Sirona Care & Health C.I.C.

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Established in October 2011, Sirona Care and Health Community Interest Company are the sole provider of NHS and local authority funded adult and children's community healthcare services across Bristol, North Somerset and South Gloucestershire (BNSSG). Sirona is a not-for-profit social enterprise committed to serving its communities and funded by the NHS and local authorities. Sirona does not have shareholders and does not pay dividends; any surplus is re-invested back into the community.

Initially providing adult health and social care in the Bath and North East Somerset region, Sirona took over provision of the community learning disability service in South Gloucestershire in October 2013, and later community health services in April 2014. In addition, the service took over the provision of community children's services in Bristol and South Gloucestershire in April 2016. This service is jointly provided by Sirona, Avon and Wiltshire Mental Health Partnership NHS Trust, University Hospital Bristol NHS Foundation Trust, Barnardo's and Off the Record, as part of the Community Children's Health Partnership.

In April 2020 Sirona took over the provision of services previously provided by Bristol Community Health and North Somerset Community Partnership and the children's community paediatric services in Weston Area Health Trust.

Services span across all ages from birth to end of life and range from preventative and pro-active support to keep people as well and independent as possible through to complex care and support in individuals' own homes to prevent admission to hospital or to support people following discharge. Sirona services are provided across 100 different locations as well as in individual's homes and in schools.

Sirona provide the following core services:

- Community mental health services with learning disabilities or autism
- Community health services for adults
- Community health inpatient services (four inpatient rehabilitation units)

Our findings

- Community end of life care
- Community health services for children, young people and families
- Urgent care services (two minor injury units and one urgent treatment centre)

Sirona are registered for the following regulated activities:

- Accommodation for persons who require nursing or personal care
- Diagnostic and screening procedures
- Personal care
- Treatment of disease, disorder or injury

Between October and November 2016 we undertook a planned announced inspection as part of our comprehensive community health services inspection programme. We inspected all core services and rated the provider as good overall and in the effective, responsive and well led key questions. We rated the provider as requires improvement in the safe key question and outstanding in the caring key question.

We carried out this unannounced inspection of two of the community health core services provided by Sirona as part of our continual checks on the safety and quality of healthcare services.

We also inspected the well-led key question for the provider overall.

Our comprehensive inspections of organisations have shown a strong link between the quality of overall management of a provider and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a provider manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Regarding this inspection report it should be noted that this inspection did not include a Use of Resources rating.

Although Sirona Health & Care Community Interest Company is not an NHS trust the word trust is used erroneously in several places in the report as the word cannot be removed from the standardised inspection report template.

Services inspected

We did not inspect community mental health services with learning disabilities or autism, community health services for adults, community end of life care or community health services for children, young people and families at this time. The provider had recently started providing a wider range of services across the geographical area and continued to be in a period of transition, so it was not appropriate to inspect these services at this time. Each of these services are currently rated good, apart from community end of life care, which is rated as outstanding.

We inspected the community inpatients and urgent care services. These had not been inspected since 2016. We wanted to follow up on issues raised at the previous inspection for community inpatients and in response to the new services not previously inspected. We also inspected urgent care in response to the recent additional pressures on the service during the Covid-19 pandemic.

Our findings

Sirona has four community-based rehabilitation services (community inpatients):

- The Henderson Rehabilitation Unit is a 20 bedded inpatient rehabilitation service on the top floor of The Grace Care Centre in Thornbury. The service specialises in the provision of services for persons who require nursing or personal care, diagnostic and screening procedures and treatment of disease, disorder or injury.
- Skylark Rehabilitation Unit is a 30 bedded inpatient rehabilitation service located on the top floor of The Meadows care home. It opened in February 2018 and is run in partnership with North Bristol NHS Trust and South Gloucestershire Council. Access is available to all adults over the age of 18.
- Elton Rehabilitation Unit is an eight bedded unit in North Somerset Community Hospital for patients who no longer require acute hospital care but are unable to safely return to their usual place of residence.
- South Bristol Rehabilitation Unit is a 60 bedded inpatient rehabilitation service situated across two wards in the South Bristol Community Hospital. On 1st April 2021, the management of the wards was transferred to Sirona from University Hospitals Bristol and Weston NHS Foundation Trust (UHBW). Ward 100 currently provides 30 beds, including for people post stroke and for people requiring intensive rehabilitation following an acute inpatient stay. Ward 200 was not fully opened due to staffing shortages and the future purpose of the unit will depend on the needs of the local region.

Sirona Care & Health CIC provides urgent care services through a minor injuries service for people in South Gloucestershire, a minor injuries service in Clevedon, and an urgent treatment centre in South Bristol.

In rating the provider, we took into account the current ratings of the four services not inspected this time. Following this inspection we rated safe as requires improvement, effective, responsive and well-led as good, and caring as outstanding.

Our rating of services stayed the same. We rated the organisation as good because:

The organisation had a leadership team with a range of skills, abilities, and commitment to provide high-quality services. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. They had identified a need to further develop and add to the leadership team, for example, a Digital Director was being recruited.

The organisation had worked flexibly and with a commitment to patient safety through the pandemic to keep patients and staff safe and well. Their commitment to patient care was at the heart of all their work. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care. The commitment to working flexibly and putting patients at the centre of everything they do was recognised and commended by system partners.

Senior leaders visited all parts of the organisation and fed back to the board to discuss challenges staff and the services faced. The organisation made sure that it included and communicated with patients, staff, the public, and local organisations.

The organisation was committed to improving services by listening and learning when things go well and when they go wrong, promoting training, research and innovation and using this learning to improve practice. Staff managed safety incidents well. There was learning from incidents to prevent any reoccurrence.

Our findings

Staff felt respected, supported and valued by their line managers. They were clear about their roles and accountabilities and focused on the needs of patients receiving care.

Staff treated patients with compassion and kindness, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.

Staff were focused on the needs of patients receiving care and were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services to meet the needs of local people. All staff were committed to improving services.

However:

The organisation had undergone considerable change and growth at the start of the pandemic. While they had a clear strategy and vision for developing and bringing the organisation together, this had been inevitably delayed due to the pandemic. The organisation now needed to move forward, at pace, with their new strategy and transformation of the organisation.

The organisation had identified that it needed to improve governance arrangements and plans were in place to revisit these. The board assurance framework was still in development, and further work was required to ensure it gave the board a high level of assurance. In addition, further improvements were needed to improve the quality of data, some improvements had been made but local managers needed increased oversight of information to ensure they were monitoring services to drive improvement.

The organisation had a structure for overseeing performance, quality and risk, with board members represented across the divisions. However, not all senior leaders were confident that the senior leadership team had oversight of all the key risk areas. While the risk management software used within the organisation had been updated, it was acknowledged that around 50% of the risks on the risk register were overdue for review as a result of the pressures on capacity and resources.

While the service had an open and supportive culture, there was work still to be done to bring the organisation together as one. Some staff, whose services had recently joined the organisation told us they did not always feel valued and felt that senior leaders were not visible or involved in their services.

While the urgent care service had the required staff numbers for the contract to care for patients and keep them safe, the increased demand on the service due to the pandemic meant that staff were not always able to see patients in the required timescales to keep them safe.

Staff at the urgent care services did not consistently assess risks to patients in a timely manner. At South Bristol Urgent Treatment Centre we found that some patients were not being triaged for long periods of time which increased the risk of a condition deteriorating. Staff were not consistently using recognised tools to monitor patients at risk of deterioration. Staff provided patients with pain relief but did not consistently monitor pain levels to support patients.

Storage facilities in Henderson rehabilitation unit were limited. Stocks of continence aids, equipment, gloves and furniture were kept in the lounge, corridors and bathrooms. There was limited space for therapies. Medicine systems on the unit were not safely managed. Stocks of needles and syringes were accessible to visitors and patients. Medicines were administered from an unlockable trolley which created a potential risk.

Our findings

Patients' privacy and confidentiality of information was not respected in Henderson and in South Bristol Rehabilitation Units. Personal details, health and care needs were accessible to visitors and staff on bedroom doors or whiteboards.

How we carried out the inspection

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

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

Before the inspection visit, we reviewed information that we held about the services and reviewed a range of information.

During the inspection visit to urgent care services, the inspection team:

- visited two minor injuries units and one urgent treatment centre
- looked at the quality of the environment
- spoke with 25 people who were using the service
- spoke with four managers
- looked at 31 treatment records of people including medicines records; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

During the inspection visit to community inpatient services, the inspection team:

- visited Henderson, Skylark, Elton and South Bristol rehabilitation services
- spoke with ward managers at all locations and in South Bristol Rehabilitation Unit the team spoke with the registered manager
- carried out a tour of the environment and checks of clinical areas in all locations
- spoke with 12 people who used the service and a family member
- participated in and observed organised activities
- spoke with 15 staff including nursing staff, agency, support workers and reception staff
- spoke with a hotel service manager, operations coordinator and discharge coordinator
- spoke with a GP, occupational therapist and physiotherapist and pharmacy technicians
- reviewed 26 care records and 21 treatment records

Our findings

- reviewed a number of meetings minutes and
- looked at a range of policies and procedures related to the running of the service.

You can find further information about how we carry out our inspections on our website: www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the provider MUST take to improve:

We told the provider that it must take action to bring services into line with four legal requirements. This action related to the urgent care services and community inpatients.

Urgent Care Services

- The provider must ensure that patients at the South Bristol Urgent Treatment Centre are triaged in line with national guidelines and targets to ensure that they are not at risk of deterioration and have clear oversight that these are being maintained at all times. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider must ensure that all locations complete Early Warning Scores (for example NEWS2 for adults or PEWS for children), and monitor patient pain, where appropriate to identify patients who are at risk of their physical health deteriorating. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider must ensure the governance frameworks provide oversight of quality and safety performance are sufficiently robust. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Community Inpatients service

- The provider must ensure evacuation plans were developed on how staff were to support patients in the event of an emergency to reach places of safety or evacuate the property. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Action the provider SHOULD take to improve:

Urgent Care services

- The provider should ensure there is a formal programme for clinical or internal audits including patient triage outcomes, to measure the effectiveness of the services.
- The provider should ensure that data management is improved to have clear oversight of improvements needed to support change and development.
- The provider should consider how patients with mobility issues can access support to Yate MIU while the second entrance is out of use.

Our findings

- The provider should ensure that initial assessments are recorded at Clevedon MIU.
- The provider should ensure that staff receive supervision and support in line with their policy.

Community Inpatients service

- The provider should ensure that consent is sought from patients in Henderson and South Bristol Rehabilitation Units before having their personal information and healthcare needs in full view of visiting public, patients or any staff without authority to view it.
- The provider should review storage facilities to ensure that in Henderson there are safe systems for storing and administering of medicines.
- The provider should ensure that records were clear on the ongoing monitoring of patient's outcomes and the progress made where risks had been identified.
- The provider should consider the impact the lack of storage facilities in Henderson has on patients.
- The provider should ensure that ReSPECT forms are clear on the discussion with patients and families about their future and ongoing treatment in the event of their ill health deterioration.
- The provider should ensure all staff feel valued by the organisation.
- The provider should consider introducing specific training and supporting staff interested in progression.

