First Community Health & Care C.I.C.

Inspection report

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Ratings

Overall trust quality rating	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

First Community Health & Care C.I.C. was established in 2011 as a social enterprise company to provide community healthcare services predominantly in East Surrey and a small part of West Sussex. The provider employs around 500 staff and approximately 70% of staff are shareholders in the company. The core service provided by First Community Health & Care C.I.C. were as follows:

- Community health services for adults
- Community health services for children, young people and families
- Community health for inpatients
- Community urgent care services

First Community Health & Care C.I.C. provides one inpatient rehabilitation ward at Caterham Dene hospital, mostly for patients who were stepping down from acute hospital admissions. It also provided a minor injuries unit at Caterham Dene hospital. The community health service for adults comprised five district nurse teams and a series of specialist teams. Community health services for children, young people and families was made up of three 0-19 health visiting teams, school nursing, children's safeguarding services and a series of specialist clinics.

We carried out inspections of the four core services provided by First Community Health & Care C.I.C. followed by a well led inspection. The community health services for adults, community health services for children, young people and families and community health services for inpatients core services were last inspected in March 2017. This was the first time the urgent care core service was inspected. It was also the first time we had undertaken a well led inspection of the provider.

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

Our findings

This inspection did not include a use of resources rating. Although First Community Health & Care C.I.C. is not an NHS trust, the word trust is used erroneously in several places in the report as the word cannot be removed from the standardised inspection report template.

We rated First Community Health & Care as good because:

- Each of the five domains, Safe, Effective, Caring, Responsive and Well Led, are rated as good overall.
- Staff were well supported by supportive and competent leaders across the organisation. Leaders were well supported with their career development and the provider had improved its approach to succession planning for senior leadership posts. Senior leaders below executive level, in associate director and service lead roles, were actively involved in the provider's governance and strategic work. This helped with their professional development and helped ground senior leaders in the experiences of patients and staff when they needed to make decisions about services.
- The provider had a clear strategic approach and mission, which was well understood by staff. This emphasised that all aspects of the provider's work and decision making should be undertaken in the context of prioritising people, then the system, then the organisation.
- Staff described an open, transparent and supportive culture that centred on what was best for patients and the wider healthcare system. Staff across the organisation worked hand in hand with partners working in the wider healthcare system, for other providers and for external agencies including the voluntary sector.
- The provider's governance system effectively provided assurance and helped keep patients safe. It helped the organisation deliver its key transformation programmes and priorities outlined in the annual business plan.
- Despite the provider's quality improvement approach being in development, we identified numerous examples of improvements that had been driven by staff working in services. For example, staff in the inclusion team had successfully demonstrated the value of the team to commissioners who had agreed to permanently fund the work of the team to benefit the local refugee, asylum seeker and Gypsy, Roma and Traveller populations. Staff at the Minor Injury Unit (MIU) had undertaken a review of the reasons why people presented at the service and subsequently set up a wound dressing clinic to help ease pressure on Emergency nurse Practitioners. Staff had also worked closely with partners to develop the remit of the MIU thereby easing pressure on other parts of the urgent and emergency care pathway, including the local emergency department.

However;

- The provider needed to strengthen its work on Equality, Diversity and Human Rights (EDHR). The board had recently received an annual equality report and the organisation did not yet have a set of equality objectives. The provider was considering how best to represent and understand the views and experiences of staff with protected characteristics.
- The provider was seeking to improve the way the board had oversight of feedback staff gave about the organisation. This was because there were numerous ways staff could provide feedback and these were not yet effectively triangulated. The Freedom to Speak Up Guardian planned to develop a triangulation mechanism and include feedback from multiple sources in their future reports to the board.
- The quality of data needed to be improved. The provider recognised that it needed to develop its business intelligence function to better summarise and represent performance themes and trajectories.
- The provider was working to develop its approaches to user involvement and quality improvement initiatives.

Our findings

- The provider continued to work closely with commissioners to address substantial waiting times for children's occupational therapy and speech and language therapy services.

Outstanding practice

Community health services for adults

The provider had developed a procedure to support carers to administer end of life treatment following careful risk assessment and training. This involved staff giving training and assessing the competency of carers to safely administer medicines. This meant that patients receive more timely pain relief and are not waiting in pain for a nurse to visit.

Staff identified the need for a Covid-19 rehabilitations service to meet the needs of the local population early on in the pandemic. This was before national commissioning guidance about this type of service had been released. The team had been nominated for a UK social enterprise award.'

Community urgent care services

Staff had proactively presented a case for a new wound dressing clinic in the MIU following the results of quality and productivity audits. The audits found that a wound dressing clinic would have several benefits, most importantly improved quality of care for local patients with ongoing wound care needs. Staff had presented these findings to commissioners who had agreed to commission the new service. The clinic provided valuable continuity of care for patients seven days a week. It alleviated pressure on the local primary care providers (GPs) who were previously providing the dressing care for these patients. Within the MIU, the clinic was staffed by junior nursing staff (band 5) which allowed more qualified nursing staff (band 7) to focus on patient care which required their level of qualification and experience.

Staff were committed to the imminent extension of services in the MIU and the resulting benefit to a wider pool of patients. Leaders and staff were preparing comprehensively for the transformation with focused training to ensure staff had all the skills they needed to provide a wider range of treatments and services.

Staff were passionate about their work and spoke with pride about the positive team culture in the MIU. Leaders were incredibly supportive of staff, who recognised and valued this support. Feedback from people who used the service was also consistently positive.

Community health services for children, young people and families

Staff went the extra mile to identify the particular needs of vulnerable population groups and tailored services to their needs. The inclusion team holistically addressed the health needs of all family members and linked in with voluntary and local authority teams to ensure families received the full range of health and social care support they needed.

Staff worked flexibly to reach members of the community in hard to reach groups. This involved working at evenings and weekends to attend cultural and religious events in the local area to encourage families to access their services.

Our findings

The inclusion team had effectively demonstrated its success in working with families from vulnerable groups and commissioners had recently agreed to fund the service on a permanent basis. Colleagues from across the country were visiting the service to learn from its good practice and make a case for similar services to be commissioned in other areas.

The service had responded rapidly to the demands of the Covid-19 pandemic. They had recognised that new mothers would likely be feeling isolated and introduced extra contacts at four weeks post-partum to help combat loneliness. They also continued to see people face to face if they felt there was a compelling need to do so.

Staff used alternative methods to help people gain access to advice and services. This included an advice line for people and professionals to use to gain advice from health visitors and nursery nurses on a range of subjects, which in turn reduced the pressure on health visitors because fewer contacts were needed. Also, there was a CHAT line for young people to use for advice on things such as mental health and development if they felt unable to contact the school nurse.

Baby cafes were offered to new mothers during the pandemic. The service was run by staff who needed to shield, and provided advice on infant feeding, online classes and support groups.

Areas for improvement

Action the provider MUST take to improve:
Community inpatient services

The provider must ensure robust governance assurance processes are in place that assess, monitor and improve the quality and safety of the service. (Regulation 17 (1) (2) (a)

Action the provider SHOULD take to improve:
Community health services for adults

The provider should ensure leaders can monitor whether staff are receiving the required managerial supervision with their supervisor.

The provider should complete its plans to re-locate the South Tandridge district nurse team base to protect the confidentiality of patient information.

The provider should develop plans to introduce training for all staff in supporting people who have a learning disability and autistic people.

Community urgent care services

The provider should make plans to ensure all staff in the MIU receive training in meeting the needs of people with learning disabilities and autistic people.

The provider should monitor whether patients leave before being seen to help leaders promptly understand the reasons for this.

Our findings

The provider should improve access to clinical supervision for staff.

The provider should ensure leaders can monitor whether staff are receiving the required managerial supervision with their supervisor.

Community inpatient services

The provider should ensure that clinical equipment is stored safely and securely. This had continued to be a challenge from the last inspection.

The provider should ensure confidential patient information is always stored securely on the ward.

The provider should ensure leaders monitor whether staff receive their required managerial supervision.

The provider should ensure staff receive training in caring for patients with learning disabilities and autism.

Community health services for children, young people and families

The provider should continue its work on ensuring caseloads for health visitors are manageable.

The provider should proactively work to reduce waiting times for occupational therapy and speech and language therapy .

The provider should ensure leaders can monitor whether staff are receiving the required managerial supervision with their supervisor.

The provider should ensure its programme of routine quality audits is re-introduced across the service.

The provider should monitor whether families who have recently moved to the local area are seen promptly following their arrival .

The provider should ensure that staff are trained to identify sepsis.

Is this organisation well-led?

This is the first time we rated well-led. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they provided, were visible in the service and approachable for patients and staff.

The provider board consisted of the chair, chief executive, three non-executive directors and three other executive directors. The non-executive directors had experience as senior leaders in a range of organisations and two had experience working in clinical roles. The chair had been in post since 2019 and had a background in public and private

Our findings

partnerships. They had experience acting as a non-executive director in various sectors and this was their first healthcare post. Non-executive directors (NEDs) had experience in chartered accountancy, audit, board-level experience at a range of organisations including other healthcare providers and experience working in patient-facing roles in healthcare.

The provider had two medical advisors to the board. They were predominantly responsible for overseeing Patient Group Directions (PGDs) and advising on other medical matters. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber such as a doctor or nurse prescriber. This included medicines such as routine vaccines provided by the 0-19 services. The provider did not employ its own doctors in the services it provided. General Practitioners (GPs) working at the inpatient service were employed by a separate GP provider who had a service-level agreement with the provider.

Board members and other senior leaders acted with integrity. Leaders worked in a unitary way and provided appropriate professional challenge to one another during the board committees we attended. This helped ensure decisions were always made in the best interest of patients. Associate directors played an instrumental role in leading discussions at board sub-committees and attended board meetings. These associate directors also worked closely with service leaders and other staff who worked directly with patients. Their presence at these meetings helped ensure decisions were made in the best interest of people using services and staff who worked directly with patients.

Fit and proper persons checks were completed for all board members. The provider had a process for carrying out their duties in respect of the Fit and Proper Persons Regulation. We reviewed the fit and proper person checks completed for two executive and two non-executive directors. All necessary pre-employment checks were completed for board-level directors including criminal record checks with the disclosure and barring service. However, although the provider ensured board-level directors had disclosed their financial solvency, this was not proactively checked by the provider.

The provider systematically reviewed leadership capacity and capability.

Leaders demonstrated a detailed knowledge of current priorities and challenges and took action to address these, often considering how to link up with stakeholders and partner provider organisations to find appropriate outcomes for patients using the wider healthcare system.

Board members visited services and teams and met with frontline staff. The programme of service visits had been suspended during much of the Covid-19 pandemic but was back up and running at the time of the inspection. NEDs visited the provider's main sites during this time to deliver food and other products as a special thank you to staff who continued to work hard during the pandemic.

Leadership development opportunities were available to staff working in the organisation, which included staff at team level who were supported to develop their skills in managing people. Staff were trusted and supported to take on additional pieces of work, including research projects, to help develop their professional experience.

Staff at middle-leadership level in associate director and service lead roles were encouraged to attend senior-level governance meetings including board committee meetings. Their involvement in senior discussions helped build their professional experience and helped develop their leadership skills.

Our findings

The provide had recently improved its approach to succession planning. For example, adjustments were being made to ensure Non-Executive director's terms of office did not come to an end at the same time as one another, which had been an historic challenge for the provider. Succession plans were also being considered for other leadership roles such as the adult safeguarding lead and emergency planning lead.

Vision and Strategy

The vision of the provider was 'rejuvenating the wellbeing of our community'.

The provider also had a clearly stated set of values, often referred to as the 'mission'. These were to achieve the vision through the provision of 'first-rate care' by 'first-rate people', offering 'first-rate value'.

The provider aimed to deliver 'first-rate care' by ensuring trained and knowledgeable professionals worked in the organisation who were committed to providing seamless, high-quality care without boundaries. Care should be empathetic to the needs of service users, their families and carers, celebrating patient choice.

The provider aimed to be represented by 'first-rate people' who were caring, conscientious, compassionate and approachable, and supported to develop their potential. People should be respectful, listen and understand what is important to others. People should be effective at communicating with confidence and authenticity. People should be flexible and adaptable to the community and its requirements of health care services.

The provider aimed to deliver first-rate value by being efficient and effective in its business, continually learning and improving, and by being intellectually curious. They aimed to deliver value for money, bespoke care, focused on the health of the service user. The provider stated that this offered value back into the community, leaving a social impact locally.

The provider's values emphasised the need for quality and sustainability.

The provider's strategic approach had been in place since 2020 and aimed to guide the annual business planning and the strategic direction of the organisation until 2024. Issues were approached with a list of ordered priorities in mind. These were people (residents, employees and patients) being put first, followed by the wider healthcare system needs (this could be the local 'place' level system, the integrated-care system or county-wide depending on the context). Both people and the system were prioritised ahead of the organisational priorities because it was believed that this was the best way to deliver the vision. This emphasised the importance of patients being at the forefront of decisions. It was clear that leaders understood the importance of developing the strategic approach in collaboration with system partners in the best interests of patients.

The strategic approach aimed to do the right thing at the right geographical scale, determined by the needs of the people who use services, what fits with partners' needs and what gives the best value for money to taxpayers.

The strategic approach also aimed to play to organisational strengths, building on what had been learnt over ten years of 'outstanding delivery'.

The provider recognised its strengths as follows:

- Delivery of outstanding, safe services that are continuously improving.

Our findings

- Adapting services to support effective system working.
- Managing robust financial management and offering excellent value for money, investing in the key areas that are critical to the organisation's future.
- Being the glue in the system, both in service delivery terms (joining up other parts of care) and by displaying collaborative behaviours.
- Being strong enough to hold uncertainty but adaptable enough to act when opportunities arise.
- Growing through integrated working and service development with partners rather than competition.

The provider had two alternating types of board meeting. Board strategy meetings took place every other month. The focus of this meeting was on business and performance in line with the providers strategy. Quality and assurance matters were dealt with at board assurance meetings. Leaders reported that the two separate board meetings worked well and had enabled the provider to better advocate for community services in the local landscape.

Staff, patients and carers had opportunities to participate in discussions about the provider's strategy. For example, during 2021 staff participated in '10-year conversations' to mark the ten-year anniversary since the formation of the provider. These were reflective discussions that helped the provider understand the vision and priorities of staff and helped leaders consider these views when shaping the strategy, such as the need to prioritise staff wellbeing, supporting new staff (lots of staff had started working for the provider during the Covid-19 pandemic) and minimising the disconnect between staff in services and the provider's corporate functions.

Culture

The culture of the organisation was open and transparent and was centred on the needs and experience of people who used the services. Staff mostly felt valued and proud about working for the organisation and their teams. We received positive feedback from staff at all levels during both the core service and well led inspections. Staff spoke positively about the small size of the organisation which they felt helped foster a cohesive and supportive staff culture. Staff described close working relationships with the most senior leaders in the organisation, who were often visible within services.

Local stakeholders we heard from, including commissioners, described having a positive and open relationship with the provider. Staff in services often worked cohesively with staff employed by neighbouring providers, particularly in community health services for children, young people and families.

Eighty percent of staff completed the staff survey in October 2021. This was substantially higher than the median response rate across healthcare organisations, which was 61%.

Ninety-one percent of respondents said the care of patients is the organisations top priority, compared with 83% across similar providers. Eighty-nine percent of staff would be happy with the standard care if offered to a friend or relative, compared with 78% across similar community providers, and 80% would recommend First Community as a place to work, compared with 70% nationally.

The experience of staff from ethnic minority backgrounds was mostly in line with the experiences of staff from ethnic minority backgrounds working in similar healthcare providers nationally, according to the Workforce Race Equality Standard (WRES). For example, 12% of staff from an ethnic minority background experienced discrimination at work from a manager/team leader or other colleague in the last 12 months, which was in line with the percentage of staff from an ethnic minority background who shared this experience nationally; although less than 4% of white staff in the

organisation shared this experience. Sixteen percent of staff from an ethnic minority background reported experiencing harassment, bullying or abuse from other staff in the last 12 months. This was in line with the experiences of white colleagues in the organisation and lower than the national average of 20% of staff from ethnic minorities who had experienced this nationally. Twenty-one percent of staff from an ethnic minority background experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This proportion as similar to the experience of white colleagues in the organisation and lower than the national average of 24% of staff from ethnic minority backgrounds who had experienced this nationally.

However, just 37% of staff from an ethnic minority background, compared with 50% nationally, felt that the provider gave equal opportunities for career progression or promotion. Leaders explained that they had recently improved job adverts to make clear that applicants from a range of diverse backgrounds were welcome.

The provider was a Community Interest Company, and therefore not required to complete a Workforce Disability Equality Standard (WDES) report. However, there were plans to introduce a WDES report during 2022.

The provider had recently completed a report on Equality Delivery Standard 2 (EDS2). This standard was launched by NHS England in 2013 to help providers, in discussion with local partners including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. However, the organisation did not yet have a set of equality objectives in place to help it address equality issues and the provider had not completed a full equality report for the board since 2020.

The provider recognised successes within the organisation. Success was recognised in the provider's newsletter and through issuing awards to teams and individuals following exceptional performance.

A council of governors (COG) consisted of staff representatives who held the board of directors to account. All permanent staff had the opportunity to be shareholders in the organisation, and approximately 70% of staff were shareholders at the time of the inspection. The COG represented staff shareholders, met bi-monthly and consulted on important issues such as the approach to a recent productivity programme, which staff felt was being rushed. COG members also helped shape the the organisation's strategy.

A community forum, made up of representatives from key local stakeholder organisations including the voluntary sector, also acted to hold the board to account.

The provider worked closely with the trade unions. However, trade union representatives reported that their activity was sometimes minimal because staff tended to feel well represented by the COG. At the time of the inspection one of the larger trade unions with the greatest number of members did not have a lead representative, but other union representatives were working to represent the views of all staff and signpost as necessary. Trade union representatives met every three months, could access senior leaders to raise feedback easily, and were supported in their union representative roles.

Staff were aware of the provider's whistleblowing process and how to contact the Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian contact details were displayed across the organisation and on the provider's intranet. They also attended induction session for new staff. Five of the 12 COG members were being trained to act as speak up ambassadors. This aimed to increase visibility of the speak up function and make it easier for staff to speak up via an ambassador.

Our findings

The board did not receive a comprehensive report on Freedom to Speak Up contacts. At the time of the inspection, the Freedom to Speak Up Guardian did not systematically report to the board because they received a small number of contacts that qualified as a speak up issue. Instead, most contacts were signposted to colleagues in an appropriate part of the organisation, such as Human Resources, to be addressed. Leaders had recognised this gap and had plans to implement a systematic Freedom to Speak Up report to the board, which included all contacts regardless of whether they qualified as a standalone speak-up issue.

The Freedom to Speak Up Guardian was also developing ways to triangulate feedback about the organisation to be included in their new board report. For example, they were considering how to gather feedback from colleagues representing the Race, Ethnicity and Cultural Heritage (REACH) network, the COG and the floor to board feedback process.

Leaders throughout the organisation supported staff through periods of poor performance effectively.

The provider understood their responsibilities in respect of the duty of candour. During the core staff inspections staff understood the term 'duty of candour' and were able to provide us with clear examples of when they would offer support and apologise to patients and families. The board had oversight of the duty of candour through the quality improvement and assurance committee.

Staff had access to support with their physical and emotional wellbeing needs. An employee assistance programme that provided mental health support via telephone could be accessed by staff at any time. Wellbeing initiatives existed across different services. A wellbeing group fed into the people plan delivery group, which in turn reported to the organisational development and workforce board sub-committee. The inclusion team attended regular reflective and wellbeing sessions with a clinical psychologist who worked for the local mental health trust.

A Race, Ethnicity and Cultural Heritage (REACH) staff network existed to represent staff members from ethnic minority backgrounds. The name of the network had recently been changed to better reflect the range of identifies of its members. Members wanted to improve representation of staff in the network. It was felt that staff in more junior roles were not well represented.

The provider did not have other staff networks representing staff with other protected characteristics under the Equality Act 2010. However, they were considering how to develop networks in partnership with other local healthcare providers, such as LGBT+ and disability networks.

Staff sickness was not an outlier. During the 12 months to February 2022 staff sickness averaged 4%. During the same timeframe staff turnover averaged 1.4%.

Statutory and mandatory training compliance at March 2022 was above 90% in most areas against a target of 85%. However, the Covid-19 pandemic had affected access to face-to-face training, and the provider was continuing to ensure staff were up to date in some of these areas. Seventy-five percent of eligible staff had completed their level 2 moving and handling training. Annual and bi-annual training in adult basic life support had been completed by 80% and 73% of eligible staff respectively.

The provider was yet to implement staff training in caring for people with a learning disability and autistic people, which was due to become a requirement set out in the Health and Care Act 2022 later in the year.

Governance

Our findings

The provider had structures, systems and processes in place to provide assurance and deliver the organisation's services and key programmes safely and effectively. There were two types of board meeting: board strategy and board assurance meetings. Board strategy and board assurance meetings place separate from one another every quarter (four times each per year).

The provider had five sub-board committees, which each met quarterly: organisational development and workforce, quality improvement and assurance, remuneration and nomination, audit, and finance. Each sub-committee was chaired by a non-executive director or the provider chairperson and was attended by relevant staff including the relevant executive director. Minutes from the sub-committees were shared at the board meeting and any areas of concern escalated. The non-executive directors were clear about their areas of responsibility and the committees they chaired. The executive directors had clearly defined areas of responsibility.

A series of groups that met monthly or quarterly fed into the board sub-committees. These included a clinical quality and effectiveness group that met monthly and fed into the quality improvement and assurance committee. Discussions about learning from incidents, themes from complaints and friends and Family Test results, updates to clinical policy, outcomes of clinical audit and service-level risks to consider for escalation to the provider level risk register were discussed.

The provider-level risk register was reviewed at the quality committee. Risks with a high score were escalated for discussion at the board assurance meeting.

The provider had dashboards providing key performance information to managers, teams, the provider senior leadership and board. At a ward and team level front line managers were clear about their responsibilities and felt they were given enough autonomy and support to perform their roles. Each team manager had access to dashboards containing essential performance information for their team. This helped to inform the management of their service.

However, although staff reported feeling well supported in their roles, leaders did not have oversight of whether staff had received their required managerial supervision. The provider could not therefore be assured that staff were receiving the necessary support from their line managers to complete their roles to a safe and effective standard.

Standard agendas were used to ensure essential information, such as learning from incidents and complaints, was shared with staff at team meetings. This helped the effective flow of information from service and team level to the board and vice versa. Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person

A medicines optimisation operational group met quarterly and reported to the quality improvement and assurance committee. Any medicines related risks were reviewed at this meeting. The Head of Medicines Management monitored the service level agreement between the provider and the pharmacy who supplied medicines to the inpatient unit. They also led on the management of controlled drugs (CD) and attended local CD intelligence meetings and shared learning from CD related incidents that had happened locally.

The Council of Governors (COG), which represented the views of staff shareholders and held the board of directors to account, met monthly on an alternating formal/informal basis. Each formal COG meeting was attended by both the chief executive officer and provider chairperson. Other senior leaders were invited to attend the COG meetings to discuss specific issues. For example, the chief nurse and director of quality and people had recently attended to discuss staff pay, reward and recognition in their capacity as executive lead for workforce.

Our findings

The provider had effective processes in place to respond to complaints. Patients and carers knew how to make a complaint. The provider ensured people were able to raise complaints easily. Information providing advice on how to complain was available on the provider's website and was supported by 'valuing your views' leaflets that were given to patients by staff or information displayed on the inpatient unit.

The provider received 28 complaints and concerns in 2021-22. In the final quarter of 2021-2022 6 complaints were received. Following investigation, three of these complaints were upheld and three were partially upheld. All were acknowledged within two working days and responded to within 25 working days, which were the provider's target times.

The provider was working with third party providers effectively to promote good patient care. The provider was part of Children and Family Health Surrey (CFHS). CFHS was a partnership of three providers, namely the two children's community health providers in Surrey, which included First Community Health & Care C.I.C, and the local mental health NHS trust. Chief executives of these organisations routinely came together to discuss children's services in the local area, and the director of CFHS reported to the children and young people Integrated Care System (ICS) meeting. By being part of CFHS, the provider widened its governance to include discussions such as learning from incidents and embedding new professional guidance consistently across the local area.

Staff working in the Minor Injuries Unit also regularly met with representatives from other local provider organisations who provided urgent and emergency care services. This also enabled them to widen their governance and learn from incidents in neighbouring providers on the same treatment pathway.

Management of risk, issues and performance

The provider had robust processes for managing risks, issues and performance. A corporate risk register was reviewed at the quality committee. Entries with high residual risk ratings were discussed at the board assurance meeting. The provider's corporate risk register, detailing risks with a score of 12 and above, was reviewed monthly at the corporate assurance group, and each risk was allocated to the relevant committee to monitor. The corporate risk register was reviewed at every Board Assurance meeting. Service-level risk registers were in place. Issues were effectively escalated to the corporate risk register if they were sufficiently severe or systemic. For example, the significant risk of demand outweighing capacity in children's services featured on the corporate risk register. The provider was sharing information about demand with commissioners, particularly in relation to occupational therapy and speech and language therapy wait times and the provider was considering the scope of staff roles to help manage demand. In addition to capacity in children's services, the other risks with an equally high residual risk score of 16 were deterioration in staff wellbeing because of the increasing cost of living, ongoing Covid-19 pandemic and ongoing war in Ukraine, and a risk of not being able to secure the number of agency staff required to maintain capacity levels and cover staff sickness. Appropriate control measures and action plans were in place for each risk entry.

The provider had a Board Assurance Framework (BAF) that was reviewed at board assurance meetings. A BAF is a structured approach for ensuring that boards get the right information, which is accurate and relevant, at the right time and with a level of assurance attributed to each source of data. The BAF was linked directly to aims outlined in the annual business plan. For example, the children and family services transformation and procurement priority featured on the BAF with a series of priorities and risks, such as the need to work closely with partners to ensure immunisation services were ready to deliver the increase in numbers of flu vaccinations and Covid-19 vaccinations in school age children.

Our findings

Quarterly incident reports were completed for each service line. Themes from these reports were discussed at the clinical quality and effectiveness group.

All incidents were reviewed on a weekly basis by senior managers. This review involved identifying incidents which required a 72-hour report and a serious incident investigation. Staff investigating incidents had received appropriate training in root cause analysis.

Clinical and internal audits provided assurance and teams acted on results where needed. Senior leaders explained that they were re-implementing their routine internal audit system in its children's services service line.

Staff understood their responsibilities in respect of the Duty of Candour. During the core staff inspections staff understood the term 'Duty of Candour' and were able to provide us with clear examples of when they would offer support and apologise to patients and families.

The provider monitored waiting times for services and considered ways to reduce the longest wait times. The average waiting times during the six months to June 2022 were 32 weeks for children's occupational therapy and 19 weeks for children's speech and language therapy. The provider had an entry in its risk register to reflect this as the joint highest risk affecting the organisation but these wait times had not yet started to decrease. Staff systematically reviewed patients on the waiting lists to identify high-risk patients who needed to be seen sooner and to signpost families to alternative providers where this was appropriate. The provider was working with commissioners and considering how to best utilise staff skill mix to meet the needs of those waiting.

The provider carried out appropriate staff recruitment checks. The provider undertook disclosure and barring service checks for all staff and reported on this monthly. The provider had an effective system to ensure staff did not start working until all the necessary checks had been completed. The provider had a robust procedure of pre-employment checks before staff started working at the provider. These checks included a review of people's employment history, identification checks, references and a disclosure and barring service certificate (police check). When required for the role, the person's professional registration was also checked.

Systems were in place to ensure nursing revalidation took place. Revalidation was monitored monthly and all staff had a valid registration. Other professional registration details were monitored, although the provider did not employ doctors.

The organisation managed finances well. There was good financial stability and control and a highly skilled team delivering tender bids and winning appropriate contracts, although the provider's strategy was aimed at collaborating with partners rather than competing for contracts. The provider had contracts with local health commissioners and local authorities for the delivery of public health services for children, young people and families.

The provider had an annual turnover of £32 million. The total projected balance remaining at the end of the current financial year was £1.2 million. The provider planned to build its reserves to pay for future building works rather then rely on borrowing. The provider's investments were risk assessed and it invested in accounts with AAA rated banks rather than the stock market.

The provider had robust arrangements for safeguarding adults and children. There was a clear governance structure for reporting to the board, with identified leads for child and adult safeguarding. The adult and child safeguarding leads gave regular support to staff and teams. Staff training requirements were mapped against intercollegiate standards guidance and competency framework to ensure staff were trained to an appropriate level. The safeguarding team disseminated any changes in policy to front line staff and ensured that learning from safeguarding adult and child

reviews were embedded in practice. The safeguarding leads monitored staff safeguarding supervision to ensure it was taking place. The safeguarding adults lead, and the safeguarding children lead, were supported by associate directors who acted as 'operational' safeguarding leads. This was a conduit role that staff felt was important. It enabled discussions about safeguarding adults and children at a senior level to be grounded in the experience of staff working directly with patients.

The provider had a modern slavery statement and provided training to staff on how to recognise modern slavery.

The provider did not own any of its estate and its main landlord was NHS property services, who the provider had a good relationship with. The provider met with their landlords monthly to ensure the estate was fit for use and complied with Health and Safety and fire legislation.

Staff could raise issues for attention by the estates team easily. The estates team triaged issues according to priority. The top priority issues were consistently addressed within two working days. All minor issues were addressed within two weeks.

The provider had effective systems in place to manage and monitor the prevention and control of infections and ensure appropriate and enough resources to enable compliance with good infection prevention and control practice.

The provider had robust plans for emergencies and other unexpected events and the emergency planning lead worked closely with partner organisations to develop contingency plans to address the needs of the wider population in the event of an emergency that effected service delivery.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received a monthly report from the learning and development department showing training compliance for individual staff.

Managers used this to alert staff to any training requirements and managers received email notifications when staff booked onto required training.

Information Management

The provider had recognised that it needed to improve the quality of its data. Although the provider's governance system worked well and gave assurance to the board about the performance of the organisation, we identified that data featuring in board and committee papers was often extensive and under-analysed. Data could have been better summarised to emphasise themes and trends. The provider's senior leaders were aware of this issue and were hoping that an ongoing productivity programme would assist the provider in deciding how to improve its business intelligence function. Despite this, board and committee papers were of a reasonable standard and contained appropriate information to assist leaders in their decision making.

The provider was considering developing statistical process control (SPC) charts to support robust statistical interpretation of measures presented over time and identify the difference between special cause or common cause variation and trends. SPC is a set of statistical methods based on the theory of variation that can be used to make sense of any process or outcome measured over time, usually with the intention of detecting improvement or maintaining a high level of performance. This would help measure the impact of any change and evaluate its worth.

The provider had effective arrangements to ensure that all notifications were submitted to external bodies as required.

Our findings

The provider made good use of information technology (IT) in the delivery of patient care. Many staff working in community teams worked virtually from patients own homes and were able to update clinical records whilst on the move using portable tablet devices. Staff also had access to work mobile telephones to keep colleagues up to date about their whereabouts. Staff had good access to IT support within the organisation when they needed it. Teams across the organisation used the same electronic records system as local GPs. This helped ensure continuity of care when patients were transferred to or from the provider's services. It also enabled staff to easily access relevant information such as test results.

Communications equipment, telephones and access to the internet were secure and ensured patient confidentiality. However, leaders took immediate action during the inspection at the inpatient unit at Caterham Dene Hospital to remove a laptop computer had been left unattended in a communal area, and to secure paper records that were kept on an unlocked trolley in a communal area.

The provider's Caldicott guardian was the chief nurse and director of quality and people. They were supported in this role by a deputy Caldicott guardian. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information.

Although performance data was readily available, not all the relevant service information was routinely analysed to give an ongoing view of service capacity and patient experience. For example, the volume of patients who presented to the Minor Injuries Unit but decided to leave before they were seen was not routinely reviewed by senior leaders for quality and safety purposed to explore the effects on patient experience.

The provider met the mandatory requirements of the Data and Security Protection Toolkit (DSPT). The DSPT is based on the national data guardian's 10 data standards. The DSPT toolkit has mandatory or non-mandatory requirements, with organisations being required to meet all the mandatory requirements in order to pass.

The director of finance and resources acted as the Senior Information Risk Owner (SIRO). They worked closely with a data protection officer who was employed by an NHS organisation and subcontracted by First Community Health and Care C.I.C. The data protection officer provided training in information governance and Caldicott guardian training. They also monitored whether the provider met the requirements of the DSPT and updated the director of finance and resources on any actions that needed to be taken.

An information governance group met quarterly. The group discussed staff training in information governance and any information governance breeches were presented to the group to be learnt from. This group reported to the finance committee. Ninety-four percent of staff across the organisation had completed training in information governance at the time of the inspection.

Engagement

The provider had a significant strength in partnership working and leaders engaged well with partner organisations. The provider acted to bring partner organisations together to tackle priorities together which had led to new or improved services for local people. For example, the provider worked closely with the local acute hospital NHS trust to consider improvements to the local urgent and emergency care pathway. This had resulted in a plan to adapt the model of the Minor Injuries Unit at Caterham Dene Hospital so it would now see children and be able to undertake more diagnostic testing in collaboration with a GP provider. This change aimed to help relieve pressure on the local emergency department. The provider was one of three providers within the Children and family Health Surrey (CFHS) partnership.

Our findings

This partnership had resulted in a consistent offer for children and young people, supported by consistent systems, processes and interpretation of professional guidance across Surrey between providers of community healthcare for children, young people and families. Some teams, such as the inclusion team and advice line, worked as one, but comprised staff who were employed by different provider organisations.

The provider's community forum was attended by representatives from voluntary community, social enterprise and other partner organisations, including local authorities. The forum met four times per year and aimed to ensure the provider was acting in accordance with its social purpose. Over the past ten years this Forum has contributed to enhancing the offer and experience for patients and residents in east Surrey. For example, through working with charitable organisations to enhance the provider's falls and stroke pathways. The provider was working to further develop the role of the community forum to support the 'East Surrey Place', which sat within the local integrated care system area. The provider supported the positive work of other organisations through the community forum. For example, the chief executive was supporting a local authority with their approach to outreach work in the local community. Board meetings were held in private and were not open to the public. Community Interest Companies (CICs) are not required to hold board meetings in public. The Board had developed a quarterly Board brief to provide public updates on its four governance areas (board meetings, community forum meetings, council of governor meetings and the network of patients and service users).

The provider had worked extensively with partners to identify and meet the healthcare needs of hard to reach communities. For example, the inclusion team worked closely with local authorities, the home office and the voluntary sector to identify families who had recently moved to the area as asylum seekers, refugees, and people from Gypsy, Roma and Traveller backgrounds. Staff in the inclusion team worked flexibly when undertaking outreach work; for example, by attending church services and community events outside normal working hours to make themselves known to communities.

Staff kept up to date with the work of the provider using the staff intranet and the provider's newsletter.

People who used services and their families could provide feedback using online feedback forms and by completing the Friends and Family Test (FFT). Details of the complaints and compliments process were also displayed on the provider's website.

Staff had opportunities to provide feedback about their experience in numerous ways, including via the Freedom to Speak Up Guardian, using feedback forms, by reporting to the Race, Ethnicity and Cultural Heritage (REACH) network, by using the floor to board feedback process or by speaking with members of the Council of Governors (COG). The Freedom to Speak up Guardian was in the process of setting up a triangulation meeting where feedback received using any of these forums would be collated and reported to the board in the Freedom to Speak Up report.

The provider was considering ways to improve how it engaged with staff from a range of equality groups. This was a particular challenge because of the small size of the organisation. The provider was considering how to implement staff networks in partnership with other local organisations for LGBT+ staff and staff with a disability. Most members of the provider's REACH network were in more senior roles and the network was considering how to improve its visibility and representation of staff in a range of different roles.

Our findings

The provider was in the process of recruiting Patient Safety Partners (PSPs) at the time of the inspection. The aim was for PSPs to provide the user voice when the provider was considering ideas for improvement and developing its strategy and business plan. Also, a First Community Network was developed in November 2021, which aimed to recruit members of the public to help shape and improve community healthcare services, although this network was still in its infancy. The provider did not have an overall patient engagement strategy.

Learning, continuous improvement and innovation

There were systems and processes in place for learning and continuous improvement, but quality improvement approaches were at an early stage in their development.

Staff across the organisation were involved in innovative pieces of work. For example, the inclusion team leader supported cross-sector professionals at a national level to successfully engage with the Gypsy, Roma and traveller community, following their success in engaging with this community to improve access to health visiting teams in Surrey. They had also to a range of local authorities and Clinical Commissioning Groups nationally about the provider's success in improving access to Covid-19 vaccination amongst vulnerable groups using outreach work.

0-19 health visiting services received WHO UNICEF Baby Friendly reaccreditation in 2021 for continuing to meet the required standards and are now aiming for the gold standard.

The provider had been nominated for numerous awards. The Covid-19 rehabilitation team won an NHS prevention and rehabilitation award and was nominated for a UK social enterprise award. The team was also highly commended at the Kent, Surrey and Sussex academic health science awards. The provider had been shortlisted for a best wellbeing and staff engagement award by the nursing times. Staff within the community stroke and neurological rehabilitation team, community heart failure team, had been shortlisted or won awards as finalists for their contribution to clinical audit. The inclusion team leader had received an award for the fund for innovation and leadership at the queens nursing institute awards.

The provider had spoken publicly about areas of good practice in the local media. These included interviews on keeping patients safe during Covid-19, using the patient panel to help shape services, adapting dietetics during Covid-19 to keep the service running, the new COvid-19 rehabilitation service and alternative ways staff were working in audiology in response to the Covid-19 pandemic.

The provider had successfully secured funding to enhance its service offer to the local population. A pilot programme to improve the wellbeing and fitness of patients before undergoing treatment for lung cancer, with a view to improving patient outcomes, had been agreed. A new digital monitoring programme for patients experiencing heart failure was being introduced. Training in Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) provision was being increased and two new podiatry posts had recently been agreed, which aimed to meet the needs of high-risk diabetic patients with podiatry needs in inpatient settings in the local area.

The provider had recently developed a Quality Improvement (QI) pathway and this was being strengthened. A quality improvement lead provided leadership and skilled expertise in this area. The provider did not prescribe which QI methodology staff should use but aimed for QI leads to coach staff through their projects.

Although the Quality Improvement process was still being formalised, we did identify some examples of innovative work at service level and staff felt empowered to take forward their ideas for improvement. These included the development

of the long-Covid service, which was developed at an early stage in the Covid-19 pandemic when staff first identified a trend in longer term Covid-19 symptoms that needed to be managed. Staff at the Minor Injuries Unit had analysed data showing the reasons why patients presented at the service. This resulted in the set-up of a specialist wound dressing clinic, which reduced pressure on Emergency Nurse Practitioners working in the service.

Progress with provider transformation projects was tracked by a change programme oversight group, which met monthly. Each project was led by a project manager who provided a monthly highlight report for their project. This group reported to the corporate assurance group, chaired by the chief executive, which in turn reported directly to the board strategy meeting.

The provider had a digital improvement programme in place and a digital change lead was due to be appointed soon. They would have responsibility for ensuring the digital strategy was followed. This programme aimed to improve things such as the provider website and accessibility of information for patients and the referrals process.

The provider ensured staff had opportunities to learn from serious incidents including deaths. All deaths of patient using services met the threshold for review by a mortality review group, who met bi-monthly and reported to the clinical quality and effectiveness group, which in turn reported to the quality improvement and assurance board sub-committee. The corporate assurance group, attended by all senior executive leaders, also reviewed all serious incidents that happened across the organisation. There had been one serious incident during the year 2021-22. Serious incidents were investigated thoroughly to identify learning. Where there were immediate lessons to be shared, these were communicated to all appropriate staff. Lessons learned were discussed at service line and team meetings.

The provider had recently introduced a new electronic incident reporting system. Previously, paper incident records were completed by staff. The new electronic system was easy for staff to navigate and senior leaders reported that they had seen an increase in the overall number of incidents being reported across the organisation, although there had been no change in severity of incidents.

The provider ensured it was compliant with standards of best practice. All newly published or updated professional guidance, particularly guidance issued by the National Institute of Health and Care Excellence (NICE) was reviewed by the quality improvement lead and discussed at the clinical quality and effectiveness group following a gap analysis, where staff reviewed whether they were compliant with the new guidance and what changes needed to be made to clinical practice to ensure they were compliant. An annual audit on the actions that had been agreed was undertaken to ensure changes to clinical practice had been followed through.

The provider was the first in Surrey to complete its preparation in readiness for the Covid-19 public inquiry. This included collating evidence of how the provider had managed the onset of the Covid-19 pandemic and its decision making, particularly where deviations to national professional guidance came about. The provider was consulting with other providers within the local integrated care system to support them to complete their own Covid-19 inquiry preparation effectively.

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good →← Aug 2022	Good →← Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good	Good	Good	Good	Good	Good
Overall trust	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022

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

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ↓ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022
Community health services for children and young people	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022
Community health inpatient services	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Requires Improvement ↓ Aug 2022	Good ➔➔ Aug 2022
Community urgent care service	Good Aug 2022	Good Aug 2022	Good Aug 2022	Outstanding Aug 2022	Outstanding Aug 2022	Outstanding Aug 2022
Overall	Good	Good	Good	Good	Good	Good

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

Community health services for adults

Good

Is the service safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Managers monitored mandatory training compliance and alerted staff when they needed to complete their training. Individual staff received emails from the training department to prompt them to attend.

At the time of the inspection, 91% of staff had completed their mandatory training across all the required training.

Some staff had not had the opportunity to update training that would usually be delivered face to face such as moving and handling, and resuscitation, which were delayed during the Covid-19 pandemic. Managers had a strategy to ensure this training was completed, which involved moving parts of the training online.

New staff joining the teams received a comprehensive induction training package, which was documented at each location. This included safeguarