emergency care practitioners and blood transfusion and IV service all of which had led to positive outcomes for patients.
- Staff regularly went the extra mile when caring for patients. For example, a staff member gave an example of when a patient did not want their close family members to be aware of the services they were receiving as it was of a sensitive nature. The service embraced creative measures to communicate with the patient - not sending appointment letters to their home, or ringing the home phone number. This ensured the patient overcame their obstacles and built trusting relationships with the service, they engaged, and received treatment that led to improvements in their heath.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The provider must ensure that staff are up-to-date with their safeguarding training at the right level for their role.
- The provider should ensure staff are able to complete their documentation contemporaneously.
- The provider should ensure all staff are compliant with mandatory training.
- The provider should continue to review the staffing levels and skill mix across the community adult's services, including bespoke services such as the IV service.
- The provider should consider a review of processes to ensure efficient and timely assessment of risks associated with patient's health and to ensure a proactive approach to managing these.

Action the provider COULD take to improve

Sirona Care & Health C.I.C.

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated the safety of the community adults services as requires improvement because:

- Individual care records did not always have risk assessments reviewed and electronic records did not always match with information kept in the patient's home.
- Staff did not always update records contemporaneously due to connectivity and confidentiality issues.
- Not all staff were compliant with mandatory training in safe systems, processes and practices. In particular compliance with safeguarding training was below the organisations own target.
- In some teams staffing levels were below established numbers which meant substantive staff had to work extra hours to cover the workload. The organisation was continuing to advertise and recruit to posts. In some clinic based services, despite staffing at commissioned levels there were long waiting lists. The lists were triaged to ensure patients with urgent needs were prioritised.

However:

- There were effective incident reporting systems in place and staff reported they received feedback and learning from these.
- The duty of candour regulation was understood by staff and we saw evidence which supported this.
- Staff had good knowledge of safeguarding procedures and felt supported in raising any safeguarding concerns.
- Good medicine management protocols were in place to keep patients and staff safe.
- Equipment was available, had been checked and was serviced regularly.

Safety performance

- The service participated in the national safety thermometer performance and achieved consistently positive results. Data on patient harm was reported each month to the NHS Health and Social Care Information Centre. This was nationally collected data providing a snapshot of patient harms on one specific

day each month. It covered incidences of hospital-acquired (new) pressure ulcers; patient falls with harm; urinary tract infections; and venous thromboembolisms (VTE).

- Sirona care and health had developed an application (app) for a tablet computer that collected the monthly data for the Safety Thermometer return. The app allowed staff to input data from the community services in real time rather than having to record the information when they returned to their base. The data was then automatically collated for the organisation and then submitted to NHS Digital.
- Safety thermometer information was being gathered at the time of the inspection. We observed staff completing this information.
- Staff told us that the results of the Safety Thermometer were made available to them. Safety Thermometer results, between June and August 2016, across all of the Community Nursing and reablement teams showed harm free care was between 85% and 100%. The lower scores were attributed to the reablement teams who provided urgent and rapid response to often very poorly people.

Incident reporting, learning and improvement

- The provider had systems in place to report incidents and near misses. The community adult's services reported 37 serious incidents requiring investigation (SIRI) between June 2015 and May 2016. Most of these related to grade three pressure ulcers with two relating to grade four pressure ulcers.
- The data available for the period following May 2016, suggested there had been a fall in the numbers of grade three and four pressure ulcers acquired whilst in the care of Sirona community nursing services.We met with the lead for the tissue viability specialist nurse team and spoke about the high level of incidents related to pressure ulcers. They described how care homes had taken action and learning from these incidents to address the high level of pressure ulcers in the community. The tissue viability service also facilitated teaching and had developed teaching materials including a DVD to support the teaching. The teaching sessions were also extended to care home staff.
- There was a policy and procedure for the prevention and management of pressure ulcers which had been reviewed and updated in May 2016; this outlined risk assessments and preventative measures as well as information about reporting pressure ulcers and raising safeguarding alerts. There were standard operating procedures for patients with different risks of developing a pressure sore; these included advice about the frequency of risk assessments, preventative aids, nutrition and moving and handling.
- All staff we spoke with, demonstrated an awareness of the need to report adverse incidents, and demonstrated an ability to do this. Staff were able to give examples of the types of events that may need reporting and why the service used electronic systems to report incidents which they described as user friendly.
- All staff, whether based in a building or out in the community said they were able to access the incident reporting system without difficulty. However staff would often complete incident report forms once they were back at their base; this was partly because of connectivity issue with the internet but also staff felt confidentiality could be better maintained. However, there was a risk that staff could forget to log incidents and we spoke with a member of staff who had dealt with a patient fall a couple of days earlier and had not logged this as an incident yet.
- Staff told us that they did not always get individual feedback when they reported incidents, but did not feel this was necessary. Themes from incidents that had been reported were shared at team meetings where appropriate, and learning shared. For more isolated incidents, feedback was available to staff via their line manager.
- In some areas, seen as "low risk", adverse incident reporting was a rare event. In others, such as the IV service it was embedded and used as a tool to monitor challenges to the service. An example was given whereby a delay was being caused in cross-matching blood for transfusion. It became clear that this was due to errors at the point of obtaining samples and completing the necessary documentation. The IV lead nurse then devised a "mock" document, completed correctly, which was circulated to community nurses to improve accuracy. This resulted in a decline in the numbers of incorrectly completed cross-match requests, and associated delays.
- The community respiratory service was able to give examples of how adverse incident reporting informed discussions at team meetings. Learning from adverse incidents was embedded into the service processes.

Requires improvement

Are services safe?

- The out of hours nursing team gave examples where incidents had happened in other teams, and learning was shared with them.

Duty of Candour

- Staff we spoke with had a good understanding and knowledge of when to apply the duty of candour. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which was introduced in November 2014. This regulation requires the service to be open and transparent when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- We reviewed investigations into incidents such as the development of a grade three pressure ulcer and found that a 'Duty of Candour' letter was sent to the patient.

Safeguarding

- The organisation had adult and children's safeguarding systems in place to keep patients safe, however compliance with training in both adult and children's safeguarding was low. Staff were aware of the systems and how to report concerns. For example staff described how they had acted to safeguard patients against financial abuse when it came to their attention that a patient's personal assistant had made inaccurate claims on their timesheet. The organisation's policy was accessible to all staff via their intranet and staff knew where they could find this.
- Staff that we spoke with were able to demonstrate a clear understanding a how to identify a safeguarding concern. They felt team leaders would support them to make a safeguarding alert to the appropriate local authority. Staff knew who the organisation's safeguarding leads were.
- Staff received training in adult safeguarding at level two and in children's safeguarding at level two as part of their mandatory training. An intercollegiate document: "Safeguarding children and young people: roles and competence for health care staff (2014)" recommends that all non-clinical and clinical staff who have contact with children or young people have their competence assessed annually. Safeguarding training formed part of the yearly one day statutory training day. However, we reviewed compliance for training in safeguarding adults and children and found compliance to be generally below the organisations own target of 90% compliance. Clinical staff were trained to level two and received a face-to-face update every three years. Here compliance was 74%; of staff required to undertake level three adult safeguarding training, 73% were compliant. Compliance with children's safeguarding training level two for clinical staff was 47% which meant that less than half of the community staff were compliant.
- Overall figures for completion of Safeguarding Adults training ranged between 69% - 74%, depending on which level of training we looked at. Information about female genital mutilation (FGM) was included in the one day mandatory training that staff attended once a year. However, not all staff could remember having had any training about the signs of FGM or about what to do if they suspected a patient had experienced FGM.

Medicines

- The services we visited in the community had clear processes to define responsibilities for prescribing and administration of medicines and oxygen.
- Medicines were obtained by a GP prescription by the patient or their relatives/carers and in some cases the medicines were delivered to the patient's door by the local pharmacy
- A list of medicines the patient took was recorded on the electronic patient record.
- Sirona employed two pharmacists in the community who visited patients in their own homes who may need a medicine review or who may be having problems with their medicines. The rehabilitation team at Patchway Clinic said they worked well with the community pharmacist and found it a great resource.
- There was an open culture for reporting medicines incidents, these were investigated and reported on.
- Nurses had specialist medicines training as required for example syringe drivers, intravenous medicines, peripherally inserted catheter (PIC) line training.
- There were 101 medicine adverse events reported between January and March 2016. Of which 44 were attributed to community services (22 underdoses, 11 overdoses, six medicines not available, four wrong patient). All incidents involving medicines were sent to the chief pharmacist for review. A summary report was

presented to the medicines management group and quality committee every three months that included an action plan. There were action plans in place following the audit.

- The IV Service service used a "Patient Group Direction" (PGD) that allowed for the administration of saline to support patients who needed intravenous therapies. Thorough processes had been followed in the composition of the PGD, which demonstrated a multi-disciplinary approach and offered clear guidelines and criteria about the use of saline.
- Patients at home were able to receive medication intravenously. The IV service kept a live log of the numbers of patients receiving IV treatment at any one time. We were told the aim of this was to manage the workload of community nurses who administered this medication.
- There was a standard operating procedure (SOP) in place to support the administration of intravenous antibiotics in the community. In order to maximise the safety of patients, we were told that the first two doses of intravenous antibiotics were given by two nurses instead of one.
- The community respiratory service worked with patients who used oxygen at home. An external organisation was commissioned to manage the equipment provided to patients at home.
- Oxygen and its associated equipment was stored safely at the clinics we visited. Equipment had been checked and signed off as safe.
- The community blood transfusion service were able to explain the process for the collection, transport and storage of blood within the clinic rooms. This involved links with the local NHS hospital and allowed for blood products to be stored at its optimum condition in the clinic environment.
- Community nursing teams did not carry any medication apart from emergency medication in case a patient suffered an anaphylactic reaction. This is a severe and potential life-threatening allergic reaction and will require immediate emergency treatment intervention. The provider had an anaphylaxis policy which stated that 'patients known allergies must be identified and documented in their records'. However, amongst the nine sets of electronic care records we found one set of notes where, although the patient had an allergy to elastic in bandages and surgical tape, this was not 'flagged up' as a warning despite wound care being the main reason for district nurse input.
- Emergency care practitioners (ECP) carried oxygen as part of their standard equipment and were covered by their professional registration to administer oxygen without a prescription in emergencies.
- We reviewed two medication charts. On one of these the application of a topical cream was signed for on three dates in 2015; there was no evidence that the prescription had been reviewed with a view to discontinue and there was no stop date for that medicine on the medicine chart.
- We spoke with staff from the podiatry service who provided outpatient appointments for people with foot ulcers; these could be diabetic foot ulcers or vascular foot ulcers caused by reduced circulation. Podiatrists are registered with the Health and Care Professions Council and are allowed by a special amendment to prescribe some antibiotics and local anaesthetics to patients as independent prescribers.

Environment and equipment

- Equipment was used to support safe patient care and treatment.
- Both B&NES and South Gloucestershire teams had access to small equipment stores at their bases. Community adult teams could access larger equipment for patients through one of two community equipment providers. This included pressure relieving mattresses, commodes and beds. Community nursing and rehabilitation teams across the two patches told us equipment could be ordered out of hours, at weekends and on bank holidays. There was an extra cost incurred for an out of hours delivery, but staff said if a clinical need was documented they had no trouble getting the equipment delivered to patients whose condition may have changed rapidly. The equipment owned by the equipment providers was also calibrated and serviced by them.
- One of the deputy locality managers was leading on updating small equipment items in their area. An inventory of equipment held was being completed and discussion ongoing with a local NHS trust about repairing and regularly checking the small equipment for them.

