Sirona Care & Health C.I.C.

Quality Report

St Martin's Hospital
Clara Cross Lane
Bath
BA2 5RP
Tel: 01225 831866
Website: www.sirona-cic.org.uk

Date of inspection visit: 18,19, 20, 21 October 2016 and 1 November 2016
Date of publication: 28/03/2017

Core services inspected	CQC registered location	CQC location ID
Community adults	Thornbury Hospital	1-333619227
	Paulton Memorial Hospital	1-297412938
	Keynsham Health Centre	1-1663905943
	Yate West Gate Centre	1-1333619241
	St Martins Hospital	1-297411781
Community inpatients	Paulton Memorial Hospital	1-297412938
	Thornbury Hospital	1-333619227
	St Martins Hospital	1-297411781
End of life	Paulton Memorial Hospital	1-297412938
	Thornbury Hospital	1-333619227
	St Martins Hospital	1-297411781
Urgent care	Yate West Gate Centre Minor Injuries Unit	1-1333619241
	Paulton Memorial Hospital Minor Injuries Unit	1-297412138
Community health services for children and young persons	St Martins Hospital	1-297411781
	Riverside Health Centre	
	Kingswood locality hub	
	Patchway locality hub	

Summary of findings

	Cadbury Heath Health Centre,	
	Yate West Gate Centre	1-1333619241
	Thornbury Health Centre	
	Osprey House	
	Eastgate House	
	Westgate House	
Services for people with learning disabilities	Church House, Kingswood	
	Thornbury office, Thornbury	
	Kingswood	
	St Martin's hospital	1-297411781

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

Summary of findings

Ratings

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

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

Summary of findings

Contents

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

Letter from the Chief Inspector of Hospitals

We undertook a planned announced inspection as part of our comprehensive community health services inspection programme between 18 and 21 October 2016. We also carried out an unannounced visit on 1 November 2016 and inspected the following core services:

- Community health services for adults
- Community health services for children, young people and families
- Community inpatients
- Community mental health services for people with learning disabilities or autism
- Urgent care services
- End of life services

Sirona Care and Health CIC also provide adult social care through a number of residential units. These did not form part of this inspection but have been inspected and reported on separately.

During the inspection we visited a variety of locations including all three community hospitals and both minor injuries units. We visited health centres and children's centres to inspect services for children, young people and families. To inspect the community adults' services, we went to a range of health centres, went out with district nursing teams to people's homes, visited health centres and clinics, and met with staff delivering palliative care, accompanying them on visits to meet the patients and families they were supporting. We spent time with the executive, non executive and leadership team, conducting interviews, held focus groups and observed a board meeting.

Staff were cooperative, open, helpful and supportive to us at all stages of the inspection.

Our key findings were as follows:

Safe:

- Compliance with training for both adults and children's safeguarding was variable and not all staff received training at the correct level.
- The premises at Thornbury Hospital was not fit for purpose. The ward was cramped meaning there was not suitable room for equipment, patient chairs, or adequate space around the beds to perform day to day duties. However, it is recognised that the organisation did not own Thornbury Hospital.
- There were issues with maintenance of the building at Ash House at St Martin's Hospital in Bath including delays in issues being rectified. For example, there was no working door bell, paint peeling from walls in toilets, stains on the carpets and the ceiling in the manager's office had recently collapsed.
- Within the learning disabilities service, interview rooms did not have alarms at any of the sites. Staff relied on administrative staff being aware that they were using rooms and for them to call for help if needed.
- Notes were not always stored securely in community hospitals. Notes trolleys were left open and unattended and one trolley did not lock at all.
- National guidance was not fully followed with regard to patient treatment escalation plans (TEP).
- Compliance with mandatory training was variable though shortfalls were being addressed by the organisation through the development of a full days training to ease staff release from the work areas. However, compliance varied from 66-91%.

However:

- There was a good culture among staff for reporting incidents. There were systems in place to report incidents and near misses that staff were familiar with and competent in their use.
- Staff had a good understanding and knowledge of when to apply the duty of candour.
- There were adult and children's safeguarding systems in place to keep patients safe. Policies were in place and staff were aware of their responsibilities in relation to safeguarding.
- The majority of medicines were stored and administered safely.

Summary of findings

- There were reliable systems in place to prevent and protect patients from healthcare associated infection.
- Staff assessed and responded to patient risk. Staff completed risk assessments and where patients presented with high levels of risk, an embedded system of multi-disciplinary working meant teams were able to seek specific support .
- There were business contingency plans in place to respond to emergencies and other major incidents.

Effective

- Patients' care and treatment were delivered in line with relevant legislation, standards and evidence-based guidance. Staff followed evidence based and current practice when assessing and planning care
- Where documentation existed we saw that pain assessment and management was integral to patient care and treatment.
- In most instances, information about people's care and treatment, and their outcomes, was collected and monitored and was used to improve care.
- There was participation in relevant local and national audits
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was adherence to the Mental Health Act 1983 and the Mental Health Act Code of Practice
- A strong multi-disciplinary working approach ensured co-ordination of care pathways and transition arrangements.

However;

- Services within the community did not consistently document the assessment and management of patients' pain.
- Whilst consent to care and treatment was, in most cases obtained in line with legislation and guidance, some staff within the minor injuries units were not entirely familiar with the way in which consent was handled for people who could not make their own decisions and within the children's services, not all staff were clear about the implications of the age of a child in relation to consent.

Caring

- People were respected and valued as individuals and were empowered as partners in their care. Partnership working, led at all times by the patient and family was observed to be embedded, and routinely applied.
- Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treated people. People were truly respected and valued.
- Staff were often described as going the extra mile and the care people received exceeded their expectations. Relationships between people who used the service, those close to them and staff was strong, caring and supportive.
- Throughout, people were provided with care that was dignified, respectful and compassionate. Staff took people's personal, cultural, social and religious needs into account and provided truly holistic care.
- People were active partners in their care. They were supported to manage their illness whenever possible and were involved in all care decisions.
- Staff adapted how they provided end of life care to fit around people, so that at all times, patients were involved as much as they wanted to be and were treated with dignity and respect. Staff skilfully balanced humour, honesty and compassion with each situation.
- People and those close to them were given appropriate and timely support and information to cope emotionally with their condition.

Responsive

- Services were planned and delivered to meet the needs of the local communities
- The equality and diversity needs of people who used the services was met at all times.
- Services were planned, delivered and coordinated to take account of people with complex needs and those in vulnerable circumstances.
- There were different approaches to ensure access to the right care at the right time for most people
- There were systems and processes in place for handling complaints and sharing learning as a result. A dedicated customer care service had been established to ensure the smooth handling and follow up of all complaints and concerns, no matter how they were raised.

However;

Summary of findings

- Waiting times for some services exceeded the NHS England targets of 18 weeks from referral to start of treatment
- The minor injuries unit in Yate, although providing the service it had been commissioned to deliver, was not able to meet the demand from patients at times. This resulted in frequent early closure of the service.

Well-led

- There was a clear vision and set of values in place that were developed with staff and demonstrated by staff at all levels.
- Throughout the organisation, quality and safety were top priorities and were taken into account whenever financial decisions were made.
- Progress against strategic objectives were measured through ongoing audit
- There was strong and well established leadership of the organisation. Reports received at board meetings were subject to scrutiny and challenge. Members and non executive directors held the executive team to account.
- The organisational ethos of 'taking it personally' was developed in conjunction with staff at all levels and was demonstrated wherever the inspection teams went.
- Staff were empowered to suggest change and develop their own services.
- Public and staff engagement occurred in all areas of the organisation. Patient feedback was welcomed and encouraged. Patient stories featured prominently at board meetings.
- The loss of a significant and sizable contract had just been announced. The executive team recognised the impact this would have on staff, services and the remainder of the organisation and were developing plans to mitigate risks and ensure continuity.
- A quality impact assessment was undertaken for all cost improvement programs with the impact of the saving reviewed throughout the year. Where the saving was felt to affect quality, it was not approved.
- Services were empowered to be innovative and progressive.

However;

- Although there were systems and process in place which ensured the governance and risk management of services, in places these required strengthening, most notably in relation to the management and oversight of lower level risks.

We saw several areas of outstanding practice including:

- All staff in the minor injuries units had been provided with a review of their practice and competence in the last year (annual appraisal). Staff also had monthly meetings with their line manager, clinical supervision, and were supported with training and development.
- The matron at the minor injuries unit at Yate had been supported over a two-year period to help establish minor injury services within 29 GP practices in South Gloucestershire. This relieved pressure on this already high-demand service and more widely for the healthcare economy in that area.
- We saw evidence that care provided to end of life patients and those people close to them across the Sirona services was outstanding. Holistic and person centred support was embedded in practice and patients and family were fully involved and informed about all aspects of treatment and care. Relationships were highly valued by both patients and families and staff. The attention to detail and level of care, treatment and support provided by staff far exceeded expectations.
- Patients with end of life care needs were prioritised at all times and care and support was provided 24 hours a day, seven days per week. Partnership working with patients, families and other professionals and services was evident throughout the service, and this enabled coordinated and responsive care to be provided. Staff at all levels were actively supported to develop their end of life knowledge, skills and practice in order to deliver a high quality service.
- Staff positively looked for ways to engage patients and those people close to them with the planning and delivery of services and a range of resources had been developed to promote equality of access to the service. Staff worked above and beyond their roles to ensure wherever possible that patients and families achieved their hopes and wishes.
- The use of reminiscence pods and other activities to stimulate patients living with cognitive impairment within the community hospitals.

Summary of findings

- The community adults service demonstrated outstanding multidisciplinary working across services, with GPs and other external health care providers.
- Feedback from patients was consistently positive; patients went to great lengths to tell us about their positive experiences.
- Patients were active partners in their care, and were encouraged to speak about their opinions of their planned treatment. Care was truly person centred, with patient's wellbeing at the heart of care.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and were fully committed to working in partnership with people.
- The organisation provided a number of bespoke services across their adult community services such as the active ageing service, falls service, emergency care practitioners and blood transfusion and intravenous service all of which had led to positive outcomes for patients.
- Within the community adults service, staff regularly went the extra mile when caring for patients.
- The transition planning for young people being undertaken by staff in the Lifetime service was outstanding as was the planning of advance care plans and the support of families in completing these.
- Sirona provided placements for people with disability or autism who were often previous users of their services. People were offered roles for a period of time to help them to gain skills in the job market and to boost their confidence.
- The learning disabilities service proactively managed risks for service users who could be detained under the Mental Health Act with other agencies. This had resulted in no admissions to hospital in four years
- In Bath and North East Somerset staff working in the learning disabilities service had a communication passport in a grab bag that they carried with them to all new assessments, designed to ensure that staff communicated with people when they first met them before they had the opportunity to assess any communication needs.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- The provider must improve its compliance rates for level two and level three adults and safeguarding training and ensure that safeguarding training is received at the right level for the role.
- The provider must ensure that the care records system/s it has in place within the learning disabilities service do not pose unnecessary risk for staff and people who use the services.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Julie Blumgart, invited independent chair.

Team Leader: Amanda Eddington, Inspection Manager, Care Quality Commission.

The team included CQC inspectors and a variety of specialists including community nurses, learning disability nurses, children's nurses, allied health professionals, clinicians specialising in end of life care and clinicians with board level experience and experience of social enterprises. We were also supported by two experts by experience who talked with patients who had consented to talk with us by telephone about their views and opinions.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew. We carried out an announced visit between 18 and 21 October 2016. During the visit we held drop in sessions and focus groups with a range of staff who worked within the service. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the service. We carried out an unannounced visit on 1 November 2016

Information about the provider

Established in October 2011, Sirona Care and Health is a Community Interest Company that provides community health and adult social care services. Initially providing health and adult social care in the Bath and North East Somerset, the service took over 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 was jointly provided by Sirona, Bristol Community Health CIC and Avon and Wiltshire Mental Health Partnership Trust, as part of the Community Children's Health Partnership. These services transferred from North Bristol NHS Trust to the new partnership on 1 April 2016 for an interim contract period of twelve months while the services were put out to tender.

As a not for profit social enterprise, any surplus made is reinvested into services and staff development. Sirona Care and Health CIC provide a range of community children's and adults health services and adult social care services across a wide geographical areas including Bath and North East Somerset, South Gloucestershire, Bristol,

Summary of findings

North Somerset, Wiltshire and Somerset. They also provide inpatient services in three community hospitals (Thornbury, Paulton and St Martin's hospital, Bath) and a minor injuries service in Yate and Paulton.

Sirona Care and Health CIC also provide adult social care through a number of residential units. These did not form part of this inspection but have been inspected and reported on separately.

Sirona Care and Health CIC is not part of the NHS, but provides NHS funded services commissioned by Bath and North East Somerset, South Gloucestershire, Bristol, North Somerset, Wiltshire and Somerset CCGs.