Is this organisation well-led?

Our comprehensive inspections of organisations have shown a strong link between the quality of overall management of a provider and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a provider manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led stayed the same. We rated it as good because:

Leadership

The board had a range of skills, knowledge and experience to perform its role but was in need of further development. As a board that had undergone a number of changes at the start of the pandemic, they had not as yet had a chance to build strong working relationships and an understanding of the board's key strengths. The organisation had identified gaps in skills and knowledge within the board membership, and agreed that there was a need for further development to address these gaps. As a result of identifying these gaps, the provider planned to recruit a Digital Director. The provider was also recruiting for the vacant Head of Estates post, although this was not a board level role.

The provider had a senior leadership team in place with a range of skills, knowledge and experience. As with the board, the senior leadership team had come together from three different organisations at the start of the pandemic and were working on moving forwards as one organisation.

The provider had a lead Executive and Non Executive Director for mental health, and a learning disability services manager.

Our findings

The provider board and senior leadership team displayed integrity on an ongoing basis. We observed an appropriate level of challenge within a board committee meeting, and heard from senior leaders about increasing levels of appropriate challenge within the wider board.

Fit and Proper Person checks were in place. All board members and members of the senior leadership team were subject to a fit and proper persons assessment prior to appointment. This was reviewed annually.

The provider reviewed leadership capacity and capability on an ongoing basis. A review of board membership had identified a need for further board development, including the recruitment of a new Non Executive Director and a Digital Director.

The leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them.

There was a programme of board visits to services. However, this programme had been paused during the height of the pandemic, restarting in July 2021. Staff noted a lack of visibility of some senior leaders during the core service inspections. The board were mindful of the importance of these visits to better understand the issues and concerns of staff and specific services, as well as giving an opportunity to extend their thanks to staff.

Leadership development opportunities were available, including opportunities for staff below team manager level. Succession planning was in place throughout the organisation. The organisation focused on developing the right skills within the teams to equip different people to grow into their roles. Some staff (for example, within the pharmacy team) were rotated into different areas to create resilience within the team and as part of a succession planning model.

Vision and strategy

The provider had a vision and set of values with quality and sustainability as priorities. The vision was one of health, happiness and dignity for all. The provider aimed to make a difference though engagement and inclusion, being a great place to work, equality and diversity, achieving excellence, and adding value, growth and sustainability. The values were all based around "Taking It Personally" and consisted of:

- courtesy and respect (so people feel welcome)
- caring and supportive (so people feel supported)
- effective communication (so people feel valued)
- effective and professional (so people feel safe).

While the organisation had a strategy for achieving their priorities and developing good quality, sustainable care, they had undergone a considerable organisational change since April 2020, and were in the process of revisiting their strategy to ensure this was current. The organisation planned to take the refreshed strategy back to the board in February 2022 with detailed plans and priorities for 2022/23 to reflect the current services and organisational challenges and priorities.

Our findings

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The provider held a series of staff engagement events around the strategy. However, not all staff felt they were given enough information about what the vision and strategy was. They felt that information wasn't always shared with them and were uncertain as to how this applied to the work of their teams.

The organisation aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans. The trust had planned services to take into account the needs of the local population. When bidding for additional contracts, the organisation had a clear plan in place to develop services, including meeting the needs of the local population. As a result of the pandemic they were unable to complete these plans, and now needed to adapt these to manage an organisation and local population in different circumstances to those which had been planned for.

The leadership team monitored and reviewed progress on delivering the strategy and local plans. As a result of the organisational changes in April 2020 coinciding with the early stages of the pandemic, the organisation refocused on ensuring that a safe service was provided. In order to do this, they moved from their previous long term service development focus to a more short term view on providing stability within a rapidly changing unprecedented situation. The organisation felt they were now moving towards more of a reflect, restore and renew approach, and were keen to move forwards on their new strategic objectives.

Culture

Staff in some parts of the organisation did not always feel respected, supported and valued. We heard that many staff members felt listened to and valued by the senior leadership team and by their direct line managers, but did not all feel valued or listened to by middle managers. As such staff tended to work within their own individual teams providing their own support, rather than working as a wider organisation. There continued to be work needed to bring the organisation together as a whole.

The organisation were mindful that at the start of the pandemic they had brought together three different organisations with different cultures and ways of working that needed to be brought together as one organisation. They were keen to move on with this, and had appointed a staff wellbeing lead to offer staff additional support as part of this work.

The organisation's strategy, vision and values underpinned a culture which was patient centred. This was apparent during our conversations as part of the well led inspection and through the core service inspections. We heard how valuing people, respecting them as individuals, and involving them in their care were key.

Staff felt positive and proud about working for the organisation and their team. It was acknowledged throughout the organisation that the changes in organisational structure had been a challenge. While there were plans in place at the start of the merger to work on the culture and bring the teams together, the pandemic had effectively forced these plans to one side and necessitated a greater focus on safety and responding to urgent issues as they arose. While staff did at times feel unsupported, isolated and occasionally unheard within the organisation, they were proud of how they had come together within their individual teams, and had supported each other through difficult times.

The provider recognised staff success by staff awards and through feedback. The organisation set up a virtual live broadcast for their recent staff awards, with over 300 staff able to join as a result. As part of the celebration of ten years of Sirona, all staff were awarded a budget of £10 to spend on wellbeing within the teams.

Our findings

It was hoped that the organisation would be able to have face to face celebrations in 2022 at some point, Covid restrictions permitting.

The provider worked appropriately with trade unions and had an open and transparent senior leadership team.

Managers addressed poor staff performance where needed.

The provider had appointed two Freedom To Speak Up Guardians and provided them with sufficient resources and support to help staff to raise concerns. The organisation had also recruited an ambassador to support staff with accessing the service. The Freedom to Speak Up service was recently nominated for a Health Service Journal (HSJ) award.

The Guardians held monthly meetings with senior leaders to discuss themes and learning, and sat on a quality intelligence group which fed into the Quality and Outcomes Committee meeting. The Guardians produced twice yearly board reports.

Staff felt able to raise concerns without fear of retribution. While we heard that staff generally felt listened to by senior leaders, they did not always feel that timely action was taken as a result of these concerns.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The Freedom to Speak up Guardian role and service had been publicised within the organisation, and staff were contacting the service to raise concerns. Staff had reported themes around management of change and team relationships. We heard how these concerns had been addressed with the support of the Freedom to Speak Up Guardians.

The organisation applied Duty of Candour appropriately. The organisation monitored compliance with Duty of Candour through the Quality and Safety Team and reported to the commissioners and the Quality and Outcomes Committee on a monthly basis. Any occasions where gaps were identified were investigated and reported to the board, including learning points and action taken.

The organisation took appropriate learning and action as a result of concerns raised. The Clinical Quality Learning Forum brought a quarterly report to the Quality and Outcomes Committee to provide an overview of any identified learning and how this was shared amongst the organisation. They reviewed the systems for sharing information, and addressed any challenges within this process. It was intended that this report would support and embed a learning culture within the organisation. However, this had only just been put in place so it was unclear as yet how effective this had been.

Staff had the opportunity to discuss their learning and career development needs at appraisal. This included agency and locum staff and volunteers. The organisation were proud of their "grow your own" approach to developing staff, and had been able to support some staff with apprenticeship opportunities. However, we did hear that when staff had approached the organisation for support with additional training and development needs these were not often approved and some staff did not feel there were clear development opportunities available to them.

Staff had access to support for their own physical and emotional health needs through occupational health. The organisation had recognised the impact of the pandemic on staff, and had developed a Health and Wellbeing Strategy and framework to address this. As part of this work they had commissioned Nilaari, a specialist counselling service for

black, Asian and minority ethnic (BAME) staff. They had also set up a network of wellbeing champions and a dedicated wellbeing resource library for staff, and were in the process of exploring options for a trauma risk incident management process (TRiM) (a peer delivered psychological support process for ensuring that staff exposed to traumatic events at work were supported to seek help).

Sickness and absence figures were not outliers. The sickness absence rate at the time of the inspection was noted at 5.2%.

The provider had seen a noticeable increase in turnover rates over the previous year. This was approximately 19.23% at the time of the inspection. This had been noted as an issue of concern and a task and finish group was established to work on staff retention. This included setting up an "Itchy Feet" programme to support colleagues who were considering leaving to address any concerns they may have and to encourage them to remain with the service.

Vacancy rates were at 7% at the time of the inspection.

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression. The organisation had committed to ringfencing learning and development funding for targeted learning and development opportunities for staff with protected characteristics, or from under represented groups They had recently received a Stepping Up Diversity Champion award for their involvement with the Stepping Up leadership development programme for black, Asian and minority ethnic (BAME) colleagues.

As part of the organisation's equality, diversity and inclusion work, the service was also undergoing a pilot project reviewing recruitment to improve BAME recruitment, and had recently held a board seminar on equality, diversity and inclusion.

The board lead for health equality had joined the equality, diversity and inclusion steering group to ensure work plans were aligned. In September 2021 a Diversity and Inclusion Workforce lead was appointed on a fixed term contract as part of a development opportunity.

In October 2021 the service had launched their Black, Asian and Minority Ethnic Anti-Racist pledge for Healthcare Student Support in Practice.

The workforce race equality standard (WRES) report and action plan for 2020/21 identified six quality principles:

- promoting accessibility
- valuing cultural diversity
- promoting participation
- promoting inclusive communities
- promoting equality of opportunity
- reducing disadvantage and exclusion.

The equality, diversity and inclusion steering group monitored the action plan.

Our findings

As part of the workforce race equality standard report the organisation had identified a decrease in the numbers of black and minority ethnic staff in support roles, but an increase in mid level clinical roles. They noted a higher representation of black and minority ethnic staff in middle and senior management roles (while acknowledging this was still low in comparison with white staff).

Staff networks were in place promoting the diversity of staff. These included lesbian, gay, bisexual and trans (LGBT+), a black, Asian and minority ethnic (BAME) global network and disability staff networks.

Governance

The provider had structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior managers. Leaders regularly reviewed these structures.

The governance arrangements included two committees, Audit and Assurance and Quality and Outcomes. A total of 14 advisory groups reported into the Quality and Outcomes Committee. The Audit Committee met four times yearly and reported directly to the board. Any other items of interest or concern that were not addressed within these meetings were either discussed within other groups and significant issues escalated to the board, or were taken directly to the board for discussion.

Oversight of finances and performance was through a senior leadership team meeting with a non executive director in attendance, before being reported to the board.