Requires improvement

Are services safe?

- Consumables, for example: cleaning wipes, gloves, aprons and sharps boxes were readily available to all staff. Stock was held at community bases and collected by staff as required.
- We looked at a number of outpatient clinic/consulting rooms at Keynsham Health Centre. They were clean and tidy with good lighting and hand rails to help those people with mobility problems. We saw there was a large seat in the outpatients waiting area for use by bariatric patients.
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- The IV service took place in a modern doctor's surgery in a dedicated area away from the main practice. On the whole this arrangement worked very well. However, the toilet facilities available to patients in this service were only accessible to ambulant patients. Those who were not ambulant had to leave the clinic room to access the general practice's disabled toilet. This had on one occasion resulted in a patient refusing to drink so that they would not need to use the toilet. This issue was identified on the service's risk assessment. The service is however, operating in a building that the organisation does not own. Therefore opportunities to improve this issue are limited.
- We looked at the equipment used in the IV service, the respiratory service, outpatient physiotherapy and the musculoskeletal (MSK) service. This was in good condition, and where appropriate had been calibrated/ serviced as required. Team leaders told us they used a service provided by a local trust to calibrate equipment and this model worked well.
- We saw one self-calibrating defibrillator at Keynsham Health Centre that had pads that were out of date. We pointed this out to staff. As a result, new pads were ordered and the system for checking the machine and equipment was reviewed.
- The MSK service provided out of Cossham Hospital operated in a modern, purpose-built department. The building itself, and the majority of other services provided from it were run by a local NHS trust. We were told that this could cause difficulties, for example not being able to use Sirona's phone lines. This particular issue had been highlighted on the service's risk register and was being addressed at the time of our inspection.
- Staff used their own vehicles to travel between visits to patients in their home. It was the responsibility of the individual to ensure the car was in a good condition and insured to use for work; the provider did not ask for or store information regarding staff's car insurance status.
- We visited the outpatient department at St Martin's Hospital and Keynsham Health Centre and found that the departments were large, bright and purpose built with consultation rooms that allowed for consultations to take place in privacy; signs were displayed outside rooms to inform others that the room was occupied and to avoid interruptions. At St Martin's Hospital, there was no reception desk and patients were required to sign in using an electronic sign-in facility. At Yate Westgate Centre, Keynsham Health Centre, Paulton Hospital and Patchway Clinic there were reception desks with Sirona staff who welcomed patients to the department and gave them directions about where to go for their appointment. There were leaflets displayed about treatments as well as information about how to complain about treatment or care received. The organisation told us there were also reception staff at all other 'patient facing bases' apart from at St Martin's hospital where they had an electronic sign in system, with switchboard staff available to signpost patients if necessary.
- The Department of Health (Health Technical Memorandum 07-01, 2013) discusses safe management of healthcare waste in community health and a risk based approach to waste segregation. Heavily soiled dressings fall under the clinical waste category of either offensive or infectious waste (if a known wound infection is present) and require different safe disposal approaches. The legislation suggests the use of orange bags in the community for the safe disposal of infectious waste as well as a recommendation of a 'double bagging' approach to non-hazardous offensive waste such as non-infectious dressings, single use instruments, stoma bags, catheter bags and incontinence pads, which may be disposed of in normal household waste with the patient's permission. The service could arrange for the council to pick up and dispose of clinical waste however, this could take up to two weeks to organise.

Quality of records

- There were two electronic patient systems in use in the two local authority areas (B&NES and South Gloucester).

Are services safe?

One system allowed staff to look at all records relevant to a patient including GP records. The other system allowed staff to look at colleagues' records made about a patient. Both systems allowed for a patient's care plan, risk assessment and evaluation notes to be documented. Patients seen at home also had a paper copy of their care plan and any other relevant documentation.

- The electronic systems allowed for warning notes to be documented. For example if there were safeguarding issues, a difficult dog in the home or access problems. This helped staff decide if they needed to visit in pairs or at specific times, i.e. during the day only.
- Care records were audited annually and we reviewed the annual records' audit from 2015 for which 876 records were audited for compliance with three themes: consent, care planning and record keeping standards. The audit demonstrated that consent was obtained and documented in 93% of the audited records for adults. There was a clearly documented care or treatment plan in 67% of the care records whereas 37% did not have a care plan or treatment plan and the audit demonstrated that the patient and their carer were not involved in discussion regarding the plan of care in 20% of the audited records in adult services. Actions were taken, in local teams, to improve their record keeping. This was monitored by localised random audits and results shared with staff during team meetings.
- Individual care records were not always written and managed in a manner that kept patients safe. The majority of records (81%) were electronic records however, managers highlighted that there were ongoing issues with connectivity, duplication of information and retrospective documentation that did not ensure contemporaneous recording and accuracy of records. There had been no adverse events in relation to the electronic patient records and the issue had been raised as a risk and placed on the risk register and with the IT service. All district nurses and community matrons had hand held electronic devices to enable them to complete electronic care records. They had access to computers at their bases/office facilities. All electronic devices were password controlled to ensure secure storage of electronic information about patients.
- Staff who worked in the out of hour's team told us that they were not able to complete records for patients contemporaneously. Very often, staff told us, they completed patient records at home after the end of their shifts. They told us that this was the only way they could ensure that other staff visiting the following day would have up to date information available to them. Staff working in the out of hour's service told us that their workloads did not allow for any other way of completing records.
- Each nurse had a paper copy of their planned visits for the day and they would add detail about visits on their plan and complete the electronic care records once they were back at their base. We asked nurses why they did not complete the records in a contemporaneous way at the time of completing a care episode; nurses told us it was more time efficient to complete the care records in the office as there were less interruptions and it allowed them to make referrals, discuss care and ensure all aspects of care were met in a holistic manner. Regular bank staff had access to electronic care records whereas agency staff did not, unless they were block booked for a longer period of time.
- All patients had a folder in their home. The folder contained information about how to contact the district nurse teams and basic care records. Patient held care records were not audited for compliance with risk assessments which meant the provider could not be assured records were current and up-to-date.
- We reviewed nine electronic care records for patients cared for by community/district nurses and found that the care plan was out of date or 'not yet done' in three of the patient records and risk assessment such as waterlow score (a tool to assess the risk of pressure ulcer developing) and malnutrition universal screening tool (MUST) was not regularly being updated. In one set of notes the waterlow score was last updated in March 2016 despite deterioration in the patient's condition which meant they were now on the end-of-life care pathway. However, care needs were met despite the out-of-date risk assessments for example staff told us that the patient was being nursed on a pressure relieving mattress.
- We reviewed two electronic care records for patients seen by community matrons and found detailed assessment and care planning with up-to-date risk assessments such as waterlow scoring, MUST assessment, falls, manual handling, mental health assessment and mobility assessment. We saw evidence that there were goals agreed with patients which meant that patients were active partners in making decisions about their care and treatment.

- We reviewed three electronic care records for patients seen by rehabilitation/reablement teams. They demonstrated that risks had been identified in relation to pain, pressure areas, manual handling, nutritional needs and falls and they were reviewed regularly.
- Adult health visitors as part of the 'Active Ageing' project had hand held electronic devices but they also carried paper copies of patient assessments; these were kept in a locked box in their car.

Cleanliness, infection control and hygiene

- Policies and procedures relevant to infection control practices were available to staff on the organisation's intranet. Staff were able to find these when we asked to see them. We saw staff adhering to handwashing procedures and being bare below the elbows during clinics and home visits.
- Aprons and gloves were readily available and we saw staff using them when attending to patients' dressings. At patients' homes and in clinic bases we saw staff washing their hands regularly. Antibacterial hand gel was also available to all adult community services' staff. We saw staff using it between patient visits.
- The outpatient clinic rooms at Keynsham Health Centre had handwashing sinks, soap dispensers, paper towels and pedal bins to help ensure good infection control practices.
- There were reliable systems in place to prevent and protect patients from healthcare associated infection. The provider carried out regular audits to assess compliance with best practice.
- The provider had recently introduced (October 2016) standardised cleaning schedules for team equipment as well as for equipment assigned to each nurse which they stored in a purposely designed trolley in their car. This was to ensure that all equipment was cleaned regularly. However, we saw nurses did not always clean equipment after use before returning the equipment for use in a different visit. For example a blood glucose meter was not cleaned before being put back into the case. This meant there was a risk of cross contamination at the next point use.
- Patients told us that they were confident that the people looking after them maintained high standards of hygiene.
- We observed the appropriate management of waste in the clinical areas we visited. Waste was separated into clinical and non-clinical bags and bins.
- Blood waste, following venesection was cited on the service's risk register. Solutions had been identified to improve the efficiency with which blood was disposed of.
- The clinical areas we visited were clean and free from odour.

Mandatory training

- The organisation had recently changed the way in which it offered mandatory training to staff. Staff now attended one day's training on the anniversary of their start date where they were offered all of their mandatory training, as opposed to individual sessions. The day was different for clinical and non clinical staff. Staff told us they felt that this training was of .good quality, relevant and useful.
- However, some clinical staff felt the basic life support training was not sufficient for their needs. The training day did not include training or updates in relation to anaphylaxis, which is a severe allergic reaction which some patients may have when given intravenous antibiotics or vaccines. Clinical staff expressed a concern that this training was now facilitated as e-learning and they were not sure if it was mandatory. The organisation told us relevant staff could access intermediate life support training on an annual basis. This was organised for staff in areas where there was access to medical emergency equipment for example in-patient areas and minor injury units.
- There was no stand-alone training on female genital mutilation but staff told us it was covered during mandatory safeguarding training.
- However, not all staff were compliant with mandatory training in safe systems, processes and practices. Attendance for training was 71% for community staff across all localities; this meant that 29% (or 195 members of staff) were not up-to-date with their training. Managers told us that following the change to the process, having mandatory training covered in one day meant it was now easier to free staff up from their other duties for one day to attend.

Assessing and responding to patient risk

- Staff completed risk assessments as part of the electronic patient record, this included nutrition, pressure ulcers and falls. We reviewed 14 sets of patient records and found that risk assessments were not always up to-date or completed at all. We saw records

where patient handling assessment charts and national early warning score (NEWS) charts, in services where they had been introduced, were not completed. We saw care plans that had not been updated; for example one patient's care plan was last reviewed on 29 July 2016.