Its services include:

- a range of preventative health improvement services;
- care in hospital,
- care at home
- residential care for adults;
- community nursing,
- health visitor and consultant paediatric services for children
- community nursing services for children with life limiting conditions and
- specialist community based services for adults with a learning disability.

Sirona employs in the region of 2,200 staff, including social workers, clinical and medical professionals and a range of trained and qualified support staff.

What people who use the provider's services say

Feedback from patients and those people close to them who used the services were overwhelmingly positive, reporting care that was delivered sensitively, compassionately and with dignity and respect. Within the end of life care service, the most commonly used word was "exceptional". Parents and children we spoke with were positive about the approach of staff and the way they were treated and listened to. Whether told verbally or by comment card, comments described a consistently positive experience which demonstrated a patient centred and caring culture across the organisation.

Good practice

- All staff in the minor injuries units had been provided with a review of their practice and competence in the last year (annual appraisal). Staff also had monthly meetings with their line manager, clinical supervision, and were supported with training and development.
- The matron at the minor injuries unit at Yate had been supported over a two-year period to help establish minor injury services within 29 GP practices in South Gloucestershire. This relieved pressure on this already high-demand service and more widely for the healthcare economy in that area.
- We saw evidence that care provided to end of life patients and those people close to them across the Sirona services was outstanding. Holistic and person centred support was embedded in practice and patients and family were fully involved and informed about all aspects of treatment and care. Relationships were highly valued by both patients and families and staff. The attention to detail and level of care, treatment and support provided by staff far exceeded expectations.
- Patients with end of life care needs were prioritised at all times and care and support was provided 24 hours a day, seven days per week. Partnership working with patients, families and other professionals and services was evident throughout the service, and this enabled coordinated and responsive care to be provided. Staff at all levels were actively supported to develop their end of life knowledge, skills and practice in order to deliver a high quality service.
- Staff positively looked for ways to engage patients and those people close to them with the planning and delivery of services and a range of resources had

Summary of findings

been developed to promote equality of access to the service. Staff worked above and beyond their roles to ensure wherever possible that patients and families achieved their hopes and wishes.

- The use of reminiscence pods and other activities to stimulate patients living with cognitive impairment within the community hospitals.
- The community adults service demonstrated outstanding multidisciplinary working across services, with GPs and other external health care providers.
- Feedback from patients was consistently positive; patients went to great lengths to tell us about their positive experiences.
- Patients were active partners in their care, and were encouraged to speak about their opinions of their planned treatment. Care was truly person centred, with patient's wellbeing at the heart of care.
- Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity and were fully committed to working in partnership with people.
- The organisation provided a number of bespoke services across their adult community services such as the active ageing service, falls service, emergency care practitioners and blood transfusion and intravenous service all of which had led to positive outcomes for patients.
- Within the community adults service, staff regularly went the extra mile when caring for patients.
- The transition planning for young people being undertaken by staff in the Lifetime service was outstanding as was the planning of advance care plans and the support of families in completing these.
- Sirona provided placements for people with disability or autism who were often previous users of their services. People were offered roles for a period of time to help them to gain skills in the job market and to boost their confidence.
- The learning disabilities service proactively managed risks for service users who could be detained under the Mental Health Act with other agencies. This had resulted in no admissions to hospital in four years
- In Bath and North East Somerset staff working in the learning disabilities service had a communication passport in a grab bag that they carried with them to all new assessments, designed to ensure that staff communicated with people when they first met them before they had the opportunity to assess any communication needs.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The provider must improve its compliance rates for level two and level three adults and safeguarding training and ensure that safeguarding training is received at the right level for the role.
- The provider must ensure that the care records system/s it has in place do not pose unnecessary risk for staff and service users.

Action the provider SHOULD take to improve:

- The provider should ensure patients' treatment escalation plans (TEP) were more fully completed.
- Staff at locality manager level and above should be able to evidence the full range of risk and quality management issues specific to end of life patients.
- All staff should have in date mandatory safeguarding children and vulnerable adults training.
- All staff should be in date with all other training identified by the organisation as mandatory.
- The provide should review the system and practices in place within the school nursing service to ensure medicines are stored securely at all times.
- The provider should review the use of abbreviations within patient records in the sexual health service to ensure that all staff understand the meaning of the records.

Summary of findings

- The provider should review the completion of medical records within the sexual health service to ensure they are all maintained appropriately.
- The provider should ensure that staff are aware of their infection control procedures and that these are followed.
- The provider should review the systems in place to ensure all staff know how to respond to emergency alarm bells within the sexual health clinic setting.
- The provider should consider monitoring patients who attended a CASH clinic and were not able to be seen and how this equated to the outcome for the patient.
- The provider should consider entering into discussion with commissioners of services to review the opening and access times of sexual health clinics to ensure they meet the needs of local people.
- The provider should review the environment in the waiting room for the sexual health clinic at the Riverside Clinic.
- The provider should ensure there is consistent understanding of the process for getting issues or concerns reported onto the provider risk register.
- The provider should ensure staff are able to complete their documentation contemporaneously.
- The provider should continue to review the staffing levels and skill mix across the community adult's services, including bespoke services such as the blood transfusion and IV service.
- The provider should consider a review of processes to ensure efficient and timely assessment of risks associated with patient's health and to ensure a proactive approach to managing these.
- The provider should improve the cleaning processes for store rooms at St. Martin's Hospital.
- The provider should improve the systems in place to check the expiry date on consumables at St. Martin's Hospital.
- The provider should improve systems to ensure that records are kept secure at St. Martin's Hospital**.**
- Continue to work on improving the triage times at the Yate service.
- Ensure the use of CCTV monitoring equipment is advertised with clearly visible and readable signs in the minor injuries units and to comply with legal requirements.
- Review how checks of stock levels are recorded in the controlled drugs register in Yate minor injuries unit.
- Ensure the resuscitation trolley in the minor injuries unit in Yate is able to demonstrate the contents have not been tampered with or removed. During this process, the checklists at both units should be reviewed to ensure they reflect national guidance appropriate to the clinical setting. The medicines management audit should ensure these areas are checked and picked up in future audits.
- Update the Sirona website to accurately reflect the services provided by the minor injuries unit at Paulton, and consider whether the name of the service could be amended to reflect that minor illnesses are also treated. The standard operating procedures at Paulton should be updated to reflect treatment for minor illnesses, as these are not described.
- Ensure patients' privacy, dignity and confidentiality is at the forefront of their care and treatment within the minor injuries units.
- With exceptions for vulnerable people, review whether there should be a method for checking with patients who attend the minor injuries unit if they are happy for their GP to be told of their visit.
- Ensure the way in which consent is recorded and obtained in the minor injuries units meets the Department of Health guidance for consent and the law.
- Decide, through audit, whether the results of X-ray audits in the minor injuries units are demonstrating good outcomes for patients, or if some patients are having X-rays unnecessarily.

Requires improvement

Are services safe?

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

- Consider whether training to deal with rude or aggressive patients would benefit the reception staff, particularly at the Yate minor injuries unit, where early closure of the unit often led to staff being verbally abused by people.
- Look into providing an assessment template for the minor injuries units to use when treating patients living with dementia, and introducing a pain assessment tool or template.
- Revisit the lack of an electronic display in the patient waiting room in the Yate minor injuries unit, which was the area that was most commented upon by patients as being missing.
- Return to the conversation with the commissioners about the rising and sometimes unmanageable demand at the Yate minor injuries unit. Return also to the conversation with the commissioners about the staffing levels and skill mix at the Paulton service.
- Look at the governance process at local level to introduce a structured approach to team meetings at the minor injuries unit, and ensure standing agenda items are agreed and included, minuted and discussed at all meetings. Ensure all local-level risks have management and mitigation recorded and tracked.
- The provider should ensure that maintenance at Ash House is completed in a timely manner and that jobs reported to estates are monitored for completion in agreed timescales.
- The provider should review the governance arrangements and consider developing local risk registers for each service.
- The provider should ensure care in the learning disabilities service is coordinated effectively in Bath and North East Somerset and that staff don't work in isolation.
- The provider should consider how it could make the waiting areas in the learning disabilities service in each environment more accessible to people in wheelchairs that might have cause to use these.
- The provider should consider how it can maintain confidentiality more effectively in Thornbury. Patient confidentiality was compromised due to poor soundproofing in the waiting area.

Requires improvement

Are services safe?

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

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

Summary of findings

We judged the safe domain to require improvement because:

- Compliance with training for both adults and children's safeguarding was variable and not all staff received training at the correct level.
- The premises at Thornbury Hospital was not fit for purpose. The ward was cramped meaning there was not suitable room for equipment, patient chairs, or adequate space around the beds to perform day to day duties.
- There were issues with maintenance of the building at Ash House at St Martin's Hospital in Bath

Requires improvement

Are services safe?

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

including delays in issues being rectified. For example, there was no working door bell, paint peeling from walls in toilets, stains on the carpets and the ceiling in the manager's office had recently collapsed. There was no process to monitor if maintenance jobs had been completed or how long they had been outstanding.

- Within the learning disabilities service, interview rooms did not have alarms at any of the sites. Staff relied on administrative staff being aware that they were using rooms and for them to call for help if needed.
- Notes were not always stored securely in community hospitals. Notes trolleys were left open and unattended and one trolley did not lock at all.
- National guidance was not fully followed with regard to patient treatment escalation plans (TEP).
- Compliance with mandatory training was variable though shortfalls were being addressed by the organisation through the development of a full days training to ease staff release from the work areas. However, compliance varied from 66-91%.

However:

- There was a good culture among staff for reporting incidents. There were systems in place to report incidents and near misses that staff were familiar with and competent to use.
- Staff had a good understanding and knowledge of when to apply the duty of candour.
- There were adult and children's safeguarding systems in place to keep patients safe. Policies were in place and staff were aware of their responsibilities in relation to safeguarding.
- The majority of medicines were stored and administered safely
- There were reliable systems in place to prevent and protect patients from healthcare associated infection.
- Staff assessed and responded to patient risk. Staff completed risk assessments and where patients presented with high levels of risk, an embedded system of multi-disciplinary working meant teams were able to seek specific support .
- There were business contingency plans in place to respond to emergencies and other major incidents.

Our findings

Incident reporting, learning and improvement

- There were systems in place to report incidents and near misses that staff were familiar with and competent to use. There was a good culture among staff for reporting incidents. Staff felt confident about reporting issues, and there were no barriers to open, blame-free reporting. However staff in the community settings often completed incident report forms once they were back at their base rather than as the incident occurred; this was partly because of connectivity issue with the internet but also staff felt confidentiality could be better maintained. However, there was a risk that staff could forget to log incidents and we heard examples of when this had occurred.
- Incidents were investigated and learning was shared between teams, often during team meetings.

Duty of Candour

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

Safeguarding

Requires improvement

Are services safe?

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

- There were adult and children's safeguarding systems in place to keep patients safe. Policies were in place and staff were aware of their responsibilities in relation to safeguarding.
- However, compliance with training for both adults and children's safeguarding was variable and not all staff received training at the correct level. For example in the Bath and North East Somerset health visiting and administration team there was 100% completion of safeguarding training. However, the support staff working within the Lifetime service were being trained to safeguarding level two. The national Intercollegiate guidance recommended level for staff lone working in this type of situation is level three. In other areas compliance with safeguarding children training at level two for clinical staff was as low as 47%. Figures for compliance with adult safeguarding training also showed large variance across services. For example only 41% of staff in the Community Children's Health Partnership community paediatrics team had completed level one and only 30% had completed level two. At Paulton Memorial Hospital 91% of staff had level two adults training. At St. Martin's Hospital only 51% of staff had level two adults safeguarding training and at Thornbury Hospital only 43% of staff had adults safeguarding training.
- Within the sexual health service team staff were provided with policies and procedures regarding the safeguarding of vulnerable adults and children. Guidance included the recognising and reporting of abuse, female genital mutilation (FGM), child sex exploitation (CSE) and trafficking.
- < > is about safeguarding people and communities from the threat of terrorism. It is one of the four elements of the Government's counter-terrorism strategy which aims to stop people becoming terrorists or supporting terrorism. There was a PREVENT strategy in development but this was not yet embedded or included in training.
- The majority of medicines were stored and administered safely. Staff in some areas, for example the Minor Injuries Units used Patient Group Directions (PGDs). These are approved documents permitting authorised members of staff to supply or use prescription-only medicines with certain groups of patients within approved guidelines. Staff using PGDs were trained in their use.
- Where used, prescription pads were used and stored securely. All pads were locked away when not in use, and accounted for when issued or used.
- Medical gases used were stored safely, were checked, and ready for use. Medicines requiring refrigeration were stored appropriately. Staff undertook checks on fridge temperatures and records were maintained.
- Within the community settings, medicines were obtained by a GP prescription by the patient or their relatives/carers and were recorded on the electronic patient record.
- Sirona employed two pharmacists in the community who visited patients in their own homes to undertake a medicine review or to provide advice to the patient regarding their medicines.
- Nurses had medicines management training at induction however no further training or updates were given unless specialist training was required for example syringe drivers, intravenous medicines, peripherally inserted catheter (PIC) line training.
- Patients at home were able to receive medication intravenously via the community IV service. The service was supported by a standard operating procedure which ensured the first two doses of intravenous antibiotics were given by two nurses instead of one.
- There was a service level agreement with a local NHS Trust to provide a clinical pharmacy service, discharge dispensing service and medicines governance support. Further support was provided by a governance pharmacist who reviewed medicines audits, medicine incidents, pharmacist interventions and prescribing on external prescriptions (FP10s); these were reported to the medicines management committee.
- Staff received a medicines management newsletter bi-monthly which discussed the number of medicines adverse events and the learning from their investigations.
- Patients identified as requiring end of life care were prescribed anticipatory medicines in a 'just in case box' which could also be customised in anticipation of specific individual patient's needs and used by whoever was providing care for the patient, whether as an inpatient or at home

Requires improvement

Are services safe?