The organisation were confident that the Quality and Outcomes Committee worked well and enabled senior leaders to understand the key pressures within the organisation. The Committee reviewed and discussed the risk register and risk summary report, escalating any risks rated over 15 (high risk) to board level. Any new risks identified in between these meetings were addressed by the Senior Leadership Team and discussed with the non executive directors during meetings with the Chief Executive.

During the pandemic a professional council was established and met on a weekly basis to ensure that all decisions impacting on clinical services were subject to clinical, quality and safety reviews. These decisions or recommendations were fed back to the board.

We heard that there were no formal reporting mechanisms for feeding back project development work into the board. While the senior leadership team had overview of the programme and planning meeting minutes, this wasn't routinely shared with the board.

There were governance structures within the organisation to ensure oversight of risk related to medicines optimisation. The organisation had recently appointed a medicines safety officer, who would be responsible for developing staff training related to medicines incidents. The Director of Nursing was recently appointed as the organisation's controlled drugs (CD) accountable officer. There was a CD monitoring group that had representatives from various locations. The aim was to highlight themes, review prescribing and usage, and ensure visibility of CD issues.

Following a review of the governance framework, areas for improvement for the structure were identified. The organisation were considering if a finance and performance committee would be a beneficial addition to the board governance arrangements.

Our findings

Papers for board meetings and other committees were of a reasonable standard and contained appropriate information.

Non-executive and executive directors were clear about their areas of responsibility. However, it was acknowledged that some board development was needed to ensure all areas of responsibility were covered by people with appropriate skills, knowledge, experience and backgrounds.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to take action as needed.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person.

The provider was working with third party providers effectively to promote good patient care. We heard how the provider had worked flexibly within the local health and care system to improve patient care during the pandemic. We also saw examples of work with third parties to manage safeguarding concerns appropriately.

Management of risk, issues and performance

The provider had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed the systems.

The organisation had implemented a root cause analysis group in December 2020 to review actions and learning from investigations, and ensure that learning was effectively shared within the organisation. This learning was also used to identify any training needs.

The head of patient safety chaired the serious incident group. All serious incidents were reported to the Director of Nursing and the Medical Director, or the on call Directors out of hours. Key themes and responses were pulled out of serious incident investigations and weekly incident review meetings.

The service had put in place additional resources for the safeguarding team. A safeguarding strategy was put in place, including a safeguarding forum and a dashboard to ensure any actions or follow up was put in place.

The provider met with the head of patient safety from neighbouring acute hospitals to discuss and reduce any hospital discharge related incidents, and with local authority colleagues to review patient safety and safeguarding training compliance.

The organisation were confident in their systems for sharing learning across the organisation and the impact of this learning. Following discussions with external partners in relation to effective management of serious incidents, all 72 hour reports were reviewed by a quality improvement panel to determine whether the threshold was met for a serious incident investigation. This relieved some element of the burden on frontline staff having to investigate all incidents.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance. The Quality and Outcomes Committee reviewed performance dashboards and reports on each locality to identify any themes and trends.

Our findings

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed. The organisation had recently retendered for new external auditors at the request of the Audit and Assurance Committee to ensure that good governance was exercised, since the previous company had been in place since the organisation began.

Action was taken following audits to improve patient care, including the rolling out of dementia and delirium training to all staff, and the updating of data software to help screen for dementia and delirium in all patients.

Staff had access to the risk register either at a team or locality level and were able to effectively escalate concerns as needed. The organisation had purchased a bespoke risk register software package which enabled the allocation of risks to different groups, specialities and localities. All risks on the register could be filtered by risk type category, to enable thematic reviews of risks. All staff has access to this system. Each directorate was responsible for reviewing and updating the risks in line with the Risk Management Policy.

Staff concerns matched those on the risk register. Services that were experiencing increased challenges and pressures during the pandemic (such as the urgent care centre in Bristol) were noted on the risk register to ensure action was taken to address and reduce the risks where possible.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'. Items on the risk register were regularly reviewed and scrutinised to ensure risk management plans were in place. Subject matter groups monitored and reviewed specific area risks, reporting these to monitoring group such as the senior leadership team and the Quality and Outcomes and Audit and Assurance Committees. This system fed into the corporate risk register at board level. The risk management system enabled real time access to the risk register for the whole organisation.

The organisation were confident that the system, which had been in place since July 2020, was now embedded, although acknowledged that there was still some room for improvement. Risk management conversations were embedded within the system, and included consideration of both the impact of the risk, and what mitigations were needed to reduce or manage this.

The board had sight of the most significant risks and mitigating actions were clear. All risks rated 15 or above were presented to the board using information extracted from the risk management system. Each one of these risks was assigned to a senior leadership team member to monitor.

Not all board members were confident that the senior leadership team had oversight of all the key risk areas. While there was confidence that the corporate risk register brought the right risks to the board, there were a number of risks that had been amalgamated from the previous organisations. This meant that some risks (such as staffing) did not stand out as much as they should on the risk register. It was also acknowledged that around 50% of the risks on the risk register were overdue for review at the time of the quarterly update report. This was attributed to the pressures on capacity and resources.

We saw board members challenging gaps in information and actions taken on risk that had been on the register for some time and where it was unclear what actions were being taken, and requesting further assurances to address this.

The board were not actively using a board assurance framework. A board assurance framework (BAF) is a structured approach for ensuring that boards get the right information, which is accurate and relevant, at the right time and with a level of assurance attributed to each source of data. The BAF was developed and managed by the Director of

Our findings

Transformation and the Corporate Governance Team on behalf of the Chief Executive and presented to the board to ensure they were sighted on risks and mitigations. The Audit and Assurance Committee reviewed the BAF to ensure the objectives were appropriate, and that the main risks were recorded. The planned review of the BAF following the structural changes in April 2020 was delayed due to the pandemic. This was updated in February 2021 and the organisation were anticipating that the new BAF and Strategic Risk Register would be submitted to the board in March 2022 alongside the forthcoming strategy, business plan and budget proposals for 2022/23.

There were plans in place for emergencies and other unexpected or expected events. For example adverse weather, a flu outbreak or a disruption to business continuity. Throughout the pandemic the organisation had responded to unexpected events.

At the start of the pandemic they responded to additional challenges and demand by moving to a command and control model. This included a move to more agile working practices and gold, silver and bronze escalation calls. Bronze calls took place daily. Silver calls focused largely on team capacity, met twice weekly and included the use of the professional council to address any potential ethical conversations. Silver calls were chaired by the Director of Operations, reporting into the Gold calls, which were chaired by the Chief Executive, and reported to the board.

The organisation had been in Operations Pressure Escalation Levels (Opel) four for several weeks. Opel is a method used to measure the stress, demand and pressure a service is under, with Opel four representing the high escalation level. This is declared when a service is "unable to deliver comprehensive care" and patient safety is at risk. The service was experiencing significant strain on their urgent care and single point of access services, with a greatly increased level of demand amidst ongoing workforce challenges. The organisation continue to review their response to this escalation.

The organisation had a winter pressures plan in place, and were on a heightened state of escalation preparing for these additional pressures, particularly in light of the current pandemic.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. All cost improvements were assessed for their impact on quality and safety. Before approval all cost improvements were subject to confirm and challenge sessions, and a detailed review by the senior leadership team based on potential impact on quality and safety. Any plans which could potentially have a considerable impact on services were also referred to the professional council before sign off. All cost improvement plans were reported to the board as part of the finance report.

Where cost improvements were taking place, they did not compromise patient care. As a community interest company, the success of the organisation was viewed in terms of the creation of maximum health and care benefit for the population they served, rather than the financial interests of the company.

Information management

The board received holistic information on service quality and sustainability.

The organisation was aware of its performance through the use of KPIs and other metrics. This data was not currently fed into a board assurance framework as this was in review and not being actively used at the time of the inspection. Information was available through performance dashboards, but this was still a work in progress in terms of data collection and presentation. The organisation were aware that there were improvements to be made with data collection and presentation. They felt they were making better use of key performance indicators, but had identified the need to appoint a Digital Director to continue this work.

Our findings

Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

The board and senior staff felt the quality of the data was improving, but that this continued to be a work in progress. Senior staff described being on a journey to getting the right information to feed to the board, but also felt frustrated by the impact on data quality of managing a number of different systems inherited from predecessor organisations. While this was part of an ongoing work programme, it was acknowledged that data quality had not reached the point where all concerns were effectively flagged.

Recent board development work and Quality Health Equality targets had highlighted the need to improve the use of data intelligence. The NHS Digital Community Services Data Set (a data collection of information for people who are in contact with NHS funded Community Health Services) identified data quality issues relating to completeness and accuracy. The organisation's level of data quality was reported as 52%, one of the lowest of the submissions within the region.

Information was in an accessible format, timely, accurate and identified areas for improvement. From April 2020 the organisation used three different systems with those inherited from predecessor organisations. The start of the pandemic brought additional pressures around equipment and software that compounded these issues. The organisation has made some progress in bringing digital systems together, but still has work to do.

The organisation did not have a digital strategy in place, but were in the processes of appointing a Digital Director and with the support of the digital steering group, were aiming to develop this in the near future.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff.

Staff had access to the IT equipment and systems needed to do their work. However, a digital incident control centre was put in place to address issues with accessing digital support. This was as a result of increased pressure on the digital team to deliver a service for staff increasingly reliant on technology through the pandemic. The team wasn't fully recruited to, and were unable to meet the demand. This was found to impact on the wider services.

Staff had access to the Connecting Care system, which enabled them to access relevant patient documents from primary and secondary care organisations.

Leaders submitted notifications to external bodies as required.

The organisation had completed and submitted the Information Governance Toolkit assessment for review.

Information governance systems were in place including confidentiality of patient records. The organisation had appointed an information governance officer to support systems.

The organisation learned from data security breaches. Staff reported any data security incidents on the electronic risk system. The Data Protection Officer and Senior Information Risk Owner reviewed all incidents to identify what action was needed, and to determine if escalation to the Information Commissioner is required. All incidents were given follow up actions and lessons learnt identified. These were followed up by the individual service areas where any incidents occurred.

Our findings

The deadline for the organisation's submission of the Data Security and Protection toolkit (part of a framework for assuring that organisations meet their statutory obligations on data protection and data security) was extended due to the pandemic. While acknowledging this as a priority, the organisation highlighted a risk on the corporate risk register that they may not have reached the required level of the toolkit purposes.

Engagement

The organisation had a structured and systematic approach to engaging with people who use services, those close to them and their representatives.

Patient and carer engagement continued throughout the pandemic. Over 50 patients and carers were actively recruited for the People's Council, with a people's charter being developed with the group to establish key priorities for ongoing work. The Council continued to meet virtually, with the provider purchasing individual licenses for any members who could not access the technology to maintain this contact.

Public board meetings included a patient or carer experience, with learning from these experiences shared through the organisation.

Patients and carers had access to a "have your say" email address to provide feedback on the service.