- We saw examples of patient allergies documented on the electronic records system
- The respiratory service provided an example where a patient at home was using oxygen in an unsafe way. They were able to adjust the type of oxygen equipment used to a much safer type, minimising the risk this presented.
- Where patients presented with high levels of risk, an embedded system of multi-disciplinary working meant that community teams were able to seek specific support , for example from the frailty team, or the tissue viability service.
- Nurses working in the out of hour's service started their shifts at an identified base. There was enough time at the start of the shift for the patients to be discussed and the work allocated.
- Community nurses discussed changing care needs and risks in a daily handover/safety briefing. Each nurse who attended discussed concerns in relation to patients and discussed possible solutions with peers and senior staff. It was a constructive process although we observed referral to the tissue viability specialist nurse was not considered as an option in relation to a concern regarding a wound.
- We observed a rehabilitation safety brief and allocation of patients meeting. These happened daily and identified patients who needed urgent or early visits and mapped their progress against identified risks.
- The provider had a payment related target for quality and innovation set by the commissioners (CQUIN) which was to introduce an early warning score to raise awareness of acute deterioration of patients' health. The provider had introduced a NEWS score in line with targets set by commissioners and adapted the actions to take to the community setting. The use of NEWS scoring was audited in the inpatient setting but it was not audited in community health. However, there was a plan in place to audit compliance with obtaining vital signs observations at all first visits to patients as a 'base line tool' to detect deterioration in a patient's condition. There was a four stage roll out throughout the organisation and there was a planned roll out to community matrons and emergency care practitioners in the last phase. NEWS scoring also formed part of the falls pathway to determine if falls were caused by low blood pressure. Staff we spoke with were aware of the rationale for checking patient's vital signs when they attended patients who had fallen. Although not yet fully embedded we saw evidence that staff were beginning to take a set of observations of patient's vital signs at the first encounter. Staff told us that using the NEWS scoring had helped communicate the severity of a patients' deterioration which led to a GP visit and admission to hospital.
- We found that risk assessments in relation to pressure ulcers were not always re-assessed in a timely manner even if the risk score was considered a high risk of pressure ulcer or if a patient's general condition had deteriorated. We reviewed the provider's 'policy and procedure for the prevention and management of pressure ulcers which stated that the waterlow risk assessment should be updated every month for patients scoring greater than 20. In the patient records we reviewed the waterlow risk assessment was out of date in three records. It was not always clear what actions had been taken to alleviate pressure for patients at high risk of pressure ulcers despite guidance being available for staff.

Staffing levels and caseload

- Staffing levels and skill mix across the adult community services were adequate to meet the needs of the patients they looked after**.**
- Staff turnover (substantive) between 1 July 2015 and 30 June 2016 was 15.8%. The total percentage of vacancies (excluding seconded staff) was 5.75%. Locality managers told us the organisation continued to advertise vacancies. New staff spoke highly of the organisation, including their induction and ongoing support mechanisms.
- In community nursing services we were told that recruitment was an ongoing concern. There were many services where temporary vacancies, such as those created by maternity leave, were not being covered. This caused ongoing issues with caseload sizes for this group of staff. We were told that staff worked over their contracted hours almost daily. Much of this was to complete records that were unable to be completed

Are services safe?

due to the volume of visits. However, we were told that caseloads were reviewed frequently and the necessity of visits was examined. This appeared to be clearly embedded in the teams that we spoke with.

- Staff providing out of hours care were generally running the service whilst short of staff. Team members would step in to cover sickness and annual leave. The team operating in the South Gloucester region, operated with two teams per evening instead on three teams of two nurses. Recruitment of staff features on the organisation's risk register.
- Within the MSK service, we were told that in order to manage the current workload another three physiotherapists would be needed. This was based on an estimate by the service lead. The service had no control over how many patients were referred as this was part of a "block contract" arrangement with the local care commissioning group (CCG). Funding did not increase with the number of patients. The MSK service used a monitoring tool to input their capacity on a regular basis. In addition, information was added about the numbers of referrals which identified the stretch in this service. This was taken to the head of division within the organisation to discuss at board level.
- We were told that a business case had been put forward to try and obtain funding for these posts. In order to try and manage some of the waiting time issues an initiative had been launched which provided "Back Education Sessions". This service aimed to support patients with low risk back pain through education and support in a group setting. Patients could choose to book onto these sessions. Following a session, patients were offered the opportunity of an appointment with a physiotherapist. Data collected by the service showed a very low uptake of this option suggesting that patients were satisfied with the sessions they have received.
- In addition, the MSK service told us that when previous increases in clinical staff had been agreed, increases in administrative support had not happened. This had resulted in a shortage of administrative staff, causing delays in administrative tasks such as typing up of letters to patients and other health care professionals. This had also been identified and added to the corporate risk register.
- . District nurses worked closely with GPs and many district nursing teams were based in GP practices.
- Visits to patients were not timed appointments as visits were allocated to nurses each day to ensure they were based on the patient's needs. This also meant the time of the visit and the competence and skills of the staff on duty could be taken into account. This meant the service took account of some visits needing more time and others needed to be done within a certain timeframe such as administering insulin. Nurses told us they had six to ten planned visits a day which they aimed to cover during the morning. This meant that they could complete paperwork, make referrals to other services and respond to new referrals in the afternoon. We reviewed some rotas and they confirmed a ratio of about six to eight planned visits per nurse in a day.
- The service used bank staff to fill vacant shifts due to sickness or leave. Bank staff were employed by the provider and as such had access to similar supervision and training as employed staff; we were told that bank nurses were almost always nurses who had previously worked for the provider. The service used very little agency staff although one location had had an agency nurse working on a long term contract for about one year; this nurse had had a local induction, had worked shadow shifts and had undertaken mandatory training in line with bank staff requirements.
- The district nursing and reablement/rehabilitation teams were engaged with collecting data to highlight the visits that they were not funded for. The project was called 'bridging the gap' and staff documented visits they provided until a care package was in place; these visits included multiple visits a day and tasks that would usually be carried out by a social service care agency. We reviewed the figures for reablement/rehabilitation and district nursing teams and found that this meant the district nursing team made an average of 37 additional visits to patients per month during the period from October 2015 to end of September 2016; for the same period the average additional visits to patients for the reablement/rehabilitation teams was 549 visits per month. However, the additional work the nurses provided enabled patients to be discharged earlier or in some cases avoid admission to hospitals.

Managing anticipated risks

- The organisation took lone working seriously and had a 'personal safety and lone working policy to support staff visiting patients in their homes. Each community based team we visited told us about their systems in place to

ensure staff were safe. This included staff ringing into or texting a designated team member when they were home after an out of hours shift or if they were visiting a difficult patient/family.

- In the Keynsham Rehabilitation team they had a procedure for distress calls from staff. This included a dedicated telephone line and a black folder that had information the person answering the distress call may need. All staff in the team knew about the system.
- Both electronic recording systems in use were able to show alerts, for example if a patient had a difficult dog, difficult access to the property or if a safeguarding alert had been made or was ongoing.
- Nurses discussed anticipated risks in nursing handover/ safety brief daily and how to best manage anticipated risks. We observed a nursing handover where nurses discussed the safe removal of a catheter as per plan and how to effectively monitor the risk of the patient not being able to pass urine following the removal of the catheter. The nurses reviewed the treatment plan to confirm it was the right time to remove the catheter and planned for nurses to contact the patient at regular intervals during the afternoon and evening to ensure there were no problems before visiting again the following day.
- The IV service had its own “task/area” risk assessment. This was written by the IV specialist nurse and outlined potential risks. The document also contained information about how the risk could be mitigated, when this could happen and by whom.
- In the community respiratory service, the team leader had devised a “project risk register” that identified potential risks to the service. This was shared at board level.
- In other specialist community services, anticipated risks, such as staffing levels were escalated and added to the corporate risk register.
- Concerns around workload for community nursing services had been added to the risk register.

Major incident awareness and training (only include at core service level if variation or specific concerns)

- Staff we spoke with were aware of the plans if there was a major incident in their area of work.
- The organisation had a business continuity plan which was available to staff on the intranet system. Staff were aware of what to do in their local area. For example in the Chew Valley when flooding occurred and it was then not easy to get to patients' houses and in the Keynsham rehabilitation team they had operation ‘snowflake’ for bad weather conditions. This included the use of a 4X4 vehicle and assistance from the fire service if required. They would ring patients (if appropriate) to let them know they were trying to get to them but they may be late. Staff said they would go to their nearest GP surgery or hospital to offer to help. All staff said at these times communication between teams was excellent and the priority was to get to patients who urgently needed a visit.
- All patients were categorised according to their care needs which enabled staff to prioritise visits according to the acuity of the patients care needs

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

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

We rated effective as good because:

- The needs of patients were assessed, planned and delivered in line with best evidence based practice using recognised assessment tools in most cases.
- There was a holistic and comprehensive approach to the assessment of patients' needs including consideration of clinical needs, mental health, physical health and wellbeing and nutrition and hydration.
- Staff were knowledgeable about assessing patient's mental capacity and cared for patients in a non-judgemental manner, respecting the rights of individuals.
- Some services collected information about patient outcomes and could demonstrate the effectiveness of their service
- The service participated in national audits, audits requested by commissioners and internal audits. The serviced used the results to review and improve services
- Staff were qualified and had the skills to carry out their roles effectively. Staff had regular appraisal and supervision.
- Multidisciplinary team working was embedded throughout the service and referrals to different healthcare professionals were coordinated and efficient.
- Consent was obtained for care and treatment interventions in line with policy and guidance.

However,

- The service did not always monitor the completion of timely assessment of risks to patients.
- There was not a consistent approach to pain assessment documented which meant there was not always a proactive approach to supporting patients to manage pain.
- Staff were aware of the obligation to gain consent but there was not a consistent approach or knowledge regarding type of consent required

Evidence based care and treatment

- Patients' needs were assessed and care and treatment delivered in line with relevant legislation, standards and evidence-based guidance. We saw many examples of pathways and procedures that staff followed when assessing and planning care which was evidence based and current. Standard operating procedures and care pathways were used both by staff visiting patients in the community but also by staff who met patients in outpatient clinics.
- The bladder and bowel service bases treatment and patient education on guidance from the National Institute for Clinical Excellence (NICE). We observed a consultation where these guidelines were explained to a patient, to aid with understanding of advice. This appeared to benefit the patient's understanding of the advice that was offered. The Parkinson's and related conditions service participated in national Parkinson's audit to measure the effectiveness of the service on patient's wellbeing. The community IV and blood service had written a pathway for the service. This was based on NICE guidelines and advice from national centres of excellence although this wasn't sited on the document itself. The IV service was 100% compliant with Blood Safety and Quality Regulations (2005) in the period from October 2015 to December 2015. This meant the service was compliant with applicable standards for the safe storage and distribution of human blood and blood components.
- We reviewed the standard operating procedures (SOPs) for the patients at risk of developing pressure ulcers. These were referenced and based upon evidence based practice, for example the 'policy for the prevention and management of pressure ulcers' referred to guidelines from the National Institute for Clinical Excellence (NICE) 2014: Pressure Ulcers – Prevention and Management . However, the policy included the use and completion of the SSKIN bundle (a tool which ensure pressure ulcer preventative measures are taken) every 24 hours or at every visit with patients with an increased risk of

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developing a pressure ulcer such as patients with a high waterlow score (a tool used to assess the risk of a patient developing a pressure ulcer) but we did not see consistent evidence that this was done.