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

- However the transportation and storage systems used by school nurses did not ensure the safe storage of medicines at all times. Medicines were not transported in locked bags or boxes and on occasions were stored at the nurses home overnight.

Safety of equipment and facilities

- Equipment was used to support safe patient care and treatment. Access was good, including an out of hours provision. Equipment was serviced and calibrated appropriately.
- Consumables, for example: cleaning wipes, gloves, aprons and sharps boxes were readily available. However, at St. Martin's Hospital we found that there were multiple consumables which were beyond their expiry date.
- Clinical areas such as clinic rooms, the minor injuries units and wards were visibly clean and tidy
- However, some areas were cramped which at times could compromise patient confidentiality.
- Staff used their own vehicles to travel between visits to patients in their home. It was the responsibility of the individual to ensure the car was in a good condition and insured to use for work; however the provider did not ask for or store information regarding staff's car insurance status.
- There were systems in place to ensure the safe management of healthcare waste in the community however, this could take up to two weeks to organise with the local council.
- The design, maintenance and use of facilities and premises at St. Martin's Hospital and Paulton Memorial Hospital kept people safe. There was ample space between patient beds to allow easy access with equipment and patients were always visible by a member of staff. Staff at St. Martin's hospital were positive about a recent refurbishment of the ward saying that it had a "a positive effect to the staff and patients". However, the premises at Thornbury Hospital was not fit for purpose. Although infection control was well maintained, we found that the ward was cramped meaning that there was not suitable room for equipment, patient chairs, or adequate space around the beds to perform day to day duties.
- Resuscitation trolleys and equipment was not tamper evident and there was not a consistent approach to their contents or location.
- There were issues with maintenance of the building at Ash House at St Martin's Hospital in Bath including delays in issues being rectified. For example, there was no working door bell. Managers told us that a team administrator normally sat in the room by the door. However, we observed that they were not always present which left the potential for service users to be left waiting. The doorbell had not been working for 20 days at the time of our inspection. Other issues included paint peeling from walls in toilets, stains on the carpets and the ceiling in the manager's office collapsing. The ceiling had collapsed six weeks prior to our inspection but work to rectify it had yet to start. There was also a delay in responding to an overflowing sanitary bin of five days. Although the service kept a log of maintenance jobs it had reported to the provider`s estates department, there was no monitoring of whether any jobs had been completed or how long the jobs had been waiting.
- Interview rooms did not have alarms at any of the sites. Staff relied on administrative staff being aware that they were using rooms and for them to call for help if needed. At Church House, staff had a system for monitoring and code words for staff to use to indicate the need for help but there was no formal system for this in Ash House.

Records management

- There were a variety of records systems across the area. Within the community adults services two electronic patient systems were use in the two local authority areas (Bath and North East Somerset and South Gloucester). One system allowed staff to look at all records relevant to a patient including GP records. The other system allowed staff to look at colleagues' records made about a patient. Both systems allowed for a patients care plan, risk assessment and evaluation notes to be documented. Patients seen at home also had a paper copy of their care plan and any other relevant documentation.
- Care records were audited and actions were taken, to improve their record keeping in local teams, however these audits did not extend to hand held paper records stored in patients own homes.
- Connectivity issues, duplication of information and retrospective documentation did not ensure contemporaneous recording and accuracy of records.

Requires improvement

Are services safe?

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

Connectivity issues had been identified as a risk and placed on the risk register and with the IT service. All electronic devices were password protected to ensure secure storage of electronic information.

- Within the community hospitals records were accurate, legible, up to date and mostly completed in full. However, here notes were not always stored securely. Notes trolleys were left open and unattended and one trolley did not lock at all.
- National guidance was not fully followed with regard to patient treatment escalation plans (TEP). These were not all completed by doctors. The TEP required a written summary of the rationale and decisions regarding treatments that had been discussed with the patient, their carers or legal representative. If discussions had not been possible, a written summary was required by a doctor to explain why not. We saw evidence that this was not consistently undertaken.
- Patient records in the Community Children's Health Partnership were paper-based. Although other areas of Sirona were using electronic records, because the contract for Community Children's Health Partnership was only for one year while re-tendering took place no investment had been made to move to electronic records. Staff were able to access records when needed, including those stored off-site once archived. However, they did feel vulnerable carrying paper-based notes and felt they had to be extra careful to ensure data protection and confidentiality was maintained.
- The sexual health service used a variety of abbreviations in the electronic patient records. Staff on duty were unable to provide an explanation of what the abbreviations stood for and there was no recognised list of accepted abbreviations for staff to refer to.

Cleanliness and infection control

- There were reliable systems in place to prevent and protect patients from healthcare associated infection. Policies and procedures relevant to infection control practices were available to staff on the organisation's intranet. Staff were seen to be adhering to handwashing procedures and being bare below the elbows during clinics, home visits and the delivery of patient care, with the exception of Bristol and South Gloucestershire area children's services where staff were seen wearing long sleeved tops, jewellery and nail varnish. Some staff were observed not washing their hands between babies.
- Areas were visibly clean with the exception of the Kingswood hub. This was raised and addressed at the time of the inspection.
- At St. Martin's Hospital we found some non-sterile consumables were stored in dirty containers. Staff took prompt action when we raised concerns to ensure they were not used.
- All hospitals had an appropriate number of side rooms to prevent spread and there were no cases of MRSA or C-Difficile in the last 12 months.
- Assurance from cleanliness was obtained through hand hygiene audits, hospital cleaning audits and patient led assessment of the care environment (PLACE) audits were completed. Alongside audits ad hoc spot checks of community hospitals and MIUs were conducted.
- Infection control training was part of the provider's mandatory training programme.

Mandatory training

- The organisation had introduced a one day mandatory training session covering all required training such as manual handling, infection control, equality, diversity and human rights, information governance and resuscitation training in June 2016. Compliance with mandatory training was variable. For example at Thornbury Hospital 91% of staff had completed mandatory training whilst this had been completed by only 66% staff in the family nurse partnership team.
- Within the community hospitals, ward managers had introduced bespoke training to "fill the gaps" left by the training day such as a practical manual handling assessment. However, although many staff told us they were happening we found that these were not recorded or consistently applied across the organisation.

Assessing and responding to patient risk

- There were systems and process across the organisation to ensure staff assessed and responded to patient risk. Staff completed risk assessments for issues such as nutrition, pressure ulcers and falls.

However whilst comprehensively completed and reviewed for the inpatient settings, in community settings these were not always up to date or re-assessed in a timely manner.

- Where patients presented with high levels of risk, an embedded system of multi-disciplinary working meant that community teams were able to seek specific support , for example from the frailty team, or the tissue viability service.
- Teams such as the community nurses, rehabilitation and the out of hour's service discussed changing care needs and risks in a daily handover/safety briefing.
- The provider had a payment related target for quality and innovation set by the commissioners (CQUIN) which was to introduce an early warning score to raise awareness of acute deterioration of patients' health. To meet this, the provider had introduced the National Early Warning Score which had been adapted for different community setting. However, its use, whilst audited in the inpatient setting was not audited in community health.
- Patients attending the minor injuries units were assessed for the risk of their injury or illness, and staff responded quickly when the risk was high. Reception staff on duty were trained to recognise higher risk conditions and the nursing staff were trained in resuscitation and emergency care.
- Time to triage in Yate Minor Injuries Unit fell below the standard expected. Target for triage, the immediate assessment of patients' needs and risks patients is within 15 minutes of their arrival. This was only achieved for around 30% of patients, although the unit had achieved 52% in August 2016.
- Within the children's services, there were pathways for staff to use when certain risks were identified, for example, domestic abuse and child sexual exploitation.
- Risk assessments within the learning disabilities service were present but difficult to find on the electronic care notes system. There was no consistent place for them and it relied on staff to highlight risks. Risk assessments varied in quality from basic risk assessment screens to detailed comprehensive understanding of risks. In south Gloucestershire there was no easily identifiable way to save risk assessments.
- Crisis plans were evident for service users who were considered high risk. The plan included liaison with the local mental health crisis team and the option of admission to a local acute mental health ward if needed.

Staffing levels and caseload

- Staffing levels and skills in most services were adequate to meet the needs of the patients though the organisation recognised recruitment as an ongoing concern and it featured on the organisation's risk register. As a result many temporary vacancies, such as those created by maternity leave, were not being covered. However, community caseloads were reviewed frequently and the necessity of visits examined. Staff used a monitoring tool to assess capacity. This was received by the Director of Nursing and Operations daily for oversight.
- The MSK service had no control over how many patients were referred as this was part of a "block contract" arrangement with the local care commissioning group. Funding did not increase with the number of patients. The service monitored its activity which was discussed at board level.
- The provider employed a bank of staff who were used to fill vacant shifts due to sickness or leave who all had access to similar supervision and training as permanently employed staff. As a result, the provider used very few agency staff.
- All three community hospitals undertook a national bed occupancy benchmarking programme which reviewed bed occupancy against other hospitals and against a 91% target. All three hospitals performed well against other hospitals. Benchmarking was also done to compare the staffing mix of non-medical clinical staff (nurses and health care assistants) and was comparable to national results.
- A caseload weighting tool was used in the Bath and North East Somerset health visiting service to manage and plan services. This met the Community Practitioners and Health Visitors Association recommend caseloads for health visitors. Although there were no significant vacancies in staffing levels for the Community Children's Health Partnership, all staff we spoke with felt their workloads were becoming difficult to manage. There was no plan to reassess workloads due to the short length of the interim contract.

Requires improvement

Are services safe?

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

- Psychiatric out of hours cover was provided by the psychiatrists on call from the local mental health trust under a service level agreement. This also provided cover for annual leave, training and sickness as necessary.

Managing anticipated risks

- The organisation took lone working seriously and had a 'personal safety and lone working policy to support staff visiting patients in their homes. Recording systems were such that alerts could be documented if there were concerns.
- Potential risks were taken into account when planning the service for seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing through comprehensive business continuity plans found at each of the community hospitals. These detailed many possible situations, the risks as a result, and the mitigation actions in a clear and concise way for any member of staff to follow.
- There was appropriate risk assessments and mitigating actions put in place to reduce risk to patients during refurbishment of areas such as St Martin's hospital.
- The needs of end of life patients and their families were always given priority over other routine clinical work. The cluster teams worked across surgeries and geographical boundaries to fill any gaps based on increased patient needs or lack of staffing to ensure end of life patient care was consistent.
- Within the sexual health clinic panic alarms were installed and staff were provided with guidance on their use.

Major incident awareness and training

- There were business contingency plans in place to respond to emergencies and other major incidents. The plans were specific to individual services but were all written in conjunction with the Sirona emergency planning officer in accordance with the Civil Contingency Act 2012and the practice guidelines from the Business Continuity Institute

Are services effective?

Good

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

Summary of findings

We judged effective to be good because

- Patients' care and treatment were delivered in line with relevant legislation, standards and evidence-based guidance. Staff followed evidence based and current practice when assessing and planning care
- Pain assessment and management was integral to patient care and treatment.
- In most instances, information about people's care and treatment, and their outcomes, was collected and monitored and was used to improve care.
- There was participation in relevant local and national audits
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was adherence to the Mental Health Act 1983 and the Mental Health Act Code of Practice
- A strong multi-disciplinary working approach ensured co-ordination of care pathways and transition arrangements.

However,

- Services within the community did not consistently document the assessment and management of how patients' pain was managed.
- Whilst consent to care and treatment was, in most cases obtained in line with legislation and guidance, some staff within the minor injuries units were not entirely familiar with the way in which consent was handled for people who could not make their own decisions and within the children's services, not all staff were clear about the implications of the age of a child in relation to consent.

Our findings

Evidence-based care and treatment

- Patients' care and treatment were delivered in line with relevant legislation, standards and evidence-based guidance. Staff followed evidence based and current practice when assessing and planning care, for example the pathway for patients in receipt of care from the intravenous and blood service which was also seen to be compliant with Blood Safety and Quality Regulations (2005). Standard operating procedures for the patients at risk of developing pressure ulcers were based upon evidence based practice.
- The frailty service used the 'Rockwood Frailty Score' to assess patients. This categorised a patients abilities into a score that helped inform their care needs. The service used this system to ensure appropriate referrals.
- The active ageing service, developed in 2014, aimed to help older people remain well and active within their communities. The service provided health promotion, health prevention advice, support and partnership working with clients to identify and manage risks.
- Staff used recognised tools such as the Waterlow Score (a screening tool used to assess patients' risk of developing a pressure ulcer) and MUST (a malnutrition universal screening tool) in assessments for patients. Whilst these were well completed within community hospitals, within the community setting, assessments were not always updated and care plans amended in a timely manner.
- Emergency care practitioners (ECP) acted as a rapid response to call outs and could help avoid admission to hospital but also had admission rights to enable them to refer patients straight to hospital without the need for them to see a GP first. However this group of staff did not have specific flowcharts or guidelines to help them make decisions about the care and treatment of the patients they saw.
- Within all three community hospitals best practice of sepsis management and acute kidney disease had been used in training and embedding of new processes. Episodes of venous thrombolysis were audited against National Institute for Health and Care Excellence (NICE) guidelines CG144 in all three community hospitals for 'the management of venous thromboembolic diseases and their role of thrombophilia testing'. Results showed that compliance with assessment, diagnosis and treatment was good. Acute kidney disease was audited against NICE guidelines CG169 for the 'prevention, detection and management of acute kidney injury up to the point of renal replacement therapy.' Compliance against the audit was good.
- End of life care was delivered in line with best practice and national guidance which was embodied within the end of life strategy action plan and all of the end of life care planning and assessment tools. This included The National Council for Palliative Care (2008, 20013), the

Are services effective?

Good

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

Department of Health (DH 2008), The Leadership Alliance for the Care of Dying People (2014) and the National Institute for Health and Care Excellence (NICE, 2014, 2015).

- The majority of GP practices held Gold Standard Framework meetings and registers. These multidisciplinary meetings, were used to discuss any potential patients nearing the end of their life, and to assess and plan in advance who may need additional support.
- The speech and language team had care pathways that were evidence based and reviewed annually. Team members contributed to research carried out by a local. During team training days, staff provided feedback to their colleagues on the training they had done and shared any information about new practice or initiatives, for example the key working of staff with children with elective mutism.
- Health visiting teams were updated on new practice or ongoing issues (for example recent advice from the Department of Health on vitamin D deficiency) with a 'Care and Health Infant Feeding' newsletter every month. Staff gave advice based on recent training and shared learning, for example explaining the use of paracetamol for infant pain relief and also the latest guidance on clusters of sneezing and yawning in babies. Staff were also observed giving evidence based advice on the leaving of weaning to six months to reduce allergy risk.
- The family nurse partnership produced an annual report that provided data collected covering a range of outcomes. This produced action plans to support the increase of breastfeeding, increase smoking cessation, decrease alcohol and drug use and increase awareness of contraception to decrease the chances of future unplanned pregnancies.
- The provider had achieved accreditation to Unicef Baby Feeding initiative in 2014. The accreditation lasts for three years and was due for reassessment in 2017.
- The Lifetime service had a group of staff who worked as an "in-house" research group, reporting back to the larger team on developments and initiatives.This included work with a local university completing research into
- School nurses used national health promotion guidance and literature to promote healthier lifestyles for children and young people they spoke with in schools and colleges. For example regarding ceasing smoking.
- The sexual health service followed the Faculty of Reproductive and Sexual Health (FRSH) guidelines. Staff were aware of the guidelines produced by the) and used these as a resource when reviewing policies and procedures.
- The recently appointed epilepsy nurse in Bath and North East Somerset had reduced the caseload of the epilepsy monitoring service from 90 to 62. This had been achieved by working with GPs to take over the monitoring of service users who had not had a seizure in over two years. This allowed more in-depth reviews for service users who had more complex presentations and for the service to be more responsive to changes in presentation.
- Practitioners were trained in positive behaviour support and used this model to work with people who presented complex behavioural issues. This had been successful in preventing people being placed out of area.

Pain relief

- Pain assessment and management was integral to patient care and treatment. However, services within the community did not consistently document care and treatment about how patients' pain was assessed and managed.
- Despite this all patients we spoke with commented that they had their pain well managed and were able to get analgesia when requested or required.
- Pain and symptom relief was prioritised in the treatment and care of end of life patients. Anticipatory medicines were prescribed to all end of life patients and stored in patients' homes so they were readily available when required.
- Patients who attended the Minor Injuries Units, when triaged were assessed for pain as part of that process using recognised tools to assess the pain, and were offered analgesia if the pain was significant.

Nutrition and hydration

- The malnutrition universal screening tool (MUST) was completed as part of the standard nutritional risk assessment for patients. During home visits community staff we heard asking patients about their appetite and

Are services effective?

Good

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

how much they were able to eat and drink. Regular healthy meals in relation to maintaining blood sugar levels within acceptable limits were discussed with patients with diabetes.

- In South Gloucestershire there was a nutrition and dietetics service which provided a patient focussed service to GPs, offered outpatient appointments and offered advice to multidisciplinary rehabilitation teams. In Bath there was an adult speech and language therapy service providing support to advise, assess and care for adult patients with communication and/or swallowing difficulties. Although the team was based in Bath, they also provided services to patients in South Gloucester and North East Somerset.

Use of technology and telemedicine

- Community nurses were able to photograph wounds to assess progress or deterioration of wound healing. It also allowed them to discuss treatment options with colleagues to ensure best care and/or make referrals to tissue viability specialist nurses. Allied healthcare professionals in the 'neuro and stroke' team, also used video recordings to assess the effectiveness of treatment.
- Community services used telehealth/telecare on occasions. This was usually on discharge from hospital to help patients stay at home for longer. Telehealth systems allowed long distance patient/clinician contact and care, advice, reminders, education, intervention and monitoring.

Approach to monitoring quality and people's outcomes

- The approach to monitoring quality and peoples outcomes varied. Whilst outcomes were effectively measured in some services, some other services described collective outcome data as difficult to measure. Where it was collected, outcomes were used to improve performance. The board had oversight of this within the quality reports received.
- For example, outcome measures in relation to pressure ulcer prevention and management demonstrated a reduction in the incidents of pressure ulcers of 17% in 2015/2016 and a reduction of grade three and four pressure ulcers by 43 % following an extensive training programme for staff.

Outcomes of care and treatment

- Sirona participated in a number of national audits such as 'National COPD audit: 'Pulmonary Rehabilitation: Steps to breathe better' (2015), National Audit for Intermediate Care (NAIC) and Sentinel Stroke National Audit Programme (SSNAP). Internal audits included audits for compliance with infection control, quality of records and others. The service also participated in audits in cooperation with a local NHS trust, such as reporting on traceability of blood components which forms part of the Blood Safety and Quality Regulations (SCQR) 2005, which require assurance that all blood and plasma components are traceable from donor to recipient.
- All three community hospitals benchmarked as part of the national benchmarking for community hospitals. Although not all hospitals in England partook in this study it allowed the hospitals to compare how they were performing against the vast majority for the modified barthel score (a measure of performance in the ability to perform day to day activities). Results were better compared to the recorded England average for the vast majority of patients audited.
- The sexual health service reported data through the NHS sexual and reproductive health activity data system. This consisted of anonymised patient level data which was submitted annually providing a rich source of contraceptive and sexual health data for a range of uses from commissioning to national reporting. Whilst the data was submitted annually, the service collated the data monthly to identify local themes and trends in patient outcomes.
- Supporting patients to be in their preferred place of care at the end of life is part of national strategy (Department of Health, 2008, Leadership Alliance for the Care of Dying People, 2014). This was monitored by Sirona and reported back to the local CCGs. Between April 2016 to September 2016 240 patients had been in receipt of end of life care by Sirona staff at the time of death. Of these, 89% of the patients living in South Gloucestershire, and 96% of patients living in Bath and North East Somerset had received care in their preferred place of choice.
- Audit outcomes were discussed in quality meetings at a local level and also featured in quality reports received by the board. Patient outcomes were also reported back to the two clinical commissioning groups
- There were low numbers of unplanned re-attendance at the minor injuries units. In the period from April to

Are services effective?

Good

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

September 2016 the average number of patients re-attending at Yate was 1.8% and at Paulton, 2.2% against a key performance indicator for the units for fewer than 5% of patients to re-attend the unit within seven days.

- However, whilst a number of the community services reviewed their caseloads for details of admissions to hospitals and the reasons why, there was not an organisation wide system that captured this information. Emergency care practitioners helped avoid hospital admissions in most cases but there was no organisation wide data to support that assurance and capture the effectiveness of the service.
- There was also limited auditing of outcomes in place in the Community Children's Health Partnership . Sirona had only been providing services as part of this partnership for six months, and this was only as part of a 12-month interim contract. The main focus had been on ensuring a smooth transition of the service and continued delivery of services to the service users.

Competent staff

- Staff had the skills, knowledge and experience to deliver effective care and treatment. Registered health care professionals had the qualifications required for their role and health care assistants were supported to gain the skills that was required to undertake the tasks asked of them.
- Staff received appraisals and supervision from their line managers and nursing staff were supported with the revalidation process. Revalidation for nurses was introduced by the nursing and midwifery council (NMC) in April 2016. Staff were supported through training sessions to support portfolio development, via their annual appraisal and it was also included supervision. The overview of revalidation was held centrally by the human resources team and locality managers received notification to enable them to support staff with the process.
- Staff were encouraged to develop their skills but there was not a consistent approach for managers to hold an overview of the competence of individual staff. This varied between teams and was often reliant on local managers knowing their teams. For example, competencies work books had been developed and used by the Keynsham and The Hollies rehabilitation teams but this was not rolled out across the whole organisation.
- Competence checking formed part of the recruitment and induction process. New staff we spoke with felt well supported during their induction and felt appropriately supervised
- Where needed, there were systems in place for supervision, support and training to be provided from other specialist providers, for example the local hospice provided end of life training and support whilst the sexual health service obtained support from a local NHS trust.

Multi-disciplinary working and co-ordination of care pathways

- Staff were extremely positive about multidisciplinary working across the organisation and there were positive examples off effective delivery of care as a result. We observed positive and effective relationships with local hospitals, GPs and specialist services outside of the organisation.
- There were clear referral pathways in place that minimised the numbers of inappropriate referrals.
- Processes known as the community hospital 'SAFER' patient flow bundle were introduced for all patients to improve the journey of patients when they are admitted. This bundle ensured all patients had an expected discharge date within 72 hours of admission, had regular and well recorded consultant ward rounds, were discussed by the multidisciplinary team twice a week, and had an aim to be discharged before midday. The 'SAFER' bundle also set out the processes to ensure flow through the community hospitals. Processes included appropriate circulation of capacity to the acute hospitals before 9am, to provide an update by 11am (to discuss allocated beds, remaining capacity and predicted discharges over the next 24 - 48 hours), internal feedback to managers by 12pm and an end of day report being sent to local providers by 4pm.
- However, there were no facilities for the consultant psychiatrist in Bath and North East Somerset to complete physical health checks or for other staff to complete them before medication reviews. The consultant had to ask the service users to visit their GPs before the medication review to get basic observations such as height and weight completed.

Referral, transfer, discharge and transition

Are services effective?