The organisation had undertaken a series of community projects through the pandemic, particularly focusing on harder to reach communities. This work included the Voices programme, developed in schools with community leaders to engage particularly with the Polish community. Work was also undertaken within local mosques, homeless shelters and asylum seeker hostels.

Communication systems such as the intranet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the provider and the services they used. Staff had access to daily intranet briefings.

We heard that the organisation was not always effective at marketing themselves to the general public, and needed to publicise their work in the community more effectively.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The People's Council represented a variety of groups, with service user representatives from adult and childrens' services, learning disabilities, mental health, homeless, ethnic minorities, people with sensory impairments and carers, as well as the involvement of Healthwatch representatives. The Council were involved in developing a work strategy for the group, and carried out specific pieces of work within the organisation, including reader's panels, recruitment and setting quality priorities.

Staff had the opportunity to feed back through the NHS Pulse Survey as well as the provider staff surveys. The organisation were mindful of the risk of survey fatigue, and so hosted a range of online events to enable up to 60 staff at each event to provide feedback and discuss concerns around hybrid working, and any particular issues within the workplace for example.

Our findings

The organisation sought to actively engage with people and staff in a range of equality groups. The organisation had a range of staff networks, including lesbian, gay, bisexual and trans (LGBT+), black, Asian and minority ethnic (BAME) and disability staff networks. The equality, diversity and inclusion plan highlighted the need to engage with all communities and enable everyone to feel welcome and engaged as part of the Sirona community.

The trust had a structured and systematic approach to staff engagement. In addition to staff networks, the organisation ran staff forums and regular staff surveys. They had recently introduced monthly Ask Anything events, where staff could ask a question or raise a concern anonymously and have this responded to by a Director.

The organisation had planned a series of face to face engagement events to demonstrate the vision and strategy and offer staff the opportunity to meet senior leaders and to discuss any issues with them, but these were cancelled due to the pandemic. There was however a continuing programme of staff engagement, including senior leaders visiting teams locally to deliver key messages and to gather feedback from front line colleagues and staff focus groups on the provider vision and values.

Patients, staff and carers were able to meet with members of the organisation's leadership team and board members to give feedback. The organisation started a programme of staff engagement in November, including a number of meet the senior leadership team sessions, monthly team briefings and Chief Executive interviews, as well as board member visits to keep staff up to date and to enable them to give feedback and engage in the running of the organisation. We heard that the executive team were receptive to new ideas, taking ideas and challenges on board, meaning that people felt their feedback was listened to. However, people were less confident that action was taken in a timely manner following feedback.

The provider was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The organisation was an active member of the Healthier Together Integrated Care System covering Bristol, North Somerset and South Gloucestershire system partners.

External stakeholders said they received open and transparent feedback on performance from the trust.

Learning, continuous improvement and innovation

The provider actively sought to participate in national improvement and innovation projects. Over the past year the organisation participated in the NHS England and NHS Improvement Disability Improvement Standards project. The organisation had also established a research group, linking in with local universities. The research lead within the organisation had obtained a grant to look at developing community services for the Somali community.

The provider had a planned approach to take part in national audits and accreditation schemes and shared learning. While involvement in audits had been limited due to the pandemic, the service had participated in two national audits. These were the patient survey element of the NHS England and NHS Improvement Learning Disabilities Improvement Standards collection, and the Prescribing Observatory for Mental Health (POMH) audit related to the Stopping Overmedication of People with Learning Disabilities (STOMP) programme.

The organisation was actively participating in clinical research studies. The organisation worked with system partners to either participate or lead on a variety of research projects. The Professional Council had agreed the arrangements for 13 currently active projects within the organisation.

Our findings

There were organisational systems to support improvement and innovation work. In 2020/21 the organisation became a member of Bristol Health Partners, a newly formed Academic Health Science Centre, bringing further opportunities for cross organisational collaboration in research and innovation. All quality improvement projects linked into the professional council and reported into the quality and outcomes committee.

A knowledge officer had been recruited to the organisation to develop an information service ensuring that all staff had access to current clinical and other evidence to support and improve practice.

Staff had training in improvement methodologies and used standard tools and methods. The organisation had a number of staff trained in the quality, service improvement and redesign (QSIR) approach to quality improvement. A cohort of 20 staff had been trained, and a further cohort were to receive training in the new year. Quality improvement was seen as everybody's business within the organisation, and all staff were expected to know the basic principles.

Effective systems were in place to identify and learn from unanticipated deaths.

External organisations had recognised the organisation's improvement work. Individual staff and teams received awards for improvements made and shared learning. The organisation was recently recognised as a Stepping up Diversity Champion. The UNICEF accreditation for the Health Visiting and Children's services in North Somerset was recently renewed, retaining the gold status within the scheme for a further three years.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← Feb 2022	Good →← Feb 2022	Outstanding →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022	Good →← Feb 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Requires Improvement	Good	Outstanding	Good	Good	Good
Overall trust	Requires Improvement ➔➔ Feb 2022	Good ➔➔ Feb 2022	Outstanding ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community mental health services for people with a learning disability or autism	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community health inpatient services	Requires Improvement ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022	Good ➔➔ Feb 2022
Community end of life care	Good Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017	Outstanding Mar 2017	Good Mar 2017	Outstanding Mar 2017
Community health services for children and young people	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community urgent care service	Requires Improvement Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022	Requires Improvement Feb 2022	Requires Improvement Feb 2022
Overall	Requires Improvement	Good	Outstanding	Good	Good	Good

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Community urgent care service

Requires Improvement

Is the service safe?

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Assessing and responding to patient risk

Staff did not consistently complete timely risk assessments for each patient. Staff did not continually identify or act on patients at risk of deterioration.

South Bristol Urgent Treatment Centre (UTC) had a system to identify critically ill patients. However; this was not working effectively. After patients registered at reception, they had an initial assessment. This assessment is often known as triage and is required to determine the seriousness of the patient's condition and to make immediate plans for their ongoing care. If the nurse decided the patient's condition was at risk of deteriorating, they prioritised treatment. Staff told us that they aimed to triage patients within 30 minutes. The Royal College of Emergency Medicine recommends that this assessment happens within 15 minutes of the patient's arrival. The service did not audit how quickly patients were assessed but, on the day of inspection we saw patients waiting up to 70 minutes for triage. This meant patients were at risk of deteriorating because they had not been clinically assessed.

We reviewed the records of 10 patients at the UTC who had been seen recently at the service. We found that an infant with a head injury had waited two hours before being clinically assessed. The Royal College of Paediatrics and Child Health states that children should have a detailed physical assessment within 20 minutes. The UTC was not meeting this standard.

Records also showed that an adult with chest pain had waited three and a half hours before being assessed by a nurse. When the patient was examined their condition had deteriorated and they required an ambulance to take them to an emergency department. Another adult with dizziness and chest pain waited over an hour to be clinically assessed. Their condition also deteriorated resulting in them being transferred to the emergency department for specialist treatment.

To manage social distancing and the safety of patients during Covid-19, the service monitored the number of patients who could wait in the reception area. For example, at South Bristol UTC this was set to a maximum of 18 patients within the reception area with an additional five outside during weekdays. This allocation was increased to a further eight patients in the atrium at weekends.

There was a procedure in place for staff to follow for ensuring patients waiting outside had been assessed to check if they needed any urgent medical attention. During the inspection we found this procedure was not consistently being followed and was a safety issue for patients.

At Yate Minor Injuries Unit (MIU) the service had increased their capacity by having two nurses completing triage. We saw that patients were being seen within the 15-minute target times to assess if their conditions or injuries were urgent. Yate had an average triage time of 14 minutes.

Community urgent care service

At Clevedon MIU initial assessment was carried out by the patient flow nurse or a healthcare assistant who had completed training to assess patients' risk of deterioration.

A patient flow nurse based at reception assessed patients as soon as they arrived. If a further assessment was required, they took the patient to a clinical area. However, the lack of space within the unit meant that the patient flow nurse did not have their own workstation. This resulted in the initial assessment of patients not being recorded on their records. We observed the initial assessment of patients during the morning of our inspection and saw that they were all assessed within 10 minutes. However, the first recorded activity on patient records was when they were seen later by an emergency nurse practitioner (ENP). We reviewed nine patient records from the previous eight weeks and found that all but one patient had been seen by an ENP within 25 minutes.

The services were not consistently using nationally recognised tools to identify deteriorating patients such as the early warning score (NEWS2) or the paediatric early warning score (PEWS). Early warning scores are used to help identify patients with sepsis or other serious conditions. NEWS2 and PEWS are a quick and systematic way of identifying adults or children who may be at risk of deteriorating. Clinical observations such as blood pressure, heart rate and respirations are recorded and contribute to a total score. Once a certain score is reached a clear escalation of treatment should be commenced. We reviewed records and saw that these were not being completed for all patients at risk of deteriorating.

Mandatory training

The service provided mandatory training in key skills including the highest level of life support training to all staff and made sure everyone completed it.

At the UTC and Yate MIU staff told us due to increased demands in the department there were sometimes delays in being able to be released to complete their training, but they did get alerts electronically to remind them when it was due.

The provider's induction and mandatory training programme for staff included moving and handling, equality and diversity, infection prevention and control, safeguarding children and vulnerable adults and information governance.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. At South Bristol UTC and Yate MIU some staff's refresher safeguarding training was overdue. This was due to a shortage of face to face training during the pandemic. Managers told us that staff at Clevedon MIU had received safeguarding training.

All staff we spoke with told us they felt confident in identifying and reporting signs of abuse in patients. Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Patients had access to interpreters should they require this.

We saw reception staff checking the safeguarding folder when processing paediatric admissions to the UTC. This ensured that any identified concerns were escalated to the appropriate staff member. We noted that the safeguarding file was updated regularly with each change dated and signed at the front of the folder. This ensured staff had the most up to date information for reference.

At the two MIUs there was an electronic system in place that alerted the receptionist should a patient with safeguarding concerns present. This information was then passed onto the clinical team.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well-maintained. Adaptations were made to meet the requirements of social distancing to reduce the risk of spreading infection during the pandemic. Staff cleaned equipment after each patient contact.

Staff followed infection control principles including the use of personal protective equipment (PPE). There was appropriate PPE available for staff to use, such as gloves and disposable aprons, and staff used these as required. There were enough supplies of hand gels for staff, patients and visitors to use and these were checked and working.

Regular cleaning was undertaken by contracted staff working to an agreed schedule. We did not see cleaning checks on display throughout the UTC. However, the provider told us following the inspection that these were in place.

Cleaning equipment was found to be accessible and stored appropriately.

Staff at the UTC told us they had an allocated room if patients needed to be isolated to minimise the risk of spreading infections, for example, patients with a high temperature or a rash. However, staff told us that often there were patients that arrived with a possible infection and until they were assessed they had to stay outside of the building if the infection room was already occupied.

Due to reception staff being very busy with the volume of patients to be seen, they did not actively encourage patients and visitors to use alcohol gel before entering the department. However, we saw most people using the alcohol gel which was visible and available at the entrance to the unit.

Hand hygiene audits were completed routinely across the services with no issues or concerns identified.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. There were emergency bells at the units that alerted the police in an emergency.

The service had suitable facilities to meet the needs of patients' families. However; due to the pandemic and social distancing requirements, changes had been made and patients were asked to enter alone where possible unless parents or carers were accompanying them. At South Bristol UTC the children's/family area had been incorporated into the waiting areas to manage social distancing seating needs. In Yate MIU they had moved the children's waiting area to another area. This was away from the main unit and staff did not have line of sight. During the inspection we saw that children in that area were accompanied by an adult which managed the risk.

The service had enough suitable equipment to help them to safely care for patients. All sites had a resuscitation room or area that provided all the required equipment.

Community urgent care service

Staff disposed of clinical waste safely.

The reception desks at South Bristol UTC and Yate MIU were located to provide open access but, while it allowed for a degree of patient confidentiality, its proximity to the seating area and other people meant that private and personal details could be overheard.

Staff told us that when required they aimed to provide a patient with a separate room if they needed a quieter waiting and treatment area.

Staffing

While the service had enough staff with the right qualifications, skills, training and experience they could not always meet patient demand and keeping them safe from avoidable harm. However, managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The number of nurses and healthcare assistants matched the amount set in the contract. However; due to the Covid-19 pandemic there had been an increase in demand. Patients presenting to the services were nearly 50% higher. Staff felt they were stretched and described experiencing being “over-run” and “burnt out.”

The service had low vacancy rates and staff turnover. Staff sickness levels had increased at South Bristol UTC and Yate MIU, some of which was due to the increased demand and aggression on the units that caused staff burnout and stress.

If it was necessary to use bank and agency staff, managers requested staff that were familiar with the service where possible. Managers made sure all bank and agency staff had a full induction and understood the service.

Records

Staff did not always keep detailed records of patients’ care and treatment. Records seen were clear, stored securely and easily available to all staff providing care.

Patient notes included good social and medical history**.** All staff could access the records easily. However, not all patients’ records were completed in a timely manner, with limited evidence of triage recordings. It was noted that triage records were not evidenced consistantly in records seen.

Records were stored securely on electronic systems.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. This included monitoring the temperature medicines were stored at.

Staff completed medicines records accurately and kept them up to date.

Controlled drugs stock levels were checked daily.

Community urgent care service

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. Discussions with staff evidenced they had a good understanding of what an incident was, and they told us they felt confident reporting them.

Members of staff we spoke with described the incident reporting process. Staff recorded incidents on an electronic system.

We reviewed a sample of all incidents reported across the three sites and found that actions had been highlighted against each incident and the outcome.

Staff met to discuss the feedback and look at improvements to patient care. Managers shared any lessons learned with the whole team. Incident trends were reported back at staff team meetings. We saw identified themes which included staffing and complaints.

Managers and staff told us that there had been an increase in aggression towards staff throughout the pandemic. This had impacted staff morale at the UTC and Yate MIU as the levels of aggression were high.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff were supported to follow best practice guidance by using clinical pathways and protocols for a variety of conditions. This included cardiac chest pain, head injury and diabetes. It should be noted, however, that the units were equipped to see and treat patients with a minor injury that did not require access to an emergency department (ED). Any patient attending the units with a serious injury were referred to the nearest hospital following assessment and stabilising.

Community urgent care service

People's physical, mental health and social needs were holistically assessed. Their care, treatment and support were delivered in line with legislation, standards and evidence-based guidance, including the National Institute for Health and Care Excellence (NICE).

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Cups had been removed from public areas to prevent cross infection following advice from the infection prevention and control (IPC) team. Patients could request a drink of cold water from the receptionists.

Hot and cold drinks and light refreshments were readily available from the hospital's café at the UTC. At the MIUs there was no café on site for patients to use. However, a new café was due to open at Clevedon Hospital in March 2022, and Yate MIU was located in a shopping centre with a range of nearby facilities.

Pain relief

Staff did not consistently assess and monitor patients regularly to see if they were in pain although they did administer pain relief when requested. They supported those unable to communicate using suitable assessment tools.

Staff did not consistently assess patients' pain using a recognised tool in line with individual needs and best practice. However, most patients received pain relief soon after it was identified they needed it, or they requested it.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

The provider did not consistently monitor the effectiveness of care and treatment.

Outcomes for patients were unclear due to the lack of data collection across the organisation for example; triage times.

While managers and staff carried out a programme of audits to check improvement over time, this did not always drive improvements across the service. Location managers did not consistently have data shared with them to manage improvements at a local level.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work. We spoke with a new staff member who confirmed they had received a comprehensive induction appropriate for their role.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff told us they had received, and data confirmed they had received their yearly appraisal.

Managers supported staff to develop through regular, constructive clinical supervision of their work. Staff told us that due to the high demand across the services supervision had not consistently been completed in the timescales set in the provider's policy. Staff however did tell us they felt supported on a local level and could speak with their line managers between supervisions and that their teams were supportive of each other.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Multidisciplinary working

Nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us they worked well with other team members.

Teams had effective working relationships with external teams and organisations such as accident and emergency departments, radiology and commissioners.

Staff worked across health care disciplines and with other agencies when required to care for patients. The service had access to mental health liaison and specialist mental health support. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff shared key information to keep patients safe when handing over their care to others.

The UTC service was participating in a project called "PharmRefer". PharmRefer provides a secure system to allow referral of low acuity patients from the UTC to community pharmacies where appropriate. Staff utilised a list which outlined what symptoms could be referred. We saw this being effectively used during the inspection.

The UTC service had a bi-weekly "clinical guardian" process for the oversight of written clinical records. This involved a GP reviewing the records and providing personalised feedback. We attended a meeting and found constructive feedback was given regarding the review of records which also included areas for consideration and improvement. Senior managers informed us that from the feedback received they held quarterly learning sessions which have included advice on areas such as; gynaecological issues, abdominal pain and rashes.

Seven-day services

Key services were available seven days a week to support timely patient care.

Staff could call for support from doctors and other disciplines and diagnostic services, including mental health services, seven days a week.

The three sites were open seven days a week from 8am to 8pm, apart from Clevedon, which was open until 9pm.

Health Promotion

Staff gave patients practical support and advice to lead healthier lives.

Health and condition specific advice was provided in leaflets and posters throughout the locations. Staff gave patients verbal advice regarding healthier lifestyle changes such as alcohol use and smoking as well as general health advice on how to help recover from their condition or injury.

Community urgent care service

Consent, Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff clearly recorded consent in the patients' records.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Staff cared for patients with compassion. We saw how people were put at ease and reassured. Staff met patients with smiles and empathy.

Staff spoke to patients in a polite, kind and respectful manner. Patients were treated with dignity and respect. Patient's privacy was respected. Consultation room doors were always closed.

We spoke with nine patients and their relatives in the UTC. Four family members said that communication was "not very good" and another said that they were not kept updated. However, all said that staff were friendly and caring.

We spoke with 16 patients across the two MIUs. Patients told us that staff were kind, respectful, kept them informed, and treated them kindly. Patients also told us that staff were confident and competent and that they had also had previous positive experiences at the MIUs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw staff supporting and reassuring parents and carers as well as the patients they were treating.

Community urgent care service

Staff we spoke with understood their role in providing emotional support to patients and their families. We heard a young adult outlining how staff were patient and friendly when they asked questions. Several parents mentioned that they felt more relaxed and reassured after speaking with clinical staff.

Staff were polite with patients and showed concern about their illness and/or injury.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff explained to patients, and where appropriate parents or carers, what treatment was required and what to expect both while at the units and after they returned home.

Staff talked to patients in a way they could understand. We saw staff explaining and reading an information leaflet to a patient. Leaflets had pictures as well as words for ease of understanding.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. All sites had an electronic feedback tablet for patients to give feedback. Due to the pandemic and the risk of spreading infection these were currently out of use. Patients could give feedback verbally or by completing feedback cards. Clevedon MIU had collected a large number of thank you cards and letters from patients. Staff in the units had also received a large number of gifts from patients and members of the public to thank them for their work.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Planning for service delivery was made in conjunction with other external providers, commissioners and local authorities to meet the needs of local people.

The service worked with the local ambulance service to develop pathways and ensure suitable patients were transported to the services where appropriate. At the UTC there was an ambulance entrance for ease of access.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Community urgent care service

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access emergency mental health support 24 hours a day, seven days a week for patients with mental health problems, learning disabilities and dementia.

Staff could describe how they adapted their approach to practice and communication when caring for patients living with dementia or a learning disability.

A translation service was available for patients that did not speak English. Telephone translation services were used and face to face interpreters could be arranged by appointment. Staff knew how to access the translation service if they were required to use it.

Information leaflets were available in English only, but staff told us they could be requested in any language if required. Leaflets had pictures to cater for patients who may have difficulty reading, they were also available in a larger font if required.

The three units were accessible for wheelchair users and were all on one level with wide doors. There were designated disabled parking bays on site. However, at Yate MIU there was limited parking meaning that patients needed to park in the adjoining shopping centre. Due to one of the entrances being out of action to minimise people walking through from the shopping centre, patients had to walk around the building to access the main entrance. There was no signage or telephone number to call so staff could either open the door, take a wheelchair or walking aid to help patients experiencing difficulties with mobility.

Staff in the reception area could call local taxi companies. There was a free service between the local hospital and the minor injuries units or Urgent Treatment Centre when required.

Access and flow

People could not always access the service when they needed it to receive the right care promptly.

Due to the increased demand at urgent care services through the pandemic, patients were regularly referred for care to other services as staff could not meet the demand. Staff checked before referring patients that they were not at risk of deteriorating.

Managers did not consistently monitor waiting times to ensure patients could access urgent care services when needed and received treatment within agreed timeframes and national targets.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Staff supported patients when they were referred or transferred between services.

In the UTC the reception staff managed the follow up appointments to the fracture clinic, change of dressings appointments and the heart clinic. This was alongside the daily attendance of patients. During the weekend there were two health care assistants (HCAs) allocated to manage patient dressings. One HCA was dedicated to appointments while the other supported patients who walked-in for treatment. This ensured they had oversight of all attendees and were able to notify the staff running the clinics. This supported the flow through the treatment centre when it was busy.

The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in an emergency department, urgent treatment centre or minor injuries unit. This standard was not being consistently met in all of the units.

Community urgent care service

During the UTC inspection we saw patients waiting over 50 minutes to be triaged which meant the service was not meeting the patient triage target. We found no evidence that this was being monitored effectively.

Learning from complaints and concerns

It was easy for people to raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas.

There was a policy for the management of complaints. Senior staff reviewed and managed the complaints and contacted the complainant to apologise as soon as possible.

Face-to-face meetings were offered after investigation. Staff we spoke with knew what steps to take should a patient or relative ask them how to make a complaint.