- The frailty service used the 'Rockwood Frailty Score' to assess patients. This system categorises a patients abilities into a score that can help inform their care needs. The service used this system to ensure appropriate referrals. Professionals involved in the care of people using the frailty service are those whose specialisms lend themselves to this group of patients, for example occupational therapists and physiotherapists.
- The community 'neuro and stroke' service provided specialist person-centred intensive rehabilitation for patients following a new stroke, brain injury or spinal cord injury. The service met guidance in the Department of Health: National Stroke Strategy (2007) and were based on guidance from the National Institute for Clinical Excellence (NICE).
- The Active Ageing service had been developed in 2014, to help older people remain well and active within their communities. The service was run and developed using the underpinning principles of health visiting and was led by specialist public health nurses (health visitors) and specially trained support staff. The service provided health promotion, health prevention advice, support and partnership working with clients to identify and manage risks.
- For community nursing services, we saw the use of recognised tools such as The Waterlow Score (a screening tool used to assess patients' risk of developing a pressure ulcer) and MUST (a malnutrition universal screening tool) in assessments for patients. The care planning, that we observed was based on individual patient needs, was appropriate and relevant. However, the assessments were not always updated and care plans amended in a timely manner. This meant that changes in patients' conditions, with the increased risks this may incur, were not always identified and plans were not always put in place, in a timely manner, to reduce the risks. Compliance for regular re-assessment was not audited although as part of an investigation the frequency of re-assessments were reviewed. This meant there was not always a proactive approach to assuring the effectiveness of risk assessments and care planning.
- The provider offered a 'falls clinic' which was led by a specialist nurse. Assessment and recommendations were based on guidelines from the National Institute for Clinical Excellence (NICE) and the impact was measured using the 'Rockwood Frailty Scale'.
- The provider employed emergency care practitioners (ECPs) who acted as a rapid response to call outs and could help avoid admission to hospital but also had admission rights so could refer patients straight to hospital without the need for them to see a GP first. They received referrals from GPs and would visit the patient for an assessment to ascertain the severity of the patient's condition, which sometimes meant they called an ambulance for the patient or they could discuss a patient's condition with their GP. The ECPs did not have specific flowcharts or guidelines to help them make decisions about the care and treatment of the patients they saw; we spoke with one ECP who stated that having adequate time helped them make decisions, seek advice and ensure the best action for the individual patient. They were aware of national guidance such as NICE guidelines about sepsis and used a recognised national early warning score (NEWS) when assessing patient's vital signs; this helped them assess the severity of a patient's condition and was used when communicating with either the GP or directly with the hospital about a patient's condition.

Pain relief

- Pain assessment and management was integral to patient care and treatment. Nursing and therapy staff asked patients about their pain levels and discussed their pain relief medication. Nurses discussed effective pain management in nursing handover; this also involved the recommendation to facilitate the prescription of an additional medicine to prevent a patient feeling nauseous, as a result of the pain killer the patient had taken to control pain effectively..
- However, services did not consistently document care and treatment about how patients' pain was assessed and managed. We reviewed 12 patient care records and found no evidence that pain scoring formed a part of care documented in those care records. We did not see evidence of recognised pain scales used or documentation about the effectiveness of pain relief.

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Are services effective?

Nutrition and hydration (always include for Adults, Inpatients and EoLC, include for others is applicable)

- The malnutrition universal screening tool (MUST) was completed as part of the standard nutritional risk assessment for patients. This helped staff assess the risk of malnutrition or if patients were losing weight whilst in the care of the service; this meant that staff could discuss diet, nutritional supplements or aids required to ensure patients had a sufficient nutritional intake to help manage their condition or maintain a healthy weight.
- During home visits with a variety of community staff we heard them asking patients about their appetite and how much they were able to eat and drink. They also asked if the person had any difficulties that made it difficult to eat and drink for example poor eyesight for reading labels and cooking instructions or arthritis that may make opening packets and jars difficult.
- During a home visit to a patient with diabetes we heard a community nurse discuss the importance of regular healthy meals in relation to maintaining blood sugar levels within acceptable limits and also the adverse effect excessive alcohol intake may have on maintaining healthy blood sugar levels. This was done in a non-judgemental way and in a manner the patient could relate to.
- In nursing handover and safety briefing we heard staff discuss nutritional supplements for a patient, who had lost weight; the discussion also included a plan to discuss this with the patient and facilitate a discussion with the patient’s GP for the prescription of a nutritional supplement, if the patient agreed to this.
- In South Gloucestershire there was a nutrition and dietetics service which provided a patient focussed service to GPs, offered outpatient appointments and offered advice to multidisciplinary rehabilitation teams. In Bath there was an adult speech and language therapy service providing support to advise, assess and care for adult patients with communication and/or swallowing difficulties. Although the team was based in Bath, they also provided services to patients in South Gloucester and North East Somerset.
- Keynsham rehabilitation team staff told us, as they sat beside the community nursing team, they would often ask questions of each other about particular patients or conditions and had good working relationships with the team. A physiotherapist from the team said if they had a patient with high MUST scores for example they would link with the community nurses to discuss options, use the ‘Food First’ guidelines. (‘Food First’ is an approach to treating poor dietary intake and unintentional weight loss using every day nourishing foods and drinks), or contact a dietician or speech and language therapist, both of whom they had contact details for.
- There was access to cold drinks in outpatient departments and there were vending machines where patients and their relatives or carers could buy snacks or hot drinks from.

Technology and telemedicine (always include for Adults and CYP, include for others if applicable)

- Community nurses were able to photograph wounds to assess progress or deterioration of wound healing. It also allowed them to discuss treatment options with colleagues to ensure best care and/or make referrals to tissue viability specialist nurses. Allied healthcare professionals in the ‘neuro and stroke’ team, also used video recordings to assess the effectiveness of treatment.
- The provider could install ‘telecare service’ in patients' homes; this was a service sometimes referred to as ‘piper lines’ or personal alarms in case patients needed to call for assistance. We spoke with staff who had arranged for the alarm to be installed which was done within two days and did not require a telephone line. The alarm would be answered by a call centre who would determine best response such as alerting a key holder (relative) or calling emergency services. The community team did not cover call outs in response to the telecare service.
- Community services used telehealth/telecare on occasions. This was usually on discharge from hospital to help patients stay at home for longer. Telehealth systems allowed long distance patient/clinician contact and care, advice, reminders, education, intervention and monitoring.

Patient outcomes

- The service collected and monitored information about outcomes of treatment for patients; some specialist services helped collect data for different audits. However, some services we looked at, worked closely with patients to aim towards individual outcomes, but there was a lack of oversight by the management of

these teams, about the collective achievement of outcomes. We were told this was for a variety of reasons for example some services said that collective outcome data would be difficult to measure. It was not possible to see how managers in these services could establish the efficiency or otherwise of their service in overarching terms, for example the numbers of patients who reached planned outcomes within a given timescale. It would, therefore, be difficult to measure improvements in such services. However the organisation told us they were developing systems designed to improve outcome measurement.

- We visited the Active Ageing Services who targeted people in the local community aged 80-84; the service assessed people's independent living; the service reached 61% of people living in the community in 2015/2016, this was in addition to the people the providers were already seeing as patients. 98% of those seen would recommend the service to others.
- We reviewed outcome measures in relation to pressure ulcer prevention and management. The tissue viability team had implemented an extensive training programme for staff and seen a reduction in the incidents of pressure ulcers of 17% in 2015/2016 and a reduction of grade three and four pressure ulcers by 43 %.
- In South Gloucestershire, information was collected about the number of patients, who were referred to the 'discharge to assess' services who remained in their home after 91 days following discharge from hospital. There were 89% of patients discharged to their own home who were still at home after 91 days.The service had three pathways to follow to support patients discharge from hospital and could either be to support patients discharged to their home or to 'step down' services,
- In the community rehabilitation service, the management kept a record of re-referrals and re-admissions to hospital. This was reported to commissioners on the weekly winter planning template and reviewed with rehabilitation teams, local authorities and acute trusts. The data from Sirona care & health, South Gloucestershire Council and North Bristol NHS trust produced an integrated performance report across the rehabilitation, reablement and recovery programmes (3R's) that was overseen by the 3R's operational board and the 3R's programme board. This allowed for allocation of resources in the organisations services to reduce length of stay in the rehabilitation teams for example.
- The musculoskeletal (MSK) service did not record outcomes on a regular basis. However, goals were agreed with patients. It was not possible to see information about how many patients reached these goals. Staff told us that this had been identified by the service as something they could do better.
- Within the community nursing services there were processes whereby patients were regularly reviewed to ensure their needs were best met by the team. For example, patients with long-term conditions would be discussed in multidisciplinary meetings to ensure care and treatment met the needs of patients.
- Whilst a number of the community services reviewed their caseloads for details of admissions to hospitals and the reasons why, there was not an organisation wide system that captured this information. The emergency care practitioners told us that they helped patients to avoid hospital admissions in most cases but there was no organisation wide data to support that assurance and to capture the effectiveness of the service.
- The service engaged with both national audits, internal audits and audits requested by commissioners. We reviewed some of the audits to benchmark the services against other similar services and to investigate how the audits' results were used to improve practice if required. The service participated in a number of national audits such as 'National COPD audit: 'Pulmonary Rehabilitation: Steps to breathe better' (2015), National Audit for Intermediate Care (NAIC) and Sentinel Stroke National Audit Programme (SSNAP). We saw evidence in minutes of meetings that the audit outcomes were discussed in the Quality Meeting. In the minutes from May 2016 a report, an annual audit summary (April 2015 to March 2016) were discussed and highlighted a focus on action plans for 2016/2017.
- Internal audits included audits for compliance with infection control, quality of records and others. The service also participated in audits in cooperation with a local NHS trust, such as reporting on traceability of blood components which forms part of the Blood Safety and Quality Regulations (SCQR) 2005, which require

assurance that all blood and plasma components are traceable from donor to recipient. The audit demonstrated 100% compliance from October to December 2015.

- The commissioner in Bath and North East Somerset requested the bowel and bladder service undertook an audit for compliance with national guidance (National Institute for Clinical Excellence: The management of urinary incontinence in women, 2013). The audit took place from August to November 2015 and consisted of 20 women which was about 10% of the women referred for urinary incontinence. The audit results showed varying result of compliance; whilst there was a high compliance rate with most measures, the service did not consistently address lifestyle interventions and in one measure (discussion with patients about their weight) there was 0% compliance. The service used this data to review processes and developed an action plan to address the recommendations and there was a plan to re-audit in October 2016

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Registered health care professionals had the qualifications required for their role and health care assistants were supported to gain the skills that were required to undertake the tasks asked of them. Staff received appraisals and supervision from their line managers. At the time of our inspection between 78% and 100 % of staff within the community adult services had had an appraisal within the last 12 months. Staff received a corporate induction when they started working for the provider; one occupational therapist (OT), who had just completed their induction, said it was the best they had ever had. Another member of staff said they had only just started working for the organisation and already felt it was best place they had ever worked and that the staff were so kind.
- Within one 'Out of Hours' community nursing team we were told that one-to-one meetings for staff at band 5 and below often happened in the car between patients as there was not time at the office for this to happen. But in a different 'out-of-hours team, staff discussed issues about patient cases during the car journeys in similar one-to-one conversations in the car between visits but meetings were held at convenient times to them either just before or after they came on duty and appraisals were held at base. Staff at band 6 and above were managed by staff who did not work in the out of hours team specifically, therefore these staff attended for supervision outside of their normal working hours. Staff told us that they were happy with this arrangement and they felt well supported by their line managers.
- Nursing staff renewed their registration on an annual basis and the human resources (HR) team informed managers that staff had renewed their registration. Revalidation for nurses was introduced by the nursing and midwifery council (NMC) in April 2016 and had to be completed every three years. Staff were supported with the process via their annual appraisal and also included supervision; the overview of whose revalidation was due was held by the HR team and locality managers would receive notification of this so that they could support staff with the process. The provider completed all revalidation documents in line with the NMC to ensure transferability of evidence.
- Staff were encouraged to develop their skills but there was not a consistent approach for managers to hold an overview of the competence of individual staff. We asked how managers were assured that staff had the skills and competence to carry out extended or new skills; managers told us that the teams were small and therefore managers knew and the individual also held records of completed training. Competence checking formed part of the recruitment/induction process, appraisals and all clinical staff had access to supervision such as joint visits to patients.
- District nurses were supported to undertake additional learning/courses in order to gain sufficient credits to achieve a degree qualification; these courses included a nurse prescriber course, a research module and a module in long term conditions management. Another popular course that district nurses completed was a 'patient assessment and clinical reasoning' course provided by a local university. Staff were supported with study time and the course fees were covered by the provider but there was a waiting list as the service only had capacity to support a limited number of nurses at any one time, depending of the size of the team.
- There was an established system within some community services whereby staff with particular skills trained other staff, for example the IV specialist nurse provided all of the IV training for the community nursing

team. Another example was the extensive training programme for clinical staff, developed by the tissue viability specialist nurses to help reduce the prevalence of pressure ulcers in the community.