Good

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

- There were clear and effective processes for staff to communicate between teams and when referring patients to other teams or services including GPs.
- Community rehabilitation teams worked with hospital discharge teams to support patients coming home who may need some extra support for up to four weeks at which point they should either be independent or require a package of care for ongoing support.
- The organisation was experiencing growing pressure from the combination of increasing volume and acuity of demand for community health and social care services. These pressures were observed in the extended length of stay and the numbers of delayed transfers of care. St. Martin's Hospital and Paulton Memorial Hospital had their capacity limited due to delays in patient discharge. Between 10 April 2016 and 29 September 2016 there were a total of 328 patients whose discharge had been delayed resulting in a total of 1331 bed days (an NHS unit used to quantify the availability or use of beds over time) being lost. Of these bed days 120 were lost due to the internal factor of awaiting further therapy. However, 97 days were lost due to patients awaiting funding, 485 days were lost due to patients awaiting assessment and 351 days were lost due to patients awaiting social services input. In the week of the 29 September 2016, the discharge of 12 patients at St Martin's Hospital had been delayed by more than 28 days. During the inspection we found that one patient had been waiting 40 days for social care placement.
- Staff worked together to assess and plan ongoing care and treatment in a timely way when people were due to move between services and there were appropriate arrangements to transfer patients in both emergency and non-emergency situations from the minor injuries units.
- District nursing teams actively supported end of life patients who chose to receive care at home. Staff confirmed that a lack of care agency staff (external) could delay the start of a patient's discharge and care package, and this was particularly problematic during holiday seasons and within rural areas. However, in practice the district nursing teams, working in partnership with local hospices frequently filled care gaps until care packages could be sourced in order to ensure patients were in their preferred place of care. The organisation, along with commissioners were in the process of reviewing the provision of these services.
- Staff worked together to assess and plan ongoing care and treatment when families or children moved between teams or services. There were clear protocols for referrals and for the discharge of children and young people.
- The 'looked after children' (LAC) nurses worked with young people up to the age of 21 years and staff used a "health passport" developed in conjunction with Barnardos and approved by the Children in Care Council.
- The Bath and North East Somerset speech and language team provided transition reports for people with autism who were moving into further education or going on to university. They also provided "communication passport" documents for children to use to help themselves integrate into their new environment.
- The Lifetime service had a structured formal process for preparing children to transfer into adult services that began at fourteen. This was based on the Nation Service Framework for children transition guidance produced by the Department of Health. Transition plans were also regularly reviewed and updated.
- The sexual health service worked closely with the department of genitourinary medicine at the local acute NHS trust. They referred patients to the department if they were not able to be treated at the clinic. Referrals could be made and advice received from the emergency gynaecology team at the local acute hospital for patients who were experiencing gynaecology complications.

Availability of information

- The organisation's policies and procedures were all available on their intranet system and staff were aware of where to find them. Staff were able to access the information they needed, to deliver effective care and treatment.
- The provider used two different electronic care records' system depending on which clinical commissioning group the team belonged to. The system used in South Gloucester was shared with the GP and enabled health care professionals to share information about patients' care and treatment with the patient's consent. The other allowed access to notes made by members of the community team but not GP or other health professionals notes.

Are services effective?

Good

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

- Within the community hospitals, all of the information needed to deliver effective care and treatment was available to staff in a timely and accessible way. Risk assessments and care plans were all stored at the end of the patients bed which ensured easy access for staff providing the care. Patient case notes were stored on the ward though following discharge care records were sent to Paulton Memorial Hospital for storage. However, these notes were not easily retrievable therefore a new set of notes was created for each admission and were joined with the old set at a later date. Staff said this disrupted joined up care and consistency between services.
- Test results were available on computer systems for authorised staff to access. However at St. Martin's Hospital there were only three computers on the ward which were often in use, making access difficult.
- Sirona's IT system was compatible with the systems used in the majority of GP practices and with the hospice based in Wiltshire. The district nurses had passwords for the surgery they were linked to and could access the IT system remotely. This enabled primary care and the district nursing teams to share and have immediate access to information.The district nursing teams updated patient contact information onto the IT system promptly and we observed when a GP was not available to talk with in person, this was achieved with IT messages.

Consent

- Community team leaders spoke with confidence about assessment of a patient's mental capacity and the challenges that could present if patients chose to ignore advice about their choices. A multidisciplinary approach was used to determine if a 'best interest 'meeting should be held. 'Best interest' meetings were held when a patient lacked mental capacity to make specific or significant decisions for themselves.
- We observed staff obtain verbal consent before care or treatment interventions and we reviewed care records and found that it was documented within the care records that consent was obtained.
- The provider had a corporate policy to support staff with issues relating to deprivation of liberties (DoLS). Registered managers and locality managers understood about deprivation of liberty safeguards and were knowledgeable about the policy and processes to follow. Staff understood what DoLS meant and that they needed to be aware of this when visiting patients in care homes.
- Additional consent procedures and resources were available and followed by staff where appropriate with end of life patients. These included guidance on: the process for making decisions with adult patients with serious medical conditions, and advance decision to refuse treatment policy. We saw these also followed national policy and guidance (NHS improving Quality Team, 2008, NHS End of life care programme, 2013).
- Staff were aware of the obligation to gain consent prior to taking photographic evidence of, for example, wounds however, there was not a consistent approach or knowledge regarding type of consent required. Some staff would ask for written consent whilst others asked for verbal consent and documented this in the electronic patient records. We reviewed the provider's consent policy which stated that expressed (written) consent must be sought if photograph or video recordings were used for any other purpose other than for assessment and treatment. This was also in line with the Department of Health's (2013) guidelines on obtaining consent.
- Staff knew about the importance of obtaining valid consent from patients or an appropriate adult in the case of children, but both staff and the organisation were not always clear about consent for people who could not make their own decisions. The patient record system within the minor injuries units required staff to document that they had asked for, and been given permission to, carry out examinations or provide treatment to patients. Staff knew how the nature of care and treatment provided by the minor injuries units meant verbal or implied consent was satisfactory, and written consent was not required. However, some staff were not entirely familiar with the way in which consent was handled for people who could not make their own decisions. Some staff talked about other adults providing consent for a patient living with, for example, dementia, and not able to decide for themselves. Equally, the audit examining consent in patients' records included the question: "has the service user (or carer/family member if more appropriate) continued to consent over time." There are very limited circumstances (legal arrangements) in which one adult might give consent for another adult, and staff admitted

Are services effective?

Good

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

these were not the circumstances they were relying upon. If a patient cannot give their own valid consent, staff are able to act in their best interests, providing they consult with a carer or an advocate for the patient. These people would be able to speak for the patient, but this would not amount to giving consent.

- There was a good understanding of consent as it related to children and young people, although some staff were not entirely clear about the implications of the age of a child. Most staff, although not all, were aware of how young people aged above 16 were presumed to be able to give their own consent, unless staff felt they did not have the maturity to do so. For children under the age of 16, most staff knew they could decide if the child demonstrated sufficient maturity to give their own consent. However, some staff thought there was a lower age limit, which is not the case. When a child was deemed not sufficiently mature to provide their own consent, staff would seek consent from the child's parent or legal guardian.

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

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

Outstanding ☆

Are services caring?

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

Summary of findings

- People were respected and valued as individuals and were empowered as partners in their care.
- Feedback from people who use the service, those who are close to them and stakeholders was continually positive about the way staff treated people.
- Staff were described as going the extra mile and the care people received exceeded their expectations. Relationships between people who used the service, those close to them and staff was strong, caring and supportive
- Throughout, people were provided with care that was dignified, respectful and compassionate. Staff took people's personal, cultural, social and religious needs into account.
- People were active partners in their care. They were supported to manage their illness whenever possible and were involved in all care decisions.
- Staff adapted how they provided end of life care to fit around people, so that at all times, people were involved as much as they wanted to be and were treated with dignity and respect. Staff skilfully balanced humour, honesty and compassion with each situation.
- People and those close to them were given appropriate and timely support and information to cope emotionally with their condition.

Our findings

Dignity, respect and compassionate care

- Staff took the time to interact with people who use services and those close to them in a respectful and considerate manner. We received comment cards which were consistently positive.
- Staff ensured people's privacy and dignity was always respected. This included during physical and intimate care.
- At Thornbury Hospital staff explained the difficulties when managing difficult conversations in a cramped ward and said that they would go to the lengths of moving other patients away when they wanted to have a sensitive conversation with a patient.
- Patient led assessment of the care environment (PLACE) allow organisations to see how well they are meeting the needs of the patient and to identify where services can improve. We found that for privacy and dignity St. Martin's Hospital scored 82.9%, Paulton Memorial Hospital scored 93.5% and Thornbury Hospital scored 80.1%. Only Paulton Memorial Hospital scored above the national average of 86 %. The challenges at Thornbury hospital were well known and understood, and the issues affecting the privacy at St Martin's hospital had been addressed during the recent refurbishment.
- We received consistently positive feedback from patient and their relatives.
- Between April 2016 and September 2016 the community hospitals had received 269 friends and family responses with 99% of these recommending the service. The service consistently received a plethora of compliments and cards from patients and their relatives showing their appreciation for the care given. Between April 2016 and September 2016 the hospitals had received 103 recorded compliments.
- Feedback from patients and those people close to them overwhelmingly reported end of life treatment and care was provided sensitively, compassionately and with dignity and respect. When asked to describe the level of satisfaction with end of life care provided by the district nursing team, the most commonly used word was "exceptional". Comments from patients and relatives included: "Exceptional care. It made me feel I was lucky to live in this country and have this wonderful service provided" and "Timely, caring, and respectful, it was absolutely personal. He wasn't a patient he was a person. Thank you so much". End of life care patients and their families were always given priority. Patients and relatives repeatedly expressed how grateful they were for the staff supporting them during what was often the most sensitive, difficult and personal of experiences. Other professionals external to Sirona told us they were very impressed with the standard of end of life care provided. GPs and other medical staff told us they would want their own care or their relatives' care to be supported by Sirona services.
- Within the minor injuries units, staff respected people's confidentiality, by, for example, not asking them personal questions when other people could overhear. Patients were not required to share their confidential or private information with the reception staff if they did

not feel comfortable to do so. Chaperones could be provided if a patient or a relative/carer requested it. Patients were told they could have a chaperone with them, and a member of staff would be able to accompany the patient should this be required. Nursing staff made sure patients were comfortable with being treated by members of the opposite gender. There were also positive results from people who used the services when asked to complete the standard NHS Friends and Family Test. In the six months from April to September 2016, 99% of people who attended the Yate unit said they would recommend the service. The response was from 915 patients. Paulton reported slightly differently, so in the period from July to September 2016, 98.3% of people said they would recommend the unit. The response was from just under 250 people. In all of the community hospitals every patient was given a computer tablet prior to discharge to complete the friends and family test on. We saw results from the friends and family test for the last 12 months and found them to consistently be 100%.

- In the community hospitals family and other people close to end of life patients were treated with kindness and compassion. Comfort cards were given to visitors during the last days and hours which conveyed a sense of kindness and respect. The cards suggested visitors could lie on the bed with the patient, sit close and hold hands and to stay as long as required. We were told whenever possible patients were offered side rooms which provided increased privacy.
- Within the learning disabilities service, service users told us that staff were supportive and caring treating them with dignity, respect and kindness. Feedback was very positive. Service users felt that staff listened to them. Carers commented that staff were interested in them and the service users as people. Staff displayed warmth and genuine interest in people using the service. This was evident in all staff within the teams. For example, administrative staff greeted service users in a friendly manner and asked if they wanted hot drinks on arrival that they would then prepare. Staff spoke about service users respectfully and in positive terms in team meetings and with other professionals. In clinical sessions, staff showed empathy and compassion to service users' needs and situations.
- We observed health visiting staff interacting with expectant mothers using a respectful and compassionate approach. All staff we observed at the Cadbury Heath Health Centre and Kingswood Hub were courteous and sensitive to the children they were seeing, as well as their parents. Staff took the time to communicate and interact with the children they were seeing, and provided reassurance and support to children and their parents.
- The family nursing partnership nurses had received 'compassionate minds' training from an external psychologist. This enabled them to have a greater understanding of compassion and how to introduce this into a clinical relationship.
- At the sexual health clinics the doors to the consulting and treatment rooms at the main clinic all locked from the inside so that no other patient could enter. Staff could enter with a key fob but we observed they always knocked at the door and said their name prior to entering. The windows to the treatment rooms were occluded. There was a curtain drawn around the examination couch during any procedure to further provide confidence of privacy and dignity. This ensured young people felt safe and that their dignity and privacy was respected.

Patient understanding and involvement

- Patients were routinely involved in planning and making decisions about their care and treatment.. On all visits we observed patients being included in discussions about their care and treatment, where applicable relatives and carers were also involved. There was a strong emphasis on patient-centred care but staff also recognised and respected the totality of patient's needs and took these into account.
- Community teams assessed patients in vulnerable circumstances and offered advice about support. They acted as advocates to help patients make decisions about their lifestyle when this impacted on their wellbeing. We saw examples of visit times arranged to suit the circumstances of individuals. Care was delivered in a non-judgemental manner which respected the individual's choices even when these had a negative impact on the patient's wellbeing. Nurses spoke with confidence an about individual's right to make choices about their care and about assessing patient's mental capacity to make choices about their life. Nurses demonstrated that patient's emotional and social needs were highly valued. This clearly informed their approach to patients and was embedded in the care offered.

Outstanding ☆

Are services caring?