When asked, patients and relatives told us they would either complain to a member of staff at the time if they had a concern or write to the hospital after they had left. Although there were very few complaints, there was evidence of comprehensive investigation and learning from complaints and incidents.

The units had investigated complaints and apologised to the patients for their poor experience. Themes from complaints were reviewed during staff meetings to identify areas for improvement.

Is the service well-led?

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Local managers had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. Managers were not always able to access data needed to effectively monitor and improve the service.

Across the units the managers did not have easy access to data such as triage times, staff training and supervision records. This made it hard to have complete oversight of the service to assess and make required improvements. The provider confirmed there were some challenges with data and that this was an area that needed to be improved.

Managers understood and could tell us the challenges within the services in order to provide high quality, timely and sustainable care. All the staff we spoke with felt their managers were approachable and supportive. However; we were told that senior leaders could be more supportive and visible.

During the inspection we saw managers being visible across the units. Managers had a good awareness of the issues that mattered to staff and the pressures staff were under and confirmed they spent time speaking with staff about their concerns.

Community urgent care service

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The UTC leads were clear on how the unit could develop, for example, to improve areas, such as improving access and flow through the department. A trial was underway whereby reception staff were able to refer and redirect patients to three local pharmacies which prevented unnecessary attendance at the UTC.

The aim of the services was to contribute to reducing waiting times in the emergency departments. This would be provided by the local community with easy access for patients who have suffered a minor injury.

Most staff spoken with were able to tell us where they could find the provider's ethos which was around "Taking it Personally". The values and behaviours were; ensuring people were made to feel welcome, supported and valued while making them feel safe. We saw staff ensuring all patients visiting the units were welcomed and accessed clinicians where applicable to support any concerns to make sure they were safe.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us they were well supported by their immediate managers and were able to raise issues. Staff told us they often experienced low morale as they were not able to provide the level of care they wanted for patients in times of increased pressure during the pandemic. The increase in aggression towards staff at the UTC and Yate MIU had also had an impact on staff morale.

There was a strong culture of patient focussed care and staff felt valued for the work they contributed.

At Clevedon MIU managers told us that they gave staff awards for their ongoing commitment and care for the patients attending the service.

The senior leadership teams had recognised the need for staff to be supported to maintain their wellbeing. The provider had initiated a wellbeing day which most staff had taken. All felt this had given them a breather from the pressure of COVID-19.

Governance

Leaders did not continually operate effective governance processes, throughout the service.

There were governance frameworks in place to provide oversight of quality and safety performance. However, we were not assured they were sufficiently robust in consistently maintaining standards across the urgent care units. Management teams could not easily access data to enable them to have full oversight.

Community urgent care service

The unit managers said there was a clear performance management reporting structure which looked at operational performance. This included a review of incidents, complaints, staffing, infection control, education and training. However, we found no evidence that the results were discussed with staff.

Management of risk, issues and performance

Leaders and teams did not use effective methods to identify and escalate relevant risks and issues. They had plans to cope with unexpected events but these were not always followed to ensure safe care and treatment of patients.

While there were processes in place to monitor and review aspects of performance to identify areas of good practice and areas for improvement, there was no formal programme for clinical or internal audits to measure patient triage outcomes to measure the effectiveness.

Managers recognised staffing was the major risk to the service. There were recruitment and retention initiatives in place to attempt to mitigate the risk due to the increased demand.

The units completed infection prevention and control compliance, training and staffing data audits. However, we did not see any process for monitoring progress with any action plans for improved performance.

All performance data was analysed by the intelligence team who fed the information to the executive team so this was not easily accessible for team managers to have direct oversight of the locations they managed. We asked to review data such as staff training completion rates and wait times for triage and managers could not access this for us on inspection.

Information Management

The service did not consistently collate reliable data and analyse it effectively. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service collected and managed patient information appropriately. Staff were able to access electronic systems which they were able to update. Staff had access to patient's health records and the results of investigations and tests in a timely manner, for example, x-ray results.

Staff were able to tell us how they would make referrals to the safeguarding team or other specialists.

The provider shared data securely with the Care Quality Commission and other agencies in accordance with legislation. Serious reportable incidents were reported when they occurred in line with the National Reporting and Learning System (NRLS) requirements.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Due to the nature of the urgent care services, it was not always easy for staff to obtain feedback from patients and their relatives. In line with guidance from NHS England, the Friends and Family Test (FFT) was suspended during the COVID-19 pandemic.

Community urgent care service

Most staff spoken with felt that engagement from the senior executive team could be improved.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them

All staff we spoke to were committed to making improvements. The service leaders as a team recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service.

Community health inpatient services

Good ● →←

Is the service safe?

Requires Improvement ● →←

Our rating of safe stayed the same. We rated it as requires improvement

Safe and clean environment

All clinical premises where patients received care were clean, well equipped, well furnished and had the necessary equipment for patients to have thorough physical examinations.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. All wards and patient's rooms visited were visibly clean. We saw up-to-date cleaning records displayed throughout the locations as well as stickers identifying which room had been cleaned. For example, cleaning audits seen for the Skylark and South Bristol Rehabilitation Units showed 100% compliance for September and October 2021.

Staff followed infection control principles including the use of personal protective equipment (PPE). All locations had access to hand sanitising gel, and we saw staff regularly washing their hands or using gel. Staff followed the provider's policy of arms being "bare below the elbow" and wore PPE. There were good quantities of PPE available, including gloves and aprons.

Audits of hand hygiene were carried out and standards assessed were given high scores. For example, Skylark scored 98%. and South Bristol Rehabilitation Unit scored 100%. However, during our inspection we saw some staff not following infection control processes at the South Bristol Rehabilitation Unit. We saw staff moving from one bay to another after patient contact without using appropriate hand hygiene techniques. This was brought to the attention of the manager who confirmed that this would be mentioned during safety huddles.

Where risks had been identified the staff completed environmental risk assessments including steps taken to reduce any risks they identified. However, storage was limited in Henderson. For example, boxes of gloves were lined down the corridor handrails, a section of the lounge was curtained and used for therapy and also for overstock of equipment. There was no private area for therapy staff to carry out administrative duties, which meant they were often in the dining room. The lounge and bathrooms were used to store continence aids, walking frames, and overstock of stores.

A risk assessment with actions was developed for a stair gate that provides access to Elton by stairs. The gate was a preventative measure to deter patients from using the stairs to leave the ward without support. Information provided following the inspection confirmed that external agencies were involved in the assessments to ensure the preventative measures reduced the potential harm.

Safe staffing

The service had enough staff, who knew the patients and received basic training to keep them safe from avoidable harm. The number of patients was not too high to prevent staff from giving each patient the time they needed.

Nursing staff

While each location had staff shortages, we saw the service had a flexible workforce to ensure there were enough nursing and support staff to keep patients safe. The full-time equivalent vacancies for nursing staff including support workers was 29% across the four locations. The majority of these vacancies were in the South Bristol Rehabilitation Unit. Agency and bank staff were used where vacancies existed. Managers told us there was a continued cycle of nursing recruitment for vacancies.

The managers planned staffing seven days in advance and kept a staffing spreadsheet of agreed and actual staffing numbers for each ward. Rosters were completed at least four to six weeks in advance. This enabled them to identify if there were unfilled shifts so this could be escalated, and mitigations could be put in place. We looked at staff rotas and saw the number of nurses and healthcare assistants matched the planned numbers. Staff told us staffing levels were pressured during the COVID-19 pandemic with staff working extra hours to ensure patient safety.

Managers accurately calculated and reviewed the number and grade of nurses, healthcare assistants and therapists needed for each shift in accordance with national guidance. There was a process for reviewing the required numbers and skill mix of staff needed to safely provide patient care. A nationally recognised tool was used by managers to assess the acuity of patients and the number of staff required to care for them.

Managers made sure all bank and agency staff had a full induction and understood the service. Agency staff were orientated to the ward at the beginning of their shift and completed an induction checklist with the nurse in charge.

Medical staff

The service had medical staff vacancies across four locations which included consultant cover at South Bristol Rehabilitation Unit. Allied Health Professional vacancies also existed in all locations and included physiotherapists and occupational therapists. Following the inspection, the provider informed us that there were no medical or Allied Health Professional vacancies at Elton rehabilitation unit.

Leaders told us there was a Specialist Services model of care used to provide in-reach support for Dietetics and Speech and Language.

Mandatory training

The service provided mandatory training in key skills to staff but not all had completed it.

Most staff were up to date with mandatory training. For example, we saw that 90% of staff for the South Gloucestershire region had completed their training. The ward manager for Ward 100 at South Bristol Rehabilitation Unit confirmed that all staff had completed their mandatory training.

Staff were provided with e-learning packages which allowed them to complete training virtually. Some face-to-face training had been cancelled due to the COVID-19 pandemic which had impacted staff training.

Leaders told us staff were given time to complete mandatory training in order to “catch up.” However, staff told us it was difficult to find the time to complete training due to staffing pressures. Staff said that their managers were supporting them to complete essential learning that had been missed due to the COVID-19 pandemic and the increased demand on services.

Community health inpatient services

Assessing and managing risk to patients and staff

Staff completed risk assessments for each patient and identified risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Patients were monitored and assessed using the National Early Warning Score (NEWS2) framework to identify potential deterioration of ill health and escalate further medical review.

We reviewed five patient notes in Skylark and saw all NEWS2 scores were calculated correctly. Staff knew about and dealt with any specific risk issues. For example, staff could explain the process to follow should a patient experience a fall. While staff completed NEWS2 assessments for patients in Henderson, Elton and South Bristol Rehabilitation Unit we found a lack of documentation on the ongoing monitoring of physical health where a risk of deterioration was identified.

Staff completed risk assessments to establish the risk of a patient developing pressure injury, malnutrition and falls. We reviewed eight patient records in Skylark and risk assessments were completed for each patient on admission which were regularly reviewed. However, the five risk assessments reviewed in Henderson and the nine reviewed in South Bristol Rehabilitation Unit lacked clear documentation on the preventative measures in place for patients identified at risk. For example, records lacked detail on the four-hourly repositioning for a patient in Henderson.

Staff completed the Waterlow screening tool used to determine patients' risk of developing pressure injury across all four locations. We found a lack of documented evidence on the ongoing actions for patients in Henderson, Elton and South Bristol Rehabilitation Unit who had been identified at high risk of developing pressure injury. Following the inspection the provider confirmed that Personal Pressure Injury Prevention Plans were used in all units.

Patients at high risk of falls in South Bristol Rehabilitation Unit were placed on enhanced supervision observations where appropriate. The need for enhanced patient supervision was determined through an initial risk assessment and daily review. This meant that patients may be nursed in a cohort bay with additional staff observing patients in the bay or may receive one to one supervision if the risk was identified as high.

Personal Emergency Evacuation Plans (PEEP) that provide staff and emergency services with guidance on how to assist a patient to safely evacuate the building or reach a place of safety were not completed across the locations visited. Patients' ability to reach a place of safety or to evacuate the building was not assessed at all locations particularly as they were all located on an upper floor. This was brought to the attention of the managers during the inspection.

Staff confirmed they had access to mental health liaison and specialist mental health support (if they were concerned about a patient's mental health).

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included all necessary key information to keep patients safe. We observed a staff handover and saw that all staff involved were give a written handover document which summarised key information about each patient in a situation, background, assessment, recommendation (SBAR) format. SBAR is a recognised tool for structured communication of critical information.

Staff access to essential information

Staff kept records of patients' care and treatment. Records were clear, and easily available to permanent staff providing care.

The service was in the process of transferring to an electronic record system and were using a dual system of both paper and electronic records. The ward managers said they did not undertake a records audit. This meant they could not be reassured the documentation was completed appropriately.

While nursing and medical records were kept separate in South Bristol Rehabilitation Unit, all staff except agency staff were able to access patient records when required. We found a clear divide and disparity between paper documentation and electronic care records. For example, only medical and therapy staff used the electronic system to document the care delivered. A ward manager explained therapy staff were using electronic records to document their input while nursing staff were using paper records.

Handover sheets were the main method used to share with staff including agency, patients current and key information. For example, admission details, nursing procedures, therapies and discharge information. Key assessments documented were patient centred in Skylark and Elton although there was a lack of review and ongoing progress notes. For example, action plans from screening assessments such as Waterlow and MUST lacked the progress made.

Records were not stored securely at the Skylark unit. We found that records containing patient identifiable and confidential information were not stored securely. While medical records were kept within trolleys, they were often left unattended within a lounge which meant that there was a potential for unauthorised people, including non-clerical members of staff, ward visitors and patients to access records.

Nursing staff completed discharge summaries for patients. A copy was provided to the patient and another sent to their GP, to ensure important information about ongoing care was shared effectively

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff in Skylark, Elton and South Bristol Rehabilitation Unit were following systems and processes for safely prescribing, administering, recording and storing medicines. Staff in Henderson were not fully following safe systems for administering and storing medicines. Although medicines were kept in a locked room outside administration rounds, they were kept in boxes on top of an open trolley. There was an additional risk of unsafe medicine management due to staff administering medicines from an unlockable trolley. For example, there was potential for distraction during medicine rounds which may be increased because missing medicines may not be identified due to medicines not being reconciled. The dressings for wounds, syringes and needles were accessible to patients and visitors. We escalated the risks to senior leadership team for action. We received written assurances that the risks of having medicines administered from a trolley without locking facilities and having syringes and needles accessible to others were addressed.

Staff managed all medicines and prescribing documents safely. Prescription charts were written by nurse practitioner where one was in post. Prescription charts were signed and dated, legible and doses were adequate and within ranges.

Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours. Staff were well-informed of this and knew the routes to contact pharmacy at all times of the day.

Where patients had specific medicines administration needs, these were clearly documented and staff followed protocols to administer medicines safely, for example via a feeding tube.

Patients at Skylark were supported to self-administer medicines if a risk assessment showed it was safe for them to do so.

Medicines were regularly reviewed by the pharmacy services. There was an emergency duty pharmacist available 24 hours a day, seven days a week to provide urgent support and advice when required.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. Staff we spoke with told us there was a good learning culture and staff were actively encouraged to report incidents in order to support learning and improvement.

Staff raised concerns and reported incidents and near misses in line with the provider policy. The November 2021 board meeting minutes for the service identified an increase in the reporting of incidents. One of the identifiable themes related to staffing concerns.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff we spoke with demonstrated a clear understanding of the duty of candour and discussed how they would be open and honest with patients. The duty of candour Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, is a regulation, which was introduced in November 2014. This regulation requires the organisation to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds.

Staff met to discuss the feedback and look at improvements to patient care. Staff we spoke with told us learning from incidents was shared during daily safety briefs. This was done at shift handover to ensure staff were up to date with any concerns. For example, lapses in infection control practices were highlighted through incident reporting. Teaching sessions were arranged to improve compliance.

Managers debriefed and supported staff after any serious incident.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Staff told us that they were made aware of any safeguarding concerns prior to accepting patient referrals.

Senior staff told us that compliance with adult safeguarding level 3 training had improved but continued to be a work in progress.

Community health inpatient services

Staff were aware of safeguarding processes and knew how to get advice from the safeguarding team who were approachable to them. They knew how to identify adults at risk and how to make a safeguarding referral. We saw staff discuss safeguarding risks at the daily handovers.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Patients had a physical health assessment during their admission process and staff were knowledgeable about any physical health need. Staff completed admission assessment booklets for each patient which included; pressure injury prevention, a falls risk review, patient lying and standing blood pressure recordings and bed rail assessments.

Ward managers in Henderson, Elton and South Bristol Rehabilitation Unit told us formal care plans were not developed due to patient's length of stay. They told us handover sheets with contact details, reason for admission, checks and tests with discharge dates were used to document and share essential information and where screening tools identified a risk, treatment plans were devised for ongoing monitoring. For example, action plans for pressure injury.

Nursing staff in South Bristol Rehabilitation Unit documented communications notes in patient's individual beside care records. This information was brief and there was a limited amount of evaluation. Care notes in Henderson were not personalised. Instead, nursing staff used intentional rounding checklists that involved carrying out regular checks on fundamental care needs to be delivered. We noted the checklist was completed alongside the medicine round. However, we saw a nurse complete the checklist without asking patients if assistance was needed with personal and physical health care.

Staff carried out holistic assessments for patients in Elton which showed patients were at the centre of their care. Care plans were personalised, holistic and recovery-orientated in Skylark. For example, week one included the completion of all risks and the patient's individual pathway assessments. Week two introduced social care if required while week three completed the discharge process.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes.

Staff delivered care in line with best practice and national guidance including National Institute for Health and Care Excellence (NICE) guidelines and quality standards. Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations.

Posters and information promoting healthier lifestyles were on display across the locations visited. Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. For example, dietitians had prescribed a clear dietary regime for patients at risk of choking.

Managers used results from audits to make improvements. Staff took part in clinical audits, benchmarking and quality improvement initiatives. The antimicrobial stewardship audit programme was paused for quarter one and two of 2020-21 due to COVID-19. In preparation for restarting the audit programme the audit tool and sample sizes were reviewed and standardised across all areas. We saw that all locations for quarter four (January to March 2021) averaged 99% except for the Skylark unit which was at 90%. As a result, the learning and development team were rolling out the national antimicrobial stewardship e-learning to all clinical staff.

Skilled staff to deliver care

The teams included or had access to the full range of specialists required to meet the needs of patients under their care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Staff were experienced, qualified and skilled to meet the needs of patients. New staff had an induction before they started work to prepare them for the role they were employed to undertake. Supporting staff told us there was a lack of progression for them. The registered manager for South Bristol Rehabilitation Unit told us that the learning and development team had run ad hoc clinics to assess progression for "unregistered staff".

Staff had the right skills and knowledge to provide safe care and treatment for patients. However, some staff explained that training was not a priority when busy and the training sessions were often delayed. Specific training was not accessible to staff despite them delivering care and treatment to patients whose health was affected by a stroke for example. The registered manager for South Bristol Rehabilitation Unit told us it was not necessary for "unregistered" staff to have this level of skills as the service was not for patients with complex needs following a stroke.

There were varied levels of supervision to support staff. Managers told us they had commenced regular supervision which was confirmed by staff spoken with.

Staff did not always receive regular appraisal by their managers. Appraisal had been impacted by the increased demands of the COVID-19 pandemic. NHS England had provided guidance to pause appraisals between January 2020 and July 2020, and between 5 November 2020 to March 2021 in order to respond to the pandemic. Managers told us they had commenced staff appraisals, and this continued to be a work in progress.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Multidisciplinary team meetings took place on the units to ensure a full medical overview was maintained and actions completed. Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. For example, the multidisciplinary meeting we joined at Elton was patient centred and discussions were based on all areas of need including psychological and social care.

Staff worked collaboratively to ensure continuity of care to patients and ensured appropriate professionals were involved in care and treatment. GPs, nursing and therapy staff worked together to facilitate care and treatment and assist patients to improve enough to go home.

A GP attended services regularly, for example three times a week at the Skylark and five times a week at South Bristol Rehabilitation Unit and Henderson. GPs could be contacted for support out of hours

Staff worked across health care disciplines and with other agencies when required to care for patients. However, there were concerns about access to social work support. We saw evidence of multidisciplinary working throughout the inspection. For example, we were present during MDT meetings where discussions about a patient's abilities to make decisions about their future were discussed.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Policies, care and treatment pathways, and clinical protocols had been developed in line with national best practice recommendations.

The provider had made all policies including Mental Health Act available to staff on the intranet system and staff demonstrated they knew how to access them.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. We did not identify any patients who were detained under the Mental Health Act during our inspection. Staff were able to tell us what they would do or who to contact for advice and support if they were caring for a detained patient. Staff could access a mental health specialist team who supported the service in improving quality of care for patients living with mental health conditions.

Good practice in applying the Mental Capacity Act (MCA)

Staff supported patients to make day to day decisions about their care.

There was a clear policy on the Mental Capacity Act. The staff knew how access the policy and they had a good understanding of the five principles.

Patients' capacity to consent was assessed during their admission and recorded in their care records. We saw staff talking with patients and obtaining consent when providing care. We heard staff asking patients for their understanding of the care to be given and their agreement and consent. However, patient consent was not gained for their personal information to be made visible to other patients in Henderson and in South Bristol Rehabilitation Unit. Personal information in Henderson was on display on the front of patient's bedroom doors. For example, COVID status, tests due, eating and drinking instructions. The whiteboards in South Bristol Rehabilitation Unit outlined details about the patient including their physical health needs. This was raised at the time of the inspection with the sister in charge and the manager who confirmed they would review to ensure patient confidentiality is maintained.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Patients were supported to make day to day decisions and the staff assessed patient's mental capacity where there were concerns about them making specific decision. Staff clearly recorded consent in the patients' records.

Staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. We saw that in Elton the staff had reached the best interest decision to apply for DoLS authorisation on behalf of a patients who lacked capacity and the application was in progress.

Community health inpatient services

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good

Kindness, compassion and support

Staff treated patients with compassion and kindness and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Patients we spoke with told us they felt well looked after and staff responded quickly to their needs. One patient said they could “not fault” the care staff provided, and another said staff were “very helpful and often checked to see I was okay.”

Patients we spoke with were positive about the service they had received. One patient told us their care was “excellent” and another that the experience was “very positive.” We saw personal messages of thanks on display from patients who felt they had received good care.

Staff we saw interacting with patients were friendly and approachable. They took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff treated them with kindness and humour at times and when appropriate.

Ward managers told us how they ensured staff were kind and caring towards patients. For example, ensuring staff adhered to the values of the organisation, role modelling and training. We saw numerous examples of staff providing reassurance to patients who may need additional support. For example, walking with patients or during daily exercises.

Although staff protected patient’s privacy when delivering personal care, we saw patient’s personal information was visible to visitors and other patients in Henderson and South Bristol Rehabilitation Unit. For example, personal details such as names and date of birth, medical conditions, tests due and personal care needs.

Involvement in care

Staff involved patients in the discussions about their care.

Involvement of patients

Staff involved patients in discussions about their treatment needs. Patients knew about their admission and we saw staff asking a patient if they felt well enough and could they cope at home. They discussed options with them and checks that they may need to do with the patient such as seeing them walk before they could go home.

Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were used by doctors across all locations to document discussions about future treatment decisions such as serious illness, acute deterioration or end of life treatment Details of the discussions were not always documented for patients across all locations. For example, the six forms reviewed in Henderson lacked any evidence of any family or patients involvement and Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) were in place for the 17 patients on the ward at the time of the inspection.

Community health inpatient services

There was limited evidence of ReSPECT forms in South Bristol Rehabilitation Unit. We reviewed nine electronic care records and only one patient had a completed ReSPECT form and DNACPR were in place for 20 of the 30 patients on the ward at the time of the inspection. Following the inspection, the provider confirmed that ReSPECT forms were generally kept at the patient's bedside.

Staff informed and involved families and carers appropriately.

Involvement of families and carers

Staff supported, informed and involved families or carers. We saw on numerous occasions nursing staff contacting families to give updates on their relative's progress. For example, we saw a health care assistant giving a detailed update on a patient's condition and well-being to a family member over the telephone in a polite and friendly manner.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The managers told us the uptake was very low and they were looking at additional ways of obtaining patient feedback.

Is the service responsive?

Good 

Our rating of responsive stayed the same. We rated it as good.

Access and waiting times

The service was easy to access and had referral criteria which did not exclude patients who would have benefitted from care.

The service had clear criteria and service endeavoured to meet target times. Managers and staff worked to make sure patients did not stay longer than they needed to, but delays did occur. The aim of the rehabilitation services was to discharge patients within 21 days. However, timeframes were not always achieved due to delays from commissioners with packages of care to enable discharge. For example, the length of stay currently on Skylark was 32 days while at South Bristol Rehabilitation Unit this was 25 days and 26 days in Henderson.

The service used systems to help them monitor waiting lists and to support patients. Managers had access to the weekly access and flow dashboard report. For example; waiting lists from September to November 2021 averaged 50 patients for home discharge with support (pathway one), 30 patients for discharge to a care setting with rehabilitation and reablement (pathway two) and 34 patients with complex needs (pathway three).

Hospital appointments arranged from the locations were at times missed due to ambulance transport delays and cancellations. For example, one patient missed their appointment when ambulance transport was cancelled.

The facilities promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported patients' treatment, privacy and dignity.

Community health inpatient services

The service had a full range of rooms and equipment to support treatment and care. Facilities and premises were appropriate for the services being delivered. The ward areas were appropriate for the care being provided. However, there was a lack of storage facilities in Henderson. For example, lounges, corridors, dining area and bathroom were used to store stocks of continence aids and equipment including walking aids, paper towels and gloves.

Patients' personal information was displayed in front of bedroom doors in Henderson and in South Bristol Rehabilitation Unit personal information was displayed in whiteboards at ends of corridors. For example, personal details such as names and date of birth, medical conditions, tests due and personal care needs.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Staff we spoke with understood the needs of patients living with dementia. Staff encouraged patients to get dressed and out of their pyjamas to mentally prepare them for discharge.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us they were able to access translation services easily. Staff were able to give examples of where they had requested clear face masks to be able to communicate effectively with people who relied upon lip reading.

The service did not have on display information leaflets in other languages. However, staff informed us they could arrange for patients to have information leaflets available in their own languages when requested.

Patients were given a choice of food and drink to meet their cultural and religious preferences. If the daily food menu did not provide a suitable meal choice, staff told us that a special request could be made to the kitchen for an alternative meal.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

The provider's website had links to information about how to resolve concerns and how to make a complaint. Patients could use an online enquiry form, email, telephone or in writing.

The complaints procedure was not displayed in all patient areas and information leaflets on how to raise concerns in the form of leaflets or posters were not available across all the locations visited. However, patients told us they felt safe and able to raise any issues with staff.

Staff understood the policy on complaints and knew how to handle them. They knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff were able to explain the complaints process and told us they would look to support patients to raise a complaint formally if they were unable to resolve the situation in the first instance.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Community health inpatient services

Is the service well-led?

Good 

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The units visited were led by a clinical lead who had the skills and abilities to run the service.

Local leadership was provided by ward managers. Staff told us that their unit managers were supportive. Managers spoken with said they felt the wards worked as a cohesive team with a consistent single team approach where staff felt empowered.

Leaders were aware of the challenges facing their services. Staff felt managers were supportive and did the best they could, but the situation had been very difficult during the COVID-19 pandemic. Most staff felt that the executive team were not visible.

Leaders spoke positively about their staff and told us they recognised the incredible efforts they had made across the service during the COVID-19 pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action.

Senior staff at the South Bristol Rehabilitation Unit told us that the transfer from University Hospitals Bristol and Weston NHS Foundation Trust to Sirona Care and Health C.I.C which took effect on 1 April 2021 continued to be a work in progress. Staff from South Bristol Rehabilitation Unit told us the systems were not in order, the induction into Sirona was not comprehensive and since the induction an evaluation had not happened.

We saw that most staff continued to view South Bristol Rehabilitation Unit as medical wards rather than rehabilitation services. While the work being undertaken by staff was rehabilitation based, staff continued to approach patients as though they were in an acute hospital setting.

We did not see any posters on display outlining the trust's vision or values. Most of the staff we spoke with did not know the provider's vision or the strategy to achieve it. However, we observed that staff followed good practice by ensuring patients were made to feel welcome, supported, valued and kept safe.

Culture

Community health inpatient services

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work but there was a lack of career development for support workers. The service had an open culture where patients, their families and staff could raise concerns without fear.

Managers encouraged learning and a culture of openness and transparency. Staff said they were encouraged to speak up and felt comfortable about raising any concerns. Staff were also aware they could raise concerns about patient care and safety, or any other anxieties they had with the Freedom to Speak Up Guardians.

Staff told us they were well supported by their immediate managers and were able to raise issues. However, they felt less supported by the executive team. Staff told us they often experienced low morale as they were not able to provide the level of care they wanted for patients in times of increased pressure. Staff were not convinced the executive team understood the challenges they faced or respected their efforts.

Staff described the months during the COVID-19 pandemic as “horrific”. Staff told us they felt exhausted. Excellent teamworking and support from colleagues were the main reasons they were able to continue. Staff told us they were supported in terms of their wellbeing and debriefs were encouraged by direct managers.

The senior leadership teams had recognised the need for staff to be supported to maintain their wellbeing. The provider had initiated a wellbeing day which most staff had taken. All felt this had given them a breather from the pressure of COVID-19.

We heard of positive examples where staff were supported in their own wellbeing. These included debriefs and support if they needed time off or a phased return to work.

We saw staff on Skylark unit had been given a “because you deserve it” award. This had been nominated by a patient in recognition for what staff had done to support their wellbeing and recovery while on the unit.

There was a culture of team working where all grades and disciplines of staff were respected. Therapy staff, nursing staff and GPs worked well together with a holistic approach to patient care. Staff were passionate about providing the best care to patients. They described how good care could be achieved through careful planning and effective risk assessments and were aware of their responsibilities and roles.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities but had not had regular opportunities to meet, discuss and learn from the performance of the service.

There were governance frameworks in place to provide oversight of quality and safety performance. However, we were not assured they were sufficiently robust in consistently maintaining standards.

Audits were completed monthly. The location managers said there was a clear performance management reporting structure which looked at operational performance which included a review of incidents, complaints, staffing, infection control and education and training. For example; the units had processes to ensure they met the planned safe nursing staffing levels. However, we found no evidence that the results were discussed with staff.

Nursing staff told us that staffing constraints meant that while they audited their units for safety and quality; they received little learning and had limited engagement in the monitoring of the quality of the services.

There were clear systems for reporting, investigating and learning from incidents. However, some staff informed us that while they had completed incidents, they did not receive any acknowledgement of feedback and were unaware if their concern had been actioned.

During our inspection we found that unit meetings were irregular and, in most areas, had not happened for some time. However, we saw that weekly safety huddles provided the opportunity for the sharing of information.

Management of risk, issues and performance

The systems used by leaders to manage performance were not always effective. There was no evidence that staff contributed to decision-making to improve services. However, the service had plans to cope with unexpected events.

The service had systems for identifying risks and plans to eliminate or reduce them.

The service kept a dashboard to monitor performance data. This data was collated to determine the current performance. This information was presented to the trust board to provide assurance.

Managers recognised staffing was the major risk to the service. There were recruitment and retention initiative in place to attempt to mitigate the risk.

The locations completed quality performance audits, infection prevention and control compliance, training and staffing data. However, we did not see any process for monitoring progress with any action plans for improved performance.

The provider did not have systems in place to manage how staff were to support patients in the event of an emergency to reach places of safety or evacuate the property.

Although managers told us that staff could talk to them and escalate concerns, had a voice and felt empowered, we did not see evidence that staff were able to actively contribute to decision making about service delivery.

We saw business continuity plans on two of the four sites (Skylark and South Bristol Rehabilitation Units) to maintain delivery of services in the event of planned or unplanned closure or the failure of equipment.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements.

During the inspection we saw records were not kept securely in Skylark. Paper records were not stored in lockable trolleys or in rooms with restricted access. We also saw whiteboards which held patient identifiable information with too much detail about individual health needs.

Staff could not easily access the provider intranet, which provided all policies and guidelines. We noted that information technology issues were identified on the risk register and was a work in progress. Access to all electronic systems was secure and required password access.

Staff were able to tell us how they would make referrals to the safeguarding team or other specialists through the intranet.

The provider shared data securely with the Care Quality Commission and other agencies in accordance with legislation. Serious reportable incidents were reported when they occurred in line with the National Reporting and Learning System (NRLS) requirements.

Engagement

Leaders and staff engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

In line with guidance from NHS England, the Friends and Family Test was suspended during the COVID-19 pandemic and formal submission restarted in December 2020. Unit managers said that they were looking at ways of capturing patient feedback on the units.

There was an awareness of the need for improved well-being and support for staff. All staff had been given the opportunity to have a wellbeing day. However, most staff spoken with felt that engagement from the senior executive team could be improved.

A weekly briefing was held on the Skylark unit while South Bristol Rehabilitation Unit used a communication book to keep staff informed.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

All staff we spoke to were committed to making improvements. The service leaders recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service.