- The community nursing teams included healthcare assistants and assistant practitioners. The healthcare assistant visited patients independently according to their skills and competence. The healthcare assistants attended mandatory training and specific training to obtain additional skills such as wound care. The healthcare assistants did not have their own case load which meant that the patients they saw also received regular visits from registered nurses. The healthcare assistants felt well supported by the wider health care team and could ask for support or joint visits when they needed assistance. Some of the healthcare assistants were also trained as phlebotomists so would often be the preferred healthcare worker to visit patients who needed blood samples taken as part of their treatment plan. The assistant practitioners had a foundation degree from a local university; they too felt well supported by registered practitioners for advice or support.
- Physiotherapists and occupational therapists (OTs), from the rehabilitation teams we visited, told us they were able to access role specific training and also attended meetings and training led by their professional leads in the organisation.
- Competencies were signed off and monitored within teams. We saw the competencies work book developed and used by the Keynsham and The Hollies rehabilitation teams. It was used for staff on induction and probation and to ensure staff were regularly checked to maintain their competencies.
- The provider employed emergency care practitioners (ECP) who were either paramedics or registered nurses with additional training in the complexities of caring for older people, dementia and chronic obstructive pulmonary disease (COPD). Some of the ECPs had a prescriber qualification.

Multi-disciplinary working and coordinated care pathways

- Staff were extremely positive about multidisciplinary working across the organisation. All necessary staff were involved in assessing, planning and delivering care and treatment to a patient. Across all of the services we spoke to, and staff that we observed, multidisciplinary working was entirely embedded in the care that was provided to patients. We observed positive and effective relationships with local hospitals, GPs and specialist services outside of the organisation. Each of the community nursing “clusters” participated in regular multidisciplinary meetings looking at patients who were particularly vulnerable or had complex needs. These were well attended by members of the wider healthcare teams and provided a regular opportunity to discuss patients most at need.
- The specialist services we looked at had clear referral pathways in place that minimised the numbers of inappropriate referrals. For example, the IV service linked effectively with the community nursing teams and had written a set of standard operating procedures that clearly stated the function and limits of the service. The frailty service and rehabilitation service were inherently multidisciplinary in their approach and structure which allowed for patient care to be coordinated and timely, optimising the outcomes for patients. The Emergency care practitioners said they were able to ‘tap into’ relevant multidisciplinary team meetings when necessary and as they were held at GP surgeries it was easy to find out when they were being held.
- We observed two multidisciplinary team (MDT) meetings where healthcare professionals from a varied background attended to discuss patients' care and treatment. There was attendance from GP, community matrons, community nurses, health visitors, dementia advisor, social worker, physiotherapists and occupational therapists. The meetings were held every two weeks and healthcare professionals would be sent a list of patients who would be discussed so that the right people could attend; during the meeting the patients' care records were displayed on a screen to assist a ‘virtual ward round’. The patients were mainly people who suffered from long term illness or palliative patients and the concerns discussed in the meeting included care and treatment relating to managing symptoms and risks such as falls, medication, attendance allowance, ability to stay in the home, mental capacity and end of life decisions such as ‘do not attempt active resuscitation’. We also observed discussions within the MDT in relation to patients' mental health care needs and safeguarding issues.
- Staff had a holistic approach to ensure the best outcomes for patients including making referrals to

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speech and language therapy, psychologist and also arranging for home delivery of cooked meals. A number of staff commented how the links with the social workers, when they were in adjacent offices, had improved the service that could be provided for the patient. For example, advice could be easily sought and joint visits could be arranged more easily.

Referral, transfer, discharge and transition

- There were clear and effective processes for staff to communicate between teams and when referring patients to other teams or services including GPs.
- The twilight community nursing service and overnight nursing service were on-call and received referrals from the out of hours GP service and emergency care practitioners (ECPs).They also received non-capacity referrals from the day teams, when they had not managed to visit a patient.
- The 'out of hours' rehabilitation teams worked different hours in different teams. The Keynsham rehabilitation team provided a rehabilitation therapy worker from 7am until 10pm with clinicians working from 8am until 6pm. If a later visit was required they referred a patient to the twilight or overnight nursing service. The South Gloucestershire community rehabilitation team had two bases (Downend and Patchway) and provided a rapid response and follow up service. They had rehab support workers available from 8.30am until 9.30pm seven days a week and clinicians (therapists) from 8.30pm until 4.30pm seven days a week. Both teams worked with hospital discharge teams to support patients coming home who may need some extra support until they are either be independent, referred on to another service or require a package of care for ongoing support, as well as planned visits and rapid response to prevent avoidable admissions to hospital. The service was needs based and assessed the length of time the service was required varying based on the needs of the service user.
- The specialist services we looked at had clear referral pathways. For example, there was clear guidance for referral to the tissue viability specialist nurses for assessment and treatment, this included advice about the urgency of the referral and for visits from the tissue viability nurses team (time scale) as well as guidance about when to refer to podiatry or for vascular studies. This meant that the numbers of inappropriate referrals were minimised.
- We saw an example of a discharge letter for a patient discharged from the Community Neuro and Strokeservice; the letter was detailed about the support the patient had had during the period he was in their care. It was stated a copy of the discharge letter was sent to both the GP and to the patient, and included information about ongoing concerns or information.
- Nurses were advised of planned new patients referred to them following multidisciplinary team meetings. These referrals were about patients discharged from hospital but GPs also referred patients to the community nursing teams as required. In one location these referrals would all be made to an administration hub which were a team of four administrators who would then allocate the right referral to a community nurse and helped ensure the most resourceful use of nurses available. They worked to the ethos of 'tell us what you need' and gave as an example that a GP had asked for a community matron to visit a patient to get a blood sample. The hub instead allocated this visit to healthcare assistant who was a trained phlebotomist instead to utilise the skills in a more resourceful manner. The 'call handlers' were not clinically trained but had access to the emergency practitioner, the locality manager and district nurses to support and advise them if required. They had access to community nurses' diaries and could contact them via phone to ensure prompt and appropriate response.

Access to information

- The organisation's policies and procedures were all available on their intranet system and staff were aware of where to find them. Staff were able to access the information they needed, to deliver effective care and treatment.
- The provider used two different electronic care records' systems depending on which clinical commissioning group the team belonged to. The system used in South Gloucester was shared with the GP and enabled health care professionals to share information about patients' care and treatment with the patient's consent. The other allowed access to notes made by members of the community team but not GP or other health professionals notes.
- Patients had a folder in their home with information about their care. The folders held different risk assessments but we found that these were not always updated or completed in full. This meant that other

health care professionals including agency staff, who did not have access to electronic records systems, may not be able fully aware of risks to patients such as risks of developing pressure ulcers. We saw an example where recommendations from the tissue viability nurse to use a reposition chart to document regular change of position was not put into action.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards (just ‘Consent’ for CYP core service)

- Community team leaders spoke with confidence about assessment of a patient’s mental capacity and the challenges that could present if patients chose to ignore advice about their choices. We observed staff in a multidisciplinary team meeting discuss the need to assess a patient’s mental capacity to determine if a ‘best interest ‘meeting should be held. ’Best interest’ meetings were held when a patient lacked mental capacity to make specific or significant decisions for themselves.
- The service obtained consent to care and treatment in line with legislation and guidance. We observed staff obtain verbal consent before care or treatment interventions and we reviewed care records and found that it was documented within the care records that consent was obtained, although they did not document the type of consent they had obtained. We saw the Sirona electronic record sharing patient leaflet that explained the principles of information sharing and how to agree or disagree to it being shared.
- We asked staff about obtaining consent prior to taking photographic evidence of, for example, wounds. Staff were aware of the obligation to gain consent but there was not a consistent approach or knowledge regarding type of consent required. Some staff would ask for written consent whilst others asked for verbal consent and documented this in the electronic patient records. We reviewed the provider’s consent policy which stated that expressed (written) consent must be sought if photograph or video recordings were used for any purpose other than for assessment and treatment. This was also in line with the Department of Health’s (2013) guidelines on obtaining consent. The guidance refers to the importance of explaining the purpose and possible future use of the photographic or video evidence; staff in the neurological outpatient clinic spoke confidently about obtaining written consent before obtaining video recordings; they used a specific consent form which was uploaded to the patient’s electronic care records.
- During a home visit with an Active Ageing service support worker we saw how consent to share information with other organisations was sought. The support worker took time to explain why consent was needed before they could help them apply for a bus pass for example.
- The provider had a corporate policy to support staff with issues relating to deprivation of liberties (DoLS). Registered managers and locality managers understood about deprivation of liberty safeguards and were knowledgeable about the policy and processes to follow. Staff understood what DoLS meant and that they needed to be aware of this when visiting patients in care homes. Staff stated they would seek advice from managers if they needed to consider or had any concerns about a DoLS application.

Outstanding

Are services caring?

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

Summary

We rated caring as outstanding because:

- Feedback from patients was consistently positive, patients went to great lengths to tell us about their positive experiences.
- Relationships between people who used the service, those close to them and staff were strong, caring and supportive, and we saw a genuine rapport.
- We saw patients who were active partners in their care, and were encouraged to speak about their opinions of their planned treatment.
- Care that we observed was truly person centred, with patient's wellbeing at the heart of care.
- Patients told us that staff always go the extra mile, and we saw a culture of this. For example we were told that nurses helped to facilitate access to 'face time' so that a patient could use their mobile phone to speak with relatives in another country.
- Patients received care from staff who treated them with dignity and respect.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.
- Staff were fully committed to working in partnership with people and made this a reality for each person.
- Staff involved patients in exploring their options, and respected the patient's wishes and requests.
- We learned of some examples of how quality care led directly to improved outcomes for patients

Compassionate care

- Staff treated patients with kindness, dignity, respect and compassion. During home visits with a variety of staff we saw staff sitting at eye level with the patients so they could hold a proper conversation with them. Patients told us that staff always allowed time to talk during visits, and were kind.
- Staff took time to interact with patients in a respectful and considerate manner. We witnessed staff talking to patients respectfully, and in ways the patient was able to engage with. We observed a patient, whose first language was not English. The nurse who cared for this patient spoke slowly and clearly and checked for understanding.
- Appointment times for specialist services were typically between 30 and 60 minutes depending on whether the appointment was an initial one or a review. We observed seven appointments of this nature during the inspection. The appointments we saw were unhurried, and gave the patient the time they needed so as not to feel rushed.
- Inspectors were given examples of when patients with additional needs had been supported. For example, a patient with a learning difficulty was always given a longer appointment so that the staff treating them was able to take the additional time it took to support that person in the most suitable way.
- Staff demonstrated an understanding of the need to respect people's personal needs and take these into account when delivering care. A staff member gave an example of when a patient did not want their close family members to be aware of the services they were receiving as it was of a sensitive nature. The service embraced creative measures to communicate with the patient - not sending appointment letters to their home, or ringing the home phone number. This ensured the patient overcame their obstacles and built trusting relationships with the service, they engaged, and received treatment that led to improvements in their heath.
- We observed interactions with patients both in their homes and in outpatient departments. Patients told us it was an excellent service with 'nothing to change'
- Patients who were visited at home told us that they didn't feel hurried, and that they felt visits covered all of the care needed in the time they had.
- The nursing teams we observed had built positive relationships with the patients they were treating. They gave examples of how they scheduled visits to suit patients wherever possible, and apologised when this couldn't happen.
- Nurses were able to explain a situation where the patient was seen in a dayroom due to conditions in their flat at the same accommodation. They spoke very warmly about this person, and their desire to help them.

They told inspectors how they had tackled this sensitive subject with the patient, and were therefore still able to offer care in conditions that were acceptable to both parties.

- Staff who we observed meeting patients for the first time, took time to understand them, and discuss with them their needs. We saw that staff ascertained the patient's preferred name.
- We observed staff ensure patient's privacy and dignity was respected. For patients whose needs were of a more personal nature, staff were sensitive and delicate in the terminology they used.
- Feedback from patients and those close to them was consistently positive about the care the staff provided and there were many examples of when patients thought staff had gone the extra mile to support them. The service obtained patient feedback through the 'friends and family' test. From May to October 2016, 93% of patients who had replied would recommend the service to their family and friends. However, the response rate was very low with only 24 returned questionnaires. In the period from November 2015 to October 2016 the total responses were 83 of which 97% would recommend the service to friends and family.
- We spoke with patients who benefitted from the visits of allied health professionals as part of the reablement team. Patients received visits up to four times a day and described the healthcare professionals as 'incredibly supportive' and would go the extra mile such as help to hang curtains for patients following discharge.
- Patients told us that specialist nurses had exceeded expectations to provide a holistic approach by facilitating access to services not directly associated with their speciality. For example a specialist nurse assisted with advice on how to get hearing aids sorted although this was not a part of their specialist service.
- The provider had a chaperone policy which primarily related to patients visiting the outpatient departments. However, we did not see any leaflets to advertise this in the outpatient departments nor did we witness clinics that involved an intimate examination where the presence of a chaperone should be offered according to the policy. The policy recognised the increased risk of lone workers such as district nurses, of actions being misconstrued or misrepresented; the policy stated that it was applicable to all staff who undertook intimate examinations or procedures and/or provided personal care. We did not see any documentation that staff had offered a chaperone in the nine electronic care records we saw, however the records did not cover episodes of care that involved practices of an intimate nature.

Understanding and involvement of patients and those close to them

- Patients were routinely involved in planning and making decisions about their care and treatment. Patients and their relatives were involved as partners in their care. On all visits we observed patients being included in discussions about their care and treatment, where applicable relatives and carers were also involved. Patients told us that they felt they were always empowered to make decisions about their care. They said they felt fully included and their opinions respected.
- We heard staff discussing a patient, during a multidisciplinary team meeting, who needed a visit possibly from more than one service. They discussed who was most appropriate to go to ensure the patient did not get too many visits from different people as they knew the person to be very private. This demonstrated a person centred approach to the care of that patient, and appeared an embedded approach to the service provided.
- There was a strong emphasis on patient-centred care but staff also recognised and respected the totality of patients' needs and took these into account. We spoke with patients about the care they received in their homes by the district nurses. Patients told us 'the nurses were doing a good job and that nurses went out of their way to do things". We were told that nurses helped to facilitate access to 'face time' so that they could use their mobile phone to speak with relatives in another country. This demonstrated an awareness and understanding of a patient's personal needs as well as their health needs.
- Community teams assessed patients in vulnerable circumstances and offered advice about support. They acted as advocates to help patients make decisions about their lifestyle when this impacted on their wellbeing. We saw examples of visit times arranged to suite the circumstances of individuals. Care was delivered in a non-judgemental manner which respected the individual's choices even when these had a negative impact on the individual's wellbeing. Nurses spoke with confidence about individual's right to make

choices about their care and about assessing an individual'st mental capacity to make choices about their life. Nurses demonstrated that patients' emotional and social needs were highly valued. This clearly informed their approach to patients and was embedded in the care offered.

- Patients told us that they felt their preferences and needs were always taken into account by the nurses that visited. They also told us that nursing staff always promoted their dignity, and worked discreetly in their home.
- We observed a daily nursing handover and safety briefing where nurses discussed concerns relating to patients they had seen that day. There was a holistic approach in the discussions to consider all aspects of the patient's care and welfare, including how to ensure the patient and those close to them were involved in decisions about the care the patients received. Relatives told us that they felt involved in their loved one's care and had established positive relationships with staff.
- We saw clear evidence that patients were active partners in their care. Patients were supported to manage their illness whenever possible; for example a patient was supported to administer their own medication with the support of a district nurse to ensure they took the right dose of insulin. We observed an allied healthcare professional confirming with a patient about sending copies of letters both to the patient and the GP to help them keep informed of their treatment and care.
- We observed a consultation with a patient in an outpatient department and found that care was taken to give the patient information. This empowered them to decide appropriate treatment options.
- We reviewed notes from a debrief session for specialist rehabilitation services; the aim of the session was to discuss what had gone well and any aspects where the team approach could be improved. The notes highlighted what the team did and why and described the actions taken by the team. Initially four visits per day were planned, with a staged withdrawal to allow the patient to regain independence. This approach enabled the patient to realise their potential in a measured way. The team supported the patient to access health promotion advice to prevent readmission and actions were identified to enable the patient to resume an active life. This process demonstrated a person centred approach to enabling recovery of a quality of life acceptable to the patient.
- The patients that we spoke to said that they felt involved in their care and understood what was being provided to them and why. They told us that they felt able to ask questions about their care, and that staff supported them to learn about how to manage their illnesses
- During the inspection we observed seven specialist clinic appointments. Staff consistently provided patients with information about the care they were receiving. All patients' observed were asked if they had any questions by the staff who were treating them. We observed strong professional/patient relationships that were supportive of the patient's needs.

Emotional support

- We found that patients were given appropriate and timely support and information to cope emotionally with their condition. We observed emotional support being given to patients during home and clinic visits on many occasions. For example, when we accompanied a support worker for the Active Ageing service on a visit, we found they quickly gauged how the person was feeling and the frustration they were feeling now they were not able to be as independent as they once were. The support worker was kind, supportive and offered the person information about a variety of services they may be able to access that would help them engage in their local community and perhaps increase their independence.

- Patients' emotional and social needs were highly valued by staff and embedded in their care practices. Staff planned their visits to enable patients to attend other commitments for example a district nurse left the base office early to ensure that they could visit a patient before she went out. Another nurse had carried out their first visit on the way to work in order to administer insulin so that the patient could have their breakfast at their preferred time. In another example a health visitor working for the Active Ageing Service helped a client set up a tablet computer to enable them to talk to their relative in Australia. The health visitor said both parties were absolutely delighted.

Outstanding

Are services caring?

- During the inspection we saw some examples of positive outcomes for patients. A patient who was being supported by the frailty service had been supported to plan, and access a trip abroad. This had been successful, and the patient had enjoyed a positive experience as a result of the support offered to him by the frailty team
- We accompanied allied healthcare professionals visiting patients in their home as part of the reablement service and found that staff were very caring and aware of both physical and emotional needs of the patients. We attended a multidisciplinary team meeting which discussed the organisation of a taxi to enable a patient to attend a funeral. Working in partnership for patients' wellbeing – both in terms of their physical and other needs, was embedded within the community services we observed. We observed a community matron having a conversation with a patient about a 'do not attempt resuscitation' decision. The community nurse was caring, supportive and took time to speak with the patient focussing on their concerns and their treatment plan.
- In the bladder and bowel service, all the patients were involved in deciding when their next appointment would happen, based on the support they needed.
- We saw that emotional support and information was provided to those close to the patient as well as to the patient. The frailty team, through a regular multi-disciplinary meeting, discussed the impact of patients' circumstances both on the patient, but also the carer. There was evidence of strong positive relationships with carers as well as patients receiving services from the frailty team. The team were highly motivated to achieve a holistic, effective service for its patients, and clearly cared about the "whole" person.
- We saw evidence of supportive relationships between staff and patients with diagnoses of potentially life limiting illnesses. Patients told us that they felt that could ask staff anything and would get a clear answer.

Good

Are services responsive to people's needs?

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

Summary

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

We rated responsiveness as good because:

- The needs of patients were taken into account when planning and delivering services. Staff were flexible to meet the needs of patients.
- Reasonable adjustments were made for people with disabilities, learning difficulties and those living in vulnerable circumstances.
- Teams worked very well together to provide the most appropriate care at the most appropriate time for patients.
- Care and treatment was co-ordinated between the community adult services.
- Patients were given information about how to make a complaint or raise a concern. There were systems in place to evaluate and investigate complaints.

However:

- There were long waiting lists to access some of the community services such as physiotherapy, although they were staffed to commissioned levels.
- Some bespoke services that needed specialist staff to run them were not able to be offered if that staff member was on leave or off sick. Although patients were offered appointments for alternative services.

Planning and delivering services which meet people's needs

- Different services within the adult community services division spoke about the commissioning of services to meet the needs of the people in the community. Staff spoke with passion and enthusiasm of services that they had been instrumental in developing with the support of the clinical commissioning groups (CCG) for South Gloucester and Bath and North East Somerset (B&NES).
- Teams carrying out home visits said they would try to accommodate patients' needs and book appointments to suit the patient where possible. We were given numerous examples of how different teams worked together to ensure patients received the most appropriate care at the most appropriate time. This meant patients were not receiving multiple appointments or visits.
- We heard an occupational therapist from one of the rehabilitation teams talking to a district nurse about a patient they were both visiting to make sure they were providing consistent support and information and were not going to be visiting at the same times.
- We spent time with the emergency care practitioners (ECP), in the South Gloucester area (they did not provide this service in the B&NES area), who took referrals from a number of sources in order to try to avoid hospital admissions. They often directed the calls to more appropriate services and visited the rest to assess the patient and provide appropriate care and support.
- The ECP service had a one hour response time after the locality administrator had taken the initial referral call. This could take the form of a phone call to make an initial assessment of the patient. The ECP service stopped taking calls if the service was working to capacity. The calls could be directed to an alternative quick response service such as one of the rehabilitation teams, or back to the referring GP as appropriate.
- A patient explained how, when they had accessed the IV service the previous week, the specialist nurse looking after them noticed they were unwell. The nurse was able to write to the patient's consultant, arrange blood tests and a consultation which resulted in a blood transfusion three days later. The patient told us that this meant they felt much better, more quickly, and was complimentary about the care they received from the service.
- The provider offered an orthopaedic interface service to provide an assessment for patients who had concerns or symptoms of a musculo skeletal nature. The aim of the service was to assess patients who would otherwise be sent to a hospital setting for surgical intervention. Patients were assessed and triaged either to be treated in the local service with physiotherapy, joint injections or similar, or if the local service was unable to meet the treatment needs, they would refer the patient for surgical intervention. Patients waiting times were reviewed weekly and the average waiting time was six to eight weeks.

Good

Are services responsive to people's needs?

- We visited a service in B&NES that facilitated discharge of patients, who had had a stroke, from a nearby NHS hospital within seven days of admission to the acute hospital. The team consisted of physiotherapists, occupational therapists, a psychologist, speech and language therapists and nurses and they facilitated up to four daily visits to help patients regain as much independence as possible following their stroke. Patients' needs were assessed and planned with the patients who set their own goals. Next of kin and/or carers were also involved in the process. The involvement of the team was goal led and not time limited. This meant there was a focus of realistic goals and would often involve teaching the family how to assist the patient in achieving the set goals such as using a hoist safely. If required the team would refer the patient to a community matron for long term help and support in managing health care needs. Referrals for this service were partly from an 'in reach' facility where staff from the service would visit the stroke unit at a nearby NHS hospital twice a week, to assess and review all patients admitted following a stroke. The service had a quality target set by commissioners to facilitate discharge for 50% of patients admitted following a stroke; the achievement of the service exceeded this target and achieved discharge within seven days for 54-80% of patients admitted to hospital.
- There was a team of three tissue viability nurses who provided care and treatment for patients with complex wounds. They received referrals from district nurses and would arrange joint visits with them to advise, agree a treatment plan and provide supervision of treatment carried out by the district nurses. In addition to this the team was also commissioned to facilitate two days a week for patients in nursing homes in B&NES. This service included teaching staff in nursing homes about the prevention of pressure ulcers.
- We visited a 'Parkinson's Disease' clinic that had a multidisciplinary approach to support patients diagnosed with Parkinson's disease. The service offered advice and support, undertook falls risk assessments and offered 'balance' exercise classes.
- Specialist services that we observed had been designed to meet the needs of people who may otherwise have had to attend hospital for treatment or consultation.
- Some of the specialist services we saw operated in more than one location. This was in order that ambulant patients attending these services had less travelling to access them.
- Of the four specialist clinics we visited, three of them were operated in bespoke areas that had been designed with the function in mind. All of these services were able to fulfil their purposes adequately. Staff told us they were happy with the buildings they worked within. Patients that we spoke with said that they felt the facilities were designed well and were pleasant to visit.
- Specialist service clinics ran at set times throughout the week in various locations. In all but one of these services, this appeared to meet the needs of the local population.
- One clinic was staffed by two specialist nurses. Intravenous and blood related treatments had been risk assessed as needing two nurses in order to run safely. This meant that in situations where two nurses were not available, for example due to sickness, annual leave or training, the clinic could not run. This meant that for a significant part of the year, this service was unavailable for patients. During this time patients attended their local hospital for treatment, which could feel disruptive for them. This had been bought to the attention of the commissioners of the service who had decided not to fund anymore staff for this service as patients could access the services in the acute trust.
- A number of the specialist services were provided at various locations across the geographical patch the organisation covered. This enabled patients to access services closer to their home.

Equality and diversity

- Services took account of the needs of individual patients and spoke about the importance of not being judgemental in the way they cared for patients. Staff spoke of people's rights to choose a way of living as their preference.
- We were given examples of where reasonable adjustments were made in order to help people with disabilities or learning difficulties. For example, space was made available for those patients who required a carer to remain with them during treatment. Disabled parking spaces were available at all main entrances of

the sites we visited. Sirona services at Keynsham Health centre were on the first floor and lift access was available. There were disabled toilets in all of the areas we visited.

- We observed a consultation with a patient who was struggling with equipment at home. The nurse was able to arrange for alternative equipment to be supplied with the aim of improving their engagement with treatment.

Meeting the needs of people in vulnerable circumstances

- The tissue viability specialist team had produced an extensive resource and teaching pack to help staff meet the needs of patients with an increased risk of developing pressure ulcers. The resource pack included information about preventions, a pocket guide and a 'pressure ulcer prevention passport'; the aim of the passport was to communicate pressure ulcer prevention needs to all involved in the patient's care. It was developed with the patient at the centre and also included a 'tell us' card aimed at reminding patients of when to tell people (care agency, GP, District nurses, next of kin) of signs of or increased risk of pressure ulcers having occurred or changed.
- We saw evidence from a case review and discharge summary from the community neuro and stroke service that support was offered to a vulnerable adult in order for them to regain the ability to live independently with limited support, including support with safe living conditions.
- The ECP nurses said the response of social services was good if they were concerned there were safeguarding concerns with a patient.
- Staff gave us an example of a patient, who lived with dementia, who attended a specialist service. Attending the clinic caused them a great deal of anxiety and she had previously attended with her daughter. Due to the relationship staff had built with the patient's daughter, they were able to review her condition without requiring her to attend the clinic, by having discussions with the patient's daughter. This provided a positive outcome for the patient.
- The frailty team specifically worked with patients whose scores were above six, on the Rockwood Frailty Score. This system measured the impact of a person's condition on their ability to carry out daily activities safely. A score of above six, indicated a moderate to severe impact. The structure of this team was aimed at ensuring the circumstances that caused frailty could be mitigated as far as was possible. The team's interventions varied for different patients depending on their type of need.
- From discussions with the Active Ageing teams and ECPs we felt they were quick to recognise people in vulnerable circumstances and had contact information to hand to refer to the relevant agencies if required.
- However, it was not always escalated when a patient's care needs could not be met. We observed an example of care needs (repositioning and recommended pressure relieving aids) not being met despite this being clear in the patient's care record. The service seemed unaware of the recommendations and there was no documentation to support that the needs of the patient had been reassessed and the care plan amended.

Access to the right care at the right time

- There were different approaches to ensure access to the right care at the right time. These included rapid response and admission avoidance, 'discharge to assess' which was for patients who were ready to be discharged from hospital but may still need short term support in their own home or community setting. There was 24 hour, seven day a week community nursing service and seven day rehabilitation/reablement services up until 9.30 pm each evening, seven days a week. Patient feedback about all of the services was without exception very good.
- The out of hour's services prioritised referrals based on pain level and end of life patients.
- Community nurses explained that they tried to see patients at times in the day or evening that suited the patients best. However, due to the nature of unplanned visits this was not always possible. We observed nurses contacting patients to discuss when they would arrive and this system worked well. Patients we spoke to said they were generally happy with the times that nurses arrived. The visits that we observed did not feel rushed and patients told us that they did not feel their visits were hurried.
- For many of the specialist services, referral to treatments times were less than one week, and in some cases was less than this. For example the rehabilitation/ reablement/ECP teams, depending on their remit to provide urgent care, were able to see patients within four hours of referral up to 48 hours from referral.

- For other services, patients were invited to contact the service to book their own initial appointment. Patients told us this worked well as they were able to attend clinics at times that suited them.
- Referral to treatment times within the musculo skeletal (MSK) service were 31 weeks at the time of our inspection. This had been identified as a risk by the team and featured on the organisational risk register. We were told that there was not enough funding to provide any more appointments. The organisation told us a business case had been submitted, to the clinical commissioning group, annually for the last three years to look at this.
- Where specialist services were running in a building not managed or owned by Sirona, the team had difficulty finding an effective phone system. There was no call waiting system on the phone line in place at the time of the inspection and this meant that patients often found it difficult to make contact by phone. This was in the process of being remedied during the inspection.
- Adult community services staff told us, where possible, they made arrangements for cover during periods of sickness or annual leave. However, due to the bespoke nature of some of these services, it was not always possible and sometimes clinics had to be rescheduled, or appointments cancelled. Although the bespoke services were staffed to commissioned levels. None of the patients that we spoke to had had an appointment cancelled by the service.
- Referral to treatment time for patients referred for falls and seen by specialist team within 18 weeks was 89% (the commissioner's target was 75%).
- We observed a visit to a patient with a long term condition who received care and intervention from a community nurse. The patient had their patient folder which included risk assessments as well as information about the customer care service and how to make a complaint. The community matron recognised more support and intervention was required and agreed with the patient to discuss in an upcoming MDT meeting with their consent. Community nurses also left their work mobile number with their patients so that they could contact them when needed; when the community matron went on holiday they would arrange for another community matron to cover and visit patients as needed; patients were informed of this and given additional contact numbers as required.
- The Parkinson's Disease service offered appointments to patients diagnosed with Parkinson's disease. The patients attended alternate clinics with consultant or specialist nurse and patients were never discharged from the service. This meant that capacity to accept new referrals could be compromised if not regularly reviewed.
- Physiotherapy waiting times for the neurology outpatient and physiotherapy service was more than 25 weeks, despite being staffed to commissioned levels. The service had entered this on a specialist service risk register in October 2016 so we were unable to assess if the mitigating actions had yet had an effect.

Learning from complaints and concerns

- Sirona Care & Health C.I.C. reported receiving 50 complaints between July 2015 and June 2016. Of these 22 complaints were upheld and no complaints were referred to the Ombudsmen. Seventeen of these complaints were attributed to community health services for adults. Of these nine were upheld. The community nursing teams had received seven complaints in total and these related to communication (one), delay in access (two), quality of care (two) and attitude of staff (two). All of the complaints were thoroughly investigated using the organisations complaints procedure. There were no themes or trends identified during the investigations. Outcomes were shared with the person who made the complaint and the relevant staff.
- The provider had changed the process for dealing with complaints by seeking to resolve issues when they were raised. This meant that there had been a reduction of 46% in complaints and an increase in the reporting of concerns by 41% in 2015 to 2016.
- Managers of the specialist services we visited demonstrated an embedded approach to managing concerns. It was normal practice to ring a person who had raised a concern to discuss the situation. We were told that this regularly resulted in concerns not being taken further.
- The organisation's information on how to make a complaint about their service was provided in leaflet form to patients receiving services in their own homes and displayed in waiting rooms in outpatient areas.

Good

Are services responsive to people's needs?

- We saw from minutes of team meetings across the adult community services that complaints and concerns were a routine agenda item and each complaint was discussed with outcomes and learning shared with all staff.

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

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

We rated well led as good because:

- Staff were aware of the organisation's values and strategy.
- There was strong local leadership in place. Staff felt able to approach their managers.
- There were governance and risk management systems in place.
- There was a very positive, supportive culture across all staff groups we spoke with.
- Patients and staff were asked for their views of the service and how it could be improved.
- The organisation listened to staff and looked to ways to improve and be innovative across their services.

However

- There was inconsistency across the two areas in which Sirona worked. This meant different systems were in place in different areas making it difficult to provide consistent and meaningful audit data and an overview of risks across the services.

Service vision and strategy

- The service had a clear vision and values. The provider's vision was to help create happier and healthier communities. The provider had set out strategies to promote the prevention of poor health and intervene early to support recovery. The provider also had a set of values which included making people feel welcome, supported, safe and valued.
- The community neuro and stroke service had a clear vision of working with patients to achieve their goals. This vision had led to staff engagement with a review of services to identify ways of achieving the team vision.
- The falls service had a vision to work with the ambulance services so that the ambulance hub would refer patients who required help following frequent falls. Plans for the future also involved targeted training of staff in residential homes and the wider public.
- The tissue viability specialist service had a pressure ulcer prevention strategy for 2016/2017 which included actions under four sub-headings: documentation and policy, training, audit and data collection and equipment. There was a tracker tool which demonstrated that some actions had been completed whereas others were still to be implemented.
- The Active Ageing service aimed to respond to the increasing demand on health services of older people by using a health preventative role that focused on improving health and wellbeing outcomes of older people by looking at people's physical, social and emotional needs. The aim was to reduce health inequalities, improve access to services and work in partnership with others.

Governance, risk management and quality measurement

- The provider had a corporate risk register where risks to performance were assessed. Amongst the highest risks were those associated with receiving 'good standards', early intervention in the prevention of risks to health and risk of failing to share best practice and learning. Corporate action points were identified although it was not clear what the timeframe for completion of action points were. We reviewed another entry on the risk register about the impact of staff shortages in the outpatient physiotherapy (musculo-skeletal) and the positive effect the mitigating actions had had in reducing the perceived risk.
- Most teams held monthly team meetings where risk, complaints and governance issues relating to their fields of work were discussed. We saw minutes that confirmed this was the case.
- The organisation had a robust complaints system and individual complaints were investigated and discussed to establish lessons learnt. These were then shared with relevant staff to ensure learning was put into place.

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- The organisation had a clear process for the reporting of, feeding back and learning from adverse incidents. We spoke to staff with varying levels of responsibility within this process. It was clear that the system was embedded and staff were confident in its use. There were systems whereby themes that were captured were fed back to teams in meetings and the shared learning discussed. Staff told us they were confident in the effectiveness of the system
- The organisation made clinical policies and guidelines available for all staff via their intranet. They were available to staff at all times. Staff showed they knew how to access relevant policies.
- We reviewed an internal publication 'CQUIN Success 2015/2016' which included information about measures taken within the organisation to ensure targets set by commissioners for quality and innovation were met. This included information about achieving 95% compliance for training in sepsis screening and achieving a reduction in pressure ulcer prevalence.
- We attended a district nurse team leaders' meeting at St Martin's Hospital and found there was a set agenda where patient feedback, adverse events and incident investigations were discussed. The team leaders cascaded the information to the team that they managed. We tested this out with district nurses across the teams and found they had been updated about risks or new procedures such as documenting cleaning of personal and team equipment.
- In the Bath and North East Somerset (B&NES) locality and South Gloucestershire there were pressure steering groups which worked to increase training about pressure ulcers, improve risk assessment and documentation completion, review investigation reports to identify and cascade learning and ensure adequate procedures to facilitate safe transfer of care of patients with increased risk of pressure ulcers.
- The emergency care practitioners (ECP) nurses and community matrons had completed an audit on antibiotic prescribing for the organisation. We did not see the results of this audit.
- The Keynsham rehabilitation team said their patient records on the electronic recording system were audited randomly by two people from the team at regular intervals. The results were fed back to staff at team meetings and we saw examples of meeting minutes that confirmed this happened.
- There was a full time governance pharmacist who had an overview of medicine optimisation. They also produced a bi-monthly newsletter which was circulated to staff via e-mail.
- We asked locality managers about local clinical risk registers and the processes for entering risks onto the provider risk register. We were told there were no clinical risk registers for the localities although some managers had a personal 'to-do-list' to take mitigating actions for locally identified risks. Managers told us they submitted identified risks to the governance team regardless of the severity of the risk (the risk score) and if the score was greater than 12 it would be logged as a risk on the provider risk register. However, this approach meant that there was no action plan to mitigate against identified risks and even though locality managers kept their own to-do-lists, risks were not recognised in a formal manner and mitigating actions were not documented, implemented and evaluated to ensure care and treatment of patients were safe.
- However, some services had their own local 'concerns' register for example the community respiratory team had set up their own local risk register in October 2016; the risks were concerned with operational pressures, and IT access. The stated mitigating actions were existing controls already in place and as such they were not proposing additional actions to resolve the issues. The proposed solutions were not specific or measurable nor did they have a named person(s) responsible but it was still in its infancy. There was also a specialist services' divisional risk register highlighting risks for provision of the heart failure service, adult audiology and neuro physiotherapy; the impact score, existing controls and further actions to mitigate the risks were identified. Some of the rehabilitation/reablement teams kept a log of their local risks. The community rehabilitation team, based at Downend Clinic called their local risks a 'work plan' and had for example identified concerns about safety of staff working on their own between 6pm and 9.30 pm and were discussing how this could be managed. One of the specialist services we visited kept a "template of concerns" which was a local document identifying what it saw as its challenges. This document informed discussions with the team leader's manager and was communicated upwards through the organisation.
- Registered managers (RM) were aware of notifications directly to the Care Quality Commission (CQC) for

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example where a Registered Manager was absent for more than 28 days or an unexpected death of a patient) but seemed less clear about notifying the CQC about other issues falling within the regulations.

Leadership of this service

- The service provided similar services in the two local authority areas they covered (Bath and North East Somerset (B&NES) and South Gloucester which meant community adult teams had slightly different management structures and descriptions for the services they offered. However, speaking to staff across the two areas we found that the two areas worked together well and patients received the care and support from the right staff at the right time and in the right place for them.
- Staff were complimentary about their locality managers and deputy locality managers and found them approachable and supportive. Staff agreed there was an open door policy with their managers. Staff said they did not see managers from a “higher” level very often, they did not see this as a problem as they were confident in their line manager’s ability to communicate clear messages.
- There were a number of meetings for service managers; these included a leadership forum, administration staff forum and a registered managers’ group.
- The IV service was led by a specialist nurse. This ensured that the service was able to run effectively because this staff member had both the clinical and managerial skills to be effective in that role.
- Other specialist services, such as the respiratory service, and musculo skeletal (MSK) service were also managed by people with both clinical and managerial skills. This had the effect of simultaneously providing clinical knowledge and managerial support to staff within those teams.
- Where services were not led by managers with relevant clinical skills, alternative arrangements had been made to enable these staff to receive the appropriate level of clinical support.
- Out of hours staff said their managers held meetings at times they could attend either in the evening or early mornings. Staff said they did attend the meetings and it made them feel valued as part of the overall service.
- A nurse from the community overnight service told us they felt supported when they had had a minor car accident in the early hours of the morning. Their manager was at their base at 8am to make sure they were alright. The organisation's transport department made sure the damaged car was collected and another vehicle was made available for them that night.

Culture within this service

- The service had values which included nurturing a just culture where staff were supported to develop high standards of care and be fairly held to account when they failed to do so.
- Team leaders, assistant locality managers and locality managers all spoke of being proud of their teams and of the care the teams provided to patients in their care.
- In a recent staff survey some staff indicated that they did not have a proper lunch break. Staff told us they would usually eat by their desk and use this time to catch up on paperwork, ordering consumables and make referrals. Staff said that “working through their lunch hour was the norm” and that they would “rather work through lunch than go home late – we go home late anyway”. Staff were not paid for one hour of their working time but very rarely used this time to take a break before afternoon visits/clinics.
- We asked staff what they were proud of and amongst many aspects of their work, staff mentioned being able to provide good end of life care, working in good and supportive teams and having strong multidisciplinary working with GPs and allied health professionals.
- Staff we spoke with generally ‘loved their job’ but we were also told of some issues that had a negative impact on staff’s lives. Some staff told us that they had recently lost their regular car user allowance and there had also been a reduction on the mileage allowance; this had a negative impact on how much people were paid and the effect it had on their private cars without any financial compensation to help maintain their car.
- We observed teams who enjoyed a positive and beneficial relationship. Communication was open and clear. Staff told us that they felt able to speak up about concerns, and that they felt supported by their teams.
- We asked staff about opportunities for professional development. Staff had yearly appraisals including supervision and registered nurses had support to complete requirements for their revalidation. Staff felt supported to develop and managers told us that they supported people to develop. An allied health professional told us they had been supported to engage with research and were allowed to participate in

teaching at a nearby university which meant they could extend their work in academia. Another member of staff had been supported to complete a Master's degree and had had support with getting an innovation patented.

- The organisation had a comprehensive lone working policy. Staff demonstrated locally how they kept each other informed of their whereabouts and called in at the end of shifts if they were not returning to their base. All teams we visited said they felt safe in their working environment.
- The twilight and overnight district nursing services worked in pairs partly for their safety and partly as many of their patient's required two staff to attend to them.

Public engagement

- Patients were able to feed back their views on the services provided via the NHS friends and family test to say if they would recommend the service. Staff told us they were told about the outcomes of this survey.
- The provider sought feedback from people who used the services and compiled an annual report for 2015 - 2016. The report showed that the organisations district nursing service had received eight complaints and 15 concerns about communication, quality of care and access to services, The report also showed that the provider had received 1,983 compliments about the care they provided which was an increase of 75% in comparison with the year before. We saw the feedback questionnaire that was sent out by the Keynsham Rehabilitation team when a patient was discharged from their care. Staff said results of the feedback were shared with them at team meetings.

Staff engagement

- The provider had an ethos of 'taking it personally'. This had been developed with the involvement of staff from different service areas. This resulted in standards of behaviour expected from all staff and included courtesy and respect, effective communication, care and support and that staff were effective and professional. Staff had participated in short videos to explain the set of behavioural standards, which were available on their website.
- Staff were aware of the organisation's staff awards which enabled staff to celebrate successes and hard work. We met two staff who had received an award, voted for by their colleagues. They spoke of being proud that their colleagues valued them so much.
- The provider facilitated staff 'away days' to allow services to review and plan the care and treatment they provided. Staff in the community neuro and stroke service had been instrumental in reviewing the service and had participated in the development of clear strategies to help patients achieve their goals. This meant that all staff felt engaged and took responsibility for ensuring goals were achieved. They had all attended an 'away day' with clear service improvement goals focussing on admissions, rehabilitation and discharge. Staff working as part of the 'Parkinson's Disease' service had also engaged with a review and further development of the service on an 'away day'.
- We reviewed the results of a staff survey from 2014 and with only a very low number of responses (11) from adult services. The results showed that there was a high satisfaction with the support in reporting errors, near misses or incidents (100%), the ability to contribute towards improvements at work (91%) and that the provider offered equal opportunities for career progression and promotion (91%). However, only 36% reported good communication between senior managers and staff and 27% felt under pressure to attend work when they felt unwell.

Innovation, improvement and sustainability

- The provider had introduced an 'Active Ageing' project which consisted of a team of health visitors and healthcare support workers carrying out preventative assessments for people in the community between the ages of 80-85 years. The service helped elderly people in the community to access pendant alarms, blue badges, referral to other agencies such as Age UK for help with applications for attendance allowance. The service also included specific assessments for example the 'Bothersome scale' (a scale to assess the severity of bothersome symptoms), a memory test to help assess symptoms of dementia and Edmonton Frailty score (a scoring system intended to support health and social care professionals in the community and in older people's own homes to recognise frail people and help them to manage their risks).
- In South Gloucestershire the provider had started a 'falls service' in July 2016; the aim of the service was falls prevention and to reduce the fear of falling. The falls service received about 30 referrals a week from GPs or a local NHS trust. The service included falls risk assessments including using the 'Berg balance test' (a

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test used to assess a patient's static and functional balance) and facilitating a 'home hazard assessment' by occupational therapists. The service had had a positive impact on waiting lists for physiotherapy and had helped to reduce the time patients waited for initial physiotherapy assessment from 10-12 weeks to six to seven weeks from referral to first assessment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment 13. – (2) Systems and processes must be established and operated effectively to prevent abuse of service users. Clinical staff were trained to level two and received a face-to-face update every three years. Here compliance was only 74%; of staff required to undertake level three adult safeguarding training, 73% were compliant. Compliance with children's safeguarding training level two for clinical staff was 47% which meant that less than half of the community staff were compliant.