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

- We saw clear evidence that patients were active partners in their care. Patients were supported to manage their illness whenever possible; for example a patient was supported to administer their own medication with the support of a district nurse to ensure they took the right dose of insulin.
- At St. Martin's Hospital they had a side room which had space for a second bed. This allowed a relative to stay with a patient when they were coming close to discharge to trial independent living. This process fully involved the carers and relatives of the patient and increased their confidence. If necessary, they were still able to call on the nurses for assistance.
- All the patients who were or had received end of life care and other people close to them spoke very positively. Comments included: "I know and trust the staff, they are interested in us and our lives" and "I have nothing to say other than praise. I feel I have been provided bespoke care, it has been made to fit around what me and my family want and need". Other people told us: "They always explained what they were doing and always asked if it was ok to do things" and "We were kept fully informed as things progressed, but in a careful and kindly way" and "They were ready to answer any questions we had. They were very professional. I don't think things could have been any better than the way they were handled".
- Other comments, repeated by several patients and family related to how much they valued the relationships with staff and the care received. This was felt to have far exceeded expectations and to be integral to patients fulfilling their hopes and plans for how they were cared for and supported. One person said: "They were exceptional. We were extremely lucky and happy to have such a team". There was a visibly strong person centred culture of working with end of life patients. Using regular discussions and open ended questions, patients were sensitively supported to identify their own needs. Staff provided care in personalised ways to suited individual circumstances. This was achieved and demonstrated with a real understanding of what was important to patients and families and by respecting choices, views and feelings. One person told us: "The care plans took into account all information given by my family. This reflected the level of all round care given".
- We observed staff adapted how they provided end of life care to fit around people, so that at all time, patients were as involved as much as they wanted to be and treated with dignity and respect. Staff skilfully balanced humour, honesty and compassion with each situation. One person told us: "we were all included from the word go. Everything was out on the table and could be discussed". Another person said: "My father was able to make his own choices and we were all listened to".
- Within the minor injuries units, staff recognised when a patient or their relative needed more support to understand and be involved in their treatment. Staff recognised a person who had hearing problems, and spoke with them more slowly and clearly. Staff also said they would recognise if a person needed help to get into the unit safely, or had any disabilities or impairments. They would generally support these people to safely move from the waiting room, and had been out to a patient's car to help support them to get safely into the unit.
- Staff made sure they knew the identity of any person attending with the patient and ensured any private information was only shared with them if the patient was happy with that. We observed one of the nurses check with a patient if the person accompanying them was their spouse and they were happy to talk in front of them. They also checked with the spouse if they were happy to remain with the patient.
- Within the learning disabilities service, people were involved in setting out the care plan and where this was not possible, family members or carers acted on their behalf. Whilst the majority of care plans considered what people identified as their needs, five care plans viewed in Bath and North East Somerset were generic in nature and lacking a person centred approach.
- People who used the learning disabilities service were involved in the recruitment of new staff for the service. Those involved in the process were very clear that they felt listened to and valued by the organisation in that process. Other people who sued services and carers described meet and greet sessions that gave them the opportunity to meet new staff. Although there were no formal participation groups, the service tried different methods of engaging with people to help shape the service. For example, in South Gloucestershire the provider had employed the services of a third sector organisation to provide an event explaining what the services provided to people and then to ask how they could be improved. These were led by people with a learning disability who felt supported and empowered to lead on this work. Further events were being planned.

Outstanding ☆

Are services caring?

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

- Within the children's and young person's service, staff took the time to explain and involve parents in all the discussion around care and support that were available. Staff used a variety of tools to support the effective delivery of information which was adapted to suit different ages and needs. These included activities, games, diagrams, animations and models. After delivery of information, staff were seen to repeatedly check understanding with young people.
- In the sexual health clinics the staff provided information to patients in the written format and verbally during their clinic visit. This information included treatment options and patients were encouraged to share their views and opinions on their preferences. This was in accordance with national recommendations contained within the NICE QS 15. This quality standard covers improving the quality of the patient experience for people who use adult NHS services.

Emotional support

- Patients were given appropriate and timely support and information to cope emotionally with their condition. Patient's emotional and social needs were highly valued by staff and embedded in their care practices. Staff planned their visits to enable patients to attend other commitments for example a district nurse left the base office early to ensure that they could visit a patient before she went out. Another nurse had carried out their first visit on the way to work in order to administer insulin so that the patient could have their breakfast at their preferred time. In another example a health visitor working for the Active Ageing Service helped a client set up a tablet computer to enable them to talk to their relative in Australia to the delight of both parties.
- Working in partnership for patient's wellbeing – both in terms of their physical and emotional needs, was embedded within the community services we observed. We saw that emotional support and information was provided to those close to the patient as well as to the patient. For example, the frailty team, through a regular multi -disciplinary meeting, discussed the impact of patient's circumstances both on the patient, but also the carer. There was evidence of strong positive relationships with carers as well as patients receiving services from the frailty team. The team were highly motivated to achieve a holistic, effective service for its patients, and clearly cared about the "whole" person.
- At Thornbury Hospital we observed a patient deteriorating and feeling light headed. We observed the calming and reassuring way the were treated. It was clear that the staff reduced the patients anxiety during a stressful time.
- We were told by all the patients and people close to them that emotional support was offered and provided whenever required. For example, one person said: "I feel safe and looked after and all the district nurses have been superb", "I know if I ring the district nurses will be here. The consistency is just amazing, they remember us and our situation, it feels personal, like they are genuinely invested in our family" and, "We want him to stay at home. The nurses have always come quickly when we needed them. I really feel like the nurses are listening to what I'm saying. It's given us the confidence to believe as a family we can do this."
- Staff recognised feelings of anxiety and offered additional support. This ranged from extend and/or additional visits with patients and families to discuss concerns and referrals to others such as counsellors, chaplains and GPs. Spiritual needs were routinely assessed and discussed as part of patients' care plans. Where required, appropriate actions were taken.
- Nothing was viewed as too much trouble by staff when trying to support the hopes and wishes of patients and families, regardless of lack of time, workload or obstacles. For example staff worked to enable the partner of one patient wished to attend a family wedding through increased care and support during their absence whilst another end of life patient (in hospital) talked about their love of fish and chips. Staff promptly purchased these for the patient (and others on the ward) in recognition that although the patient could no longer eat, the smell was evocative of past positive memories.
- The school nurses supported young people with mental health issues and were able to refer or signpost them to relevant specialist services when needed. We observed one young person attended a school clinic in a distressed state and the school nurse was calm, kind and showed empathy for the young person.The school nurses had also introduced a cognitive behaviour therapy model into primary schools which had included working with whole classes to reduce anxiety amongst the children.

Promotion of self-care

Outstanding ☆

Are services caring?

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

- There was support available for people to manage their own health and maximise their independence. Staff had a number of services to which they could signpost people to provide either emotional support, or more appropriate specialist support. For example, smoking-cessation services, drug and alcohol support groups, domestic violence helplines, charities and other support organisations.

Good

Are services responsive to people's needs?

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

Summary of findings

We judged the responsive domain to be good because:

- Services were planned and delivered to meet the needs of the local communities
- The equality and diversity needs of people who used the services was met at all times.
- Services were planned, delivered and coordinated to take account of people with complex needs and those in vulnerable circumstances.
- There were different approaches to ensure access to the right care at the right time for most people
- There were systems and processes in place for handling complaints and sharing learning as a result. A dedicated customer care service had been established to ensure the smooth handling and follow up of all complaints and concerns, no matter how they were raised.

However

- Waiting times for some services exceeded the NHS England targets of 18 weeks from referral to start of treatment
- The minor injuries unit in Yate, although providing the service it had been commissioned to deliver, was not able to meet the demand from patients at times. This resulted in frequent early closure of the service.

Our findings

Planning and delivering services which meet people's needs

- Services were planned and delivered to meet the needs of the local communities. Staff within the community adults service spoke with passion and enthusiasm of services that they had been instrumental in developing with the support of the clinical commissioning groups (CCG) for South Gloucester and Bath and North East Somerset.
- Teams carrying out home visits attempted to book appointments to suit the patient where possible. Different teams worked together to ensure patients received the most appropriate care at the most appropriate time, eliminating the need for multiple appointments or visits.
- Emergency care practitioners in the South Gloucester area (they did not provide this service in the Bath and North East Somerset area), took referrals from a number of sources in order to try to avoid hospital admissions. Calls were often directed to more appropriate services and the rest visited to assess the patient and provide appropriate care and support within a one hour response time.
- There was an orthopaedic interface service to provide an assessment for patients who had concerns or symptoms of a musculo skeletal nature. The aim of the service was to assess patients who would otherwise be sent to a hospital setting for surgical intervention. Patients waiting times were reviewed weekly and the average waiting time was six to eight weeks.
- A service in Bath and North East Somerset facilitated discharge of patients, who had had a stroke, from a nearby NHS hospital within seven days of admission. The multidisciplinary team facilitated up to four daily visits to help patients regain as much independence as possible following their stroke. Patients' needs were assessed and planned with the patients who set their own goals and next of kin and/or carers were also involved in the process. The service had a quality target set by commissioners to facilitate discharge for 50% of patients admitted following a stroke; the achievement of the service exceeded this target and achieved discharge within seven days for 54-80% of patients admitted to hospital.
- The team of tissue viability nurses provided care and treatment for patients with complex wounds. They received referrals from district nurses and arranged joint visits with them to advise, agree a treatment plan and provide supervision of treatment carried out by the district nurses. In addition to this the team was also commissioned to facilitate two days a week for patients in nursing homes in Bath and North East Somerset. This service included teaching staff in nursing homes about the prevention of pressure ulcers.
- The 'parkinson's disease' clinic had a multidisciplinary approach to support patients diagnosed with Parkinson's disease. The service offered advice and support, undertook falls risk assessments and offered 'balance' exercise classes.
- Some of the specialist services operated in more than one location in order that ambulant patients attending these services had less travelling to access them. However, the intravenous and blood related treatments

Good

Are services responsive to people's needs?

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

provided could only run where two nurses were available. At times of sickness, annual leave or training, the clinic could not run. There were no plans to address this shortfall.

- At St. Martin's Hospital there were eight designated stroke beds which provided step down rehabilitation for the local acute hospital. These beds were managed by a stroke clinical nurse specialist and had two consultant ward rounds each week. Within the community hospitals, adjustments had been made to improve wellbeing for those living with dementia. At the hospital, reminiscence was encouraged through a memory group. Other activities included a balance group, painting group, gardening group, and a knitting group
- The end of life service lead worked with commissioners to plan and deliver services to meet the needs of the local population. Sirona staff attended the commissioners' end of life meetings and commissioning priorities were incorporated into Sirona's end of life work plan and overall strategy. Sirona staff also worked proactively with other services to meet the needs of end of life patients and those close to them. For example, a working group was convened specifically to review discharge processes. In the community hospitals, visitors to end of life patients were permitted on the wards at any time. Snacks and drinks were available and recliner chairs were provided for those who wished to stay for extended periods or overnight.
- The services of the minor injuries units met the clinical needs of patients and what they had been established to deliver. The service was commissioned to provide an alternative for local people rather than seeing their GP, and for local people and visitors to the area attending an accident and emergency department for minor injuries. The hours of the service at the Paulton unit were longer in the week and more extensive on the weekends than the Yate unit. This reflected the unit being in a more rural location and 30-45 minutes from the nearest accident and emergency department . However, the services the Paulton unit provided were not made entirely clear to patients on the organisation's website as they were also for people with minor illnesses. This was not mentioned on the Sirona website and two of three people we asked at the service were not all aware of the minor illnesses service. The standard operating procedures for the Paulton unit were also not clear in relation to what minor illnesses would be treated.
- The amount of space provided for the minor injuries service in Paulton was not always ideal. On a weekday, the service shared the area with a number of other services, including local NHS outpatient clinics, physiotherapy clinics, the fracture clinic and a doctors' urgent care service. The unit had only one dedicated clinic room, and its other room was shared with the other services when required. This was being managed by the staff as much as possible, but it limited the amount of patients that could be seen at times.
- Although there were X-ray facilities at both minor injuries units (provided by a local NHS trust) facilities were not open across the same hours as the minor injuries units. This meant patients had to return to the unit at the next opportunity, or were referred to another service if the situation was more urgent.
- There were telephone-based translation services for people who had no or limited English. Staff were aware of the service and how to access it. There was also a system within the Sirona intranet to produce their leaflets in another language for patients
- The Bath and North East Somerset health visiting service provided the nationally prescribed four levels of care including the "universal provision" and "universal partnership plus". There was a family nurse partnership scheme in both the Bath and North East Somerset and the South Gloucestershire areas.
- An "early days baby feeding circle" pilot was jointly run with the community midwife service. This had been set up to provide extra support for women experiencing breastfeeding problems. They aimed to develop a service that met the UNICEF Baby Friendly requirements.
- The Lifetime service provided support, care and advice to children and their families with life limiting illnesses and conditions.The service was planned to effectively meet, as comprehensively as possible, the needs of the families and children that accessed the service. At the time of our inspection there were approximately 250 children, and their families, receiving some form of service from the Lifetime team. The service had a team of nurses and psychologists who worked with the children and families and also a team of care assistants who provided direct care and support in the child's home. The service covered a wide area, reaching into five different clinical commissioning groups areas. It also provided support groups for siblings and additional activities during school holidays as well as transition

Good

Are services responsive to people's needs?

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

arrangements for children who were moving into adult services. Guidance was provided for working with children and families experiencing grief and there was written material available for staff to share with families dealing with bereavement. The service continued to provide bereavement support to families for a period of eighteen months if this was asked for. There were clear written guidelines around this support which also ensured the family were provided additional information around any other support services they needed. Staff also ensured that the families had prompt practical help with the removing of equipment from the family home.

- As part of Community Children's Health Partnership, Sirona worked with a charity in developing a participation strategy. This strategy outlined how children, young people and their families could be involved with service feedback, development and improvement. Regular meetings took place between Sirona's leadership and service users. These meetings provided a forum for feedback and learning so Sirona could develop their services with the service user's voice included.
- The sexual health clinic at the Riverside Health Centre was located in the centre of Bath, near public transport routes and public carparks which enabled easy access for patients. The clinic was open five days each week closing on Wednesdays and Sundays. Times of the clinics varied providing both walk-in and booked appointments with one evening open until 7pm. Patients spoke positively about the convenience of attending a walk-in. Those that had made an appointment expressed there had been no problems in getting through to book the appointment and that they had been provided with a date and time promptly.
- Within the learning disabilities service there was a range of well-presented easy read formats which were sent to service users and carers on referral. However, these were not available in the waiting areas. In Bath and North east Somerset staff had a communication passport in a grab bag that they carried with them to all new assessments. It had an introduction with "my name is…." and a photograph. The bag also contained photographs of other team members, locations and photos of common emotions and other key words, for example, happy, angry or sad. There were also symbol cards and a white board with a marker pen. The communication passports were designed to ensure that staff communicated with service users when they first met them before they had the opportunity to assess any communication needs. Staff created care plans in easy read format or social stories when appropriate for service users. Staff used a variety of formats including sign language, pictures, symbols and other methods of engaging service users appropriate to their needs.
- However information for service users on the provider's website was not clear. The provider had 12 different learning disability services on the same webpage that were a mix of social care and health provision. A number of services had similar names. It was not obvious which services were provided for which geographical location or the type of provision the service provided.

Equality and diversity

- Services took account of the needs of individual patients and staff spoke about the importance of not being judgemental in the way they cared for patients. Staff spoke of people's rights to choose a way of living as their preference. Reasonable adjustments were made in order to help people with disabilities or learning difficulties. For example, space was made available for those patients who required a carer to remain with them during treatment. Disabled parking spaces were available at all main entrances of the sites we visited. Sirona services at Keynsham Health centre were on the first floor and lift access was available. There were disabled toilets in all of the areas we visited.
- There were no mixed sex breaches in the last 12 months. Two thirds of bays and side rooms were for female patients to meet the demand. There were contingency plans in place to move patients into side rooms if there was a risk of breaching.
- End of life patients with particularly complex needs were effectively supported. Sirona's learning disability services had put in place action plans regarding end of life care for adults with learning disabilities. This promoted inclusion and equality and was based on evaluation of audit undertaken during March 2015 in consultation with South Gloucestershire commissioners. The learning disability services in Bath and North East Somerset had recently commenced similar work.

Meeting the needs of people in vulnerable circumstances

- Services were planned, delivered and coordinated to take account of people with complex needs and those in

vulnerable circumstances. For example, the tissue viability specialist team had produced an extensive resource and teaching pack to help staff meet the needs of patients with an increased risk of developing pressure ulcers. The resource pack included information about preventions, a pocket guide and a 'pressure ulcer prevention passport'; the aim of the passport was to communicate pressure ulcer prevention needs to all involved in the patient's care. It was developed with the patient at the centre and also included a 'tell us' card aimed at reminding patients of when to tell people (care agency, GP, district nurses, next of kin) of signs of or increased risk of pressure ulcers having occurred or changed. Staff described a patient, who lived with dementia, who attended a specialist service. Attending the clinic caused them a great deal of anxiety and she had previously attended with her daughter. Due to the relationship staff had built with the patient's daughter, they were able to review her condition without requiring her to attend the clinic, by having discussions with the patient's daughter. This provided a positive outcome for the patient.

- The frailty team specifically worked with patients whose Rockwood Frailty Score was above six indicating a moderate to severe impact of a person's condition on their ability to carry out daily activities safely. Where possible the circumstances that caused frailty were mitigated with interventions varying depending on people's needs.
- The active ageing teams and emergency care practitioners were quick to recognise people in vulnerable circumstances, referring to relevant agencies if required.
- At all three hospitals there were strong links with the organisation's learning disability service to ensure that reasonable adjustments were made where appropriate. Staff also worked with the local acute trust, and the local authority to maintain a consistent level of support between providers. People living with dementia all had a 'This Is Me' passport (a written discussion between a nurse and a patient to allow them to tell staff about their needs, preferences, likes, dislikes and interests.)
- At Paulton Memorial Hospital there were specific rooms to ensure safety and to reduce confusion of patients living with dementia. For example one bay and two side rooms had a cushioned floor to reduce the risk of harm during a fall, as well as daylight bulbs to maintain a consistent level of light during the day. Outside organisations, who specialise in dementia care, were invited into the hospital every few weeks to facilitate activities and a specially trained care dog came into the hospital to visit patients regularly.
- However, Thornbury Hospital was not meeting the needs of patients living with dementia and this was reflected in the PLACE assessments. Thornbury Hospital scored 55.3% which was significantly lower than the national average of 74.5%.
- All referrals for end of life care in the community were accepted by the district nursing teams. This was regardless of the person's age, life limiting condition, beliefs or any personal circumstances.
- The minor injuries units saw where patients might be in vulnerable circumstances, and recognised where these patients would benefit from being seen more quickly. A patient recognised or described as living with dementia, a patient with a learning disability or difficulty, a patient under the influence of drugs and alcohol, and challenging, angry or aggressive patients, were among those who may be seen more quickly. This was for the safety of the patient, to reduce anxiety for the patient, and possibly to reduce anxiety for other patients and relatives who were waiting to be seen. Staff had been trained to recognise and support patients who said or displayed symptoms of domestic violence or abuse. There were procedures to follow to help people who would agree to guidance or support being offered. There were also procedures to safeguard any children that might be part of the family group.
- The family nurse partnership service was available to a commissioned number of families in the Bath and North East Somerset area and the South Gloucestershire area. This is a service for first time mothers aged 20 or younger and provided a greater level of intervention and support than the heath visiting service. An extended eligibility criterion to include mothers up to the age of 24 years who have ever been 'looked after' or with a special educational need or disability had been launched. Visits to each individual occurred once a fortnight. However, we saw that on occasions this was increased to weekly if the family nurse considered this was necessary to provide appropriate support to the young person.
- There was both a designated nurse and doctor for 'looked after children' in the South Gloucestershire area. The details of these leads were made available to patients and carers, and were also published on the

Good

Are services responsive to people's needs?

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

community children's health partnership website. The designated leads had good working relationships with the health visitors and school nurses, as well as the local authority. They also worked closely with social workers and received regular updates about the 170 'looked after' children in the area. A small number of young asylum seekers were being cared for in the South Gloucestershire area. All had been initially assessed and were being seen on a regular basis by a community paediatrician. Interpreters were booked through the local authority in advance of any appointments.

Access to the right care at the right time

- There were different approaches to ensure access to the right care at the right time. These included rapid response and admission avoidance, 'discharge to assess' which was for patients who were ready to be discharged from hospital but may still need short term support in their own home or community setting. There was 24 hour, seven day a week community nursing service and seven day rehabilitation/reablement services up until 9.30 pm each evening, seven days a week.
- For many of the specialist services, referral to treatments times were less than one week, and in some cases was less than this. For example the rehabilitation/ reablement/ emergency care practitioners teams, depending on their remit to provide urgent care, were able to see patients within four hours of referral up to 48 hours from referral. For other services, patients were invited to contact the service to book their own initial appointment. Patients told us this worked well as they were able to attend clinics at times that suited them.
- However referral to treatment times within the musculo skeletal (MSK) service were 31 weeks at the time of our inspection. This had been identified as a risk by the team and featured on the organisational risk register. There was insufficient funding to provide any more appointments although a business plan and was undder consideration. Physiotherapy waiting times for the neurology outpatient and physiotherapy service was more than 25 weeks and as such did not meet NHS England targets of 18 weeks from referral to start of treatment. The service had only just entered this on a specialist service risk register in October 2016.
- Although the therapies staffing was at full establishment some staff said that they could not always get to the patients they needed to in a day due to the complexity and acuity of other patients they were seeing. For example at Paulton Memorial Hospitaltwo days before the inspection, six patients went without therapy, and the day before the inspection three patients went without therapy due to staffing issues. Although patients were not receiving unsafe care, they were not receiving the optimum level of therapy possible.
- End of life care in the community hospitals and within patients' homes provided by district nursing teams was provided 24 hours a day, seven days per week. Specialist end of life advice and support was accessible at all times through two local hospices.
- Priority was always given to end of life patient treatment and care. We observed during shift handovers how staff worked flexibly to prioritise patients whose needs became urgent. This included how care was planned for and during out of hours.
- Partnership working with other services and professions was embedded within end of life practice. This enabled increased ability to access the right care for patients and families when required. We saw care plans were detailed and shared as required between all services involved with the patient. Needs were reviewed and evaluated at every contact and staff used their knowledge and skills in part to anticipate needs in advance.
- End of life patients who had been assessed as requiring fast track treatment and care were supported through two dedicated services covering both local clinical commissioning areas. The assessments were completed promptly and the majority of patients achieved their preferred place of care goals (89% of South Gloucestershire patients and 96% of patients living in Bath and North East Somerset).
- Although the Minor injuries unit in Yate provided the service it had been commissioned to deliver, its capacity was not able to meet the demand from patients at all times. The service was also not systematically reporting the data for service closures through its performance report in order to gauge the extent of the issues. Closures were reported as part of the organisation's 'Safer Services' measure, but this tended to mask the issue among the other stronger areas of service provision. However, staff told us the unit had to close early "several times a week" and "most weekends". The Paulton unit had not closed to new patients for as long as the staff could remember. The weekday closures had been placed on the Sirona corporate risk register just over two years ago. The weekend issues had been raised

Good

Are services responsive to people's needs?

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

in October 2016. The problems had been discussed on a number of occasions with the local commissioners, but without any increase to service provision due to financial pressures. We raised this with the organisation during feedback and received assurance of an increased focus at monthly joint meetings with the commissioners going forward.

- In the Bath and North East Somerset area, children and their families were able to access services in a timely way for assessment and treatment. Services were appropriate and were within nation referral to treatment time targets for appointments. Services were also able to accommodate urgent appointments when these were assessed as being required. However the performance within the Community Children's Health Partnership was less positive. For example, only 89% of service users between April and August 2016 were able to access community paediatricians within 18 weeks, against a target of 95% and only 53% of new born visits had been completed within 14 days, significantly worse than the 90% target. In the Community Children's Health Partnership family nurse partnership between May and July 2016 only 60% of visits were completed during pregnancy, worse than the target of 80%. However, this was an improvement on the previous three months prior to Sirona taking over the contract where performance had only been 33%.

Complaints handling and learning from feedback

- There were systems and processes in place for handling complaints and sharing learning as a result. Sirona had changed the process for dealing with complaints by seeking to resolve issues when they were raised. A dedicated customer care service had been established to ensure the smooth handling and follow up of all complaints and concerns, no matter how they were raised. This had resulted in a reduction of 46% in complaints and an increase in the reporting of concerns by 41% in 2015 to 2016. It was normal practice to ring a person who had raised a concern to discuss the situation and resolve the concern quickly.
- The organisation's information on how to make a complaint about their service was provided in leaflet form to patients receiving services in their own homes and displayed in waiting rooms in outpatient areas and was available on wards. It was also available in easy read format and in other languages.
- Complaints and concerns were a routine agenda item at team meetings, with complaints discussed and learning shared with all staff.
- Staff discussed openness and transparency when managing complaints, regardless of the outcome of the investigation, and if the service user has been disappointed with the service, staff would always say sorry.
- All complaint responses were read by the director of nursing and operations before being signed by the chief executive. A summary of complaints and actions taken were received by the quality committee, which reported into the board.

Are services well-led?

Good

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

Summary of findings

We rated the well-led domain as good because:

- There was a clear vision and set of values in place that were developed with staff and demonstrated by staff at all levels.
- Throughout the organisation, quality and safety were top priorities and were taken into account whenever financial decisions were made.
- Progress against strategic objectives were measured through ongoing audit
- There was strong and well established leadership of the organisation. Reports received at board meetings were subject to scrutiny and challenge. Members and non executive directors held the executive team to account.
- The organisational ethos of 'taking it personally' was developed in conjunction with staff at all levels and was demonstrated wherever the inspection teams went.
- Staff were empowered to suggest change and develop their own services.
- Public and staff engagement occurred in all areas of the organisation. Patient feedback was welcomed and encouraged. Patient stories featured prominently at board meetings.
- The loss of a significant and sizable contract had just been announced. The executive team recognised the impact this would have on staff, services and the remainder of the organisation and were developing plans to mitigate risks and ensure continuity.
- A quality impact assessment was undertaken for all cost improvement programs with the impact of the saving reviewed throughout the year. Where the saving was felt to affect quality, it was not approved.
- Services were empowered to be innovative and progressive.

However;

- Though there were systems and process in place which ensured the governance and risk management of services, in places these required strengthening, most notably in relation to the management and oversight of lower level risks.

Our findings

Vision and strategy

- The provider's vision was to help 'create happier and healthier communities through working with you to achieve your goals'. There was a clear set of values entitled 'Taking it Personally' which underpinned the vision. These had been developed with the involvement of various staff across the organisation and had been recognised and given a Health and Wellbeing award by the Royal Society for Public Health in 2015. 'Taking it Personally' was described and demonstrated by staff at all levels of the organisation who were able to discuss the impact it had on patient care and what it meant to them. Taking it Personally involved patients being treated with courtesy and respect – so people felt welcome; there being effective communication – so people felt valued; staff being caring and supportive – so people felt supported; and care being effective and professional – so people felt safe. Staff were proud of the organisation and the services the teams they worked in were providing.
- Individual services had their own visions which aligned to the core vision and strategic objectives of the organisation. For example, the falls service had plans for the future which involved targeted training of staff in residential homes and the wider public and the active ageing service aimed to respond to the increasing demand on health services of older people by using a health preventative role that focussed on improving health and wellbeing outcomes of older people by looking at peoples' physical, social and emotional needs.
- Throughout the organisation, quality and safety were top priorities. This message was effectively cascaded to all staff.
- Progress against strategic objectives were measured through ongoing audit, for example changes in catering provision at Thornbury Hospital and evidence of progress against the six national ambitions (National Palliative and End of Life Care Partnership, 2015-2020).

Governance, risk management and quality measurement

- There were systems and process in place which ensured the governance and risk management of services, however in places these required strengthening. Their

Are services well-led?

Good

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

function had been subject to an external review. There was a corporate risk register where risks to performance were assessed. Actions were identified although it was not clear what the timeframe for completion always were. All risks were received centrally and then added to the risk register. However, this process was person centred, being reliant on the central team entering risks onto the risk register once raised locally. There were no formal risk registers held and maintained by services to allow the oversight and management of lower level risks. As a result, many had developed their own departmental risk register, sometimes referred to as a concerns register or even a 'to do' list. This fragmented system meant there was no formal mechanism to ensure all risks, particularly clinical risks were captured, monitored or acted upon.

- There were a number of registered managers within the organisation. Each were aware of the need for notifications directly to the Care Quality Commission in certain circumstances (for example where a Registered Manager was absent for more than 28 days or an unexpected death of a patient) but were less clear about notifying the Care Quality Commission about safeguarding alerts and other issues falling in with the requirements of the Health and Social care act (2008). As there was no central oversight of what was reported, the governance processes had failed to identify this.
- The quality committee was a sub committee of the board. Chaired by a non – executive director, this group met at least six times per year and received assurance reports from a variety of groups such as the medicines management group, nutrition and hydration group, infection prevention and control group and the adverse incident learning group. It also received the quality score card. This meeting reported directly to the board via a quality report.
- All unexpected deaths whilst in receipt of care by the organisation were reviewed jointly by the medical director and lead nurse for infection, prevention and control. These were reported to the board to ensure oversight and identify any concerns, trends or themes emerging.
- There was a clear process for the reporting of, feeding back and learning from adverse events and for the oversight of this by the board. The system was embedded and staff were confident in its use. Themes were captured and feed back shared learning occurred.
- Performance reports, scorecards and safer services reviews were used to monitor activity and support the quality reports on a monthly basis. Where concerns were identified, executives were able to request an indepth review. For example, there had been an increase in complaints relating to one ward. The ward had a review by an executive member and a member of staff from the compliance team. Issues were identified that were affecting staff, such as a lack of team meetings as well as unaddressed environmental concerns. As a result, changes were instigated including additional training and support as well as some changes to the décor. This resulted in an improved working area, a better ambiance on the ward and a reduction in complaints and concerns relating to that area.
- The board were responsible to members of the organisation, whose remit was similar to shareholders of a public company but without the financial interest. As a result, members received reports on the organisations performance thereby supporting the governance processes.There were a total of 26 members, consisting of nine staff members, five service users or members of the community, six provider members, four members from the council and two directors. Members meetings were chaired by the Chair of the organisation, and each member had a one to one discussion with the chair annually.
- Quarterly reports to the clinical Commissioning Groups included governance information related to audit, policy and staff training.
- There were strong governance arrangements in place in the Community Children's Health Partnership. An operational delivery group met monthly to discuss human resources, performance, finance and risk across the service. This group included representation from all three partner organisations, including operational managers and heads of service.

Leadership

- The board was both strong, with a cross section of skills, and stable, with most non executives, the Chairman, Chief Executive and Director of Nursing and Operations being in post since the creation of the company. We observed a board meeting during the inspection where appropriate challenge occurred.
- The organisation was sub divided into five divisions with a clear clinical leadership in place at the head who all

Are services well-led?

Good

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

met weekly with the Director of Nursing and Operations. Well respected, these leaders were given the authority to lead and develop their services to improve and enhance patient care.

- Senior and local leadership was highly visible. Senior leaders attended induction, staff meetings and visited different work areas, however there was not an organised program of walk arounds within the executive team or a systematic process for feedback on findings.
- The structure and responsibilities of directors in the organisation, whilst not seen in many organisations, worked well. For example, the director of nursing also held the role of director of operations, and the lead director for governance was the director of finance. This was possible due to the size of the organisation, and the processes for deputising.

Culture across the provider

- The organisational ethos of 'taking it personally' was developed in conjunction with staff. A group was established with a full cross section of staff. As a result, the values were owned by the organisation and commence at induction where members of the senior team join new starters for lunch. Staff described a culture where people really wanted to help each other, were open and honest and always put the patient at the heart of what they did. Staff felt valued and respected.
- Staff felt empowered to suggest change and develop their own services. For example, the customer care team had made the suggestions that resulted in the provision of a concerns line which enabled concerns to be addressed before they escalated into formal complaints.

Fit and proper person requirement

- The chairman, chief executive, three non-executive directors, the director of finance and the director of nursing and operations were all registered with Companies House as directors of Sirona Care and Health CIC. All members of the board were subject to a fit and proper person's assessment in line with the requirements of the Health and Social Care Act (2008). We reviewed personnel records in relation to this and found adequate checks had been made to provide assurance against this requirement.

Public and staff engagement

- Most staff described feeling actively engaged in the organisation. There were monthly briefings on the intranet and whist staff were concerned regarding the future following the loss of the Bath and North East Somerset contract, all staff we spoke with told us they felt the organisation was being open and honest and was keeping them fully informed.
- There was a system called 'Ask HR' where staff could contact the human resources department in working hours to ask employment questions. There was also a system called 'Ask anything' which had been set up to allow staff to ask for clarity or raise concerns regarding the future of the organisation anonymously. These were answered by senior members of the executive team, often the chief executive.
- There were services provided or signposted by Sirona for staff wellbeing. These included occupational health reviews and guidance, employee counselling services, and in-house physiotherapy services.
- Staff were recognised for their contribution to the organisation and patient care through an annual staff excellence award scheme.
- There were various processes across the organisation to capture the views of the public. In addition, the board received a 'patient story' each month. This was delivered where possible by the patient or relative themselves. These ranged from positive to negative stories and were described as another way in which the organisation kept to the values of 'taking it personally'. During the inspection we observed a board meeting in action. The patient story was meaningful to the services delivered and described the effect of a highly responsive service that had reduced their hospital admissions and allowed them to leave with their condition, describing the service received as "having the doctors surgery in my own home".
- Paulton Memorial Hospital had a very active 'League of Friends' who consistently funded hospital projects. These included the refurbishment of the occupational therapy gym and kitchen, the dementia friendly rooms, and the day room.
- Public opinion was sought and used in the development of end of life services. The organisation worked in partnership with a community group to host an event during May 2016 to encourage more openness regarding end of life issues. More than 80 local people attended and feedback was positive. This event linked with the end of life strategy to build and support more compassionate communities and encourage end of life discussions.

Are services well-led?

Good

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

Workforce race equality

- The Workforce Race Equality Standard requires NHS Trusts and independent acute healthcare providers where annual aggregated income from NHS-funded care is at least £200,000 to demonstrate progress against nine indicators of workforce equality, including a specific indicator to address the low levels of black and minority ethnic (BME) board representation. The Equality Delivery System 2 (known as EDS2), was designed to review and improve organisations performance for people with characteristics protected by the Equality Act 2010. The organisation had undertaken a review and taken a shared approach with Bath and North East Somerset council due to the small numbers of staff who fell into the category. It was not clear what actions were planned to be taken by the organisation. A paper received by the board in June 2016, entitled equalities and diversity action plan 2016/17 had a section referring to the workforce. This described the open recruitment process and the values of the organisation to support race equality.

Innovation, improvement and sustainability

- At the time of the inspection, Bath and North East Somerset Clinical Commissioning Group had just announced the preferred bidder for community services was a private commercial company. The loss of that contract meant Sirona would lose 60%, approximately £70million of its business, at the end of March 2017. The executive team recognised the impact this would have on staff, services and the remainder of the organisation. Staff transfers would be arranged through the Transfer of Undertakings (Protection of Employment) Regulations 1981. The purpose of the Regulations is to protect employment rights when employees transfer from one business to another.
- Succession planning was being reviewed following the loss of contract. There was a plan to review once the future staff structure was known. This included the board constitution as most non executive directors took up post at the same time.
- All staff were invited to be involved in suggestions for the cost improvement program. A quality impact assessment was undertaken for all cost improvement programs and was reviewed by the director of finance and the director of nursing and operations before approval with the impact of the saving reviewed throughout the year. Where the saving was felt to affect quality, it was not approved.
- A safety thermometer application for use on tablets has been developed to allow the collection of data for the safety thermometer return. This allows staff to input data from the wards and community in real time.
- There were numerous examples of innovative work across the organisation. For example:
- Development of a demand and capacity modelling tool for community services that is used to ensure capacity is targeted at areas of greatest need.
- Paulton Memorial Hospital and St. Martin's Hospital had been working with a university on a project looking at the impactthe local population had on a community hospital and the impact a community hospital had on a local population. Whist not yet finished, staff described the positive comments they received about the impact they had.
- In Bath and North East Somerset the psychology team had undertaken research on the effectiveness of mindfulness in people with learning disabilities. This was about to be published.
- Children and young people were involved with the recruitment process for new staff. Working with a charity as part of the Community Children's Health Partnership, the provider had prepared a number of children and young people to sit on interview panels and score interviews. Children and young people had sat on 70% of the interview panels since April 2016, including interviews for receptionists, nurses and managers. The scoring system used to inform the recruitment decisions took into account the scores awarded by the children and young people.
- The provider had introduced an active ageing' project which consisted of a team of health visitors and healthcare support workers carrying out preventative assessments for people in the community between the ages of 80 and 85 years. The service helped elderly people in the community to access pendant alarms, blue badges and referral to other agencies such as Age UK for help with applications for attendance allowance. The service also included specific assessments for example the 'bothersome scale' (a scale to assess the severity of bothersome symptoms), a memory test to help assess symptoms of dementia and Edmonton

Are services well-led?

Good

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

Frailty score (a scoring system intended to support health and social care professionals in the community and in older people's own homes to recognise frail people and help them to manage their risks).

- In South Gloucestershire a 'falls service' had commenced in July 2016; the aim of the service was falls prevention and to reduce the fear of falling. The service had had a positive impact on waiting lists for physiotherapy and had helped to reduce the time patients waited for initial physiotherapy assessment from 10 to12 weeks to six to seven weeks from referral to first assessment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **18**(2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The provider must ensure that all staff are up to date with their safeguarding training and that this is completed to the required level as per national guidance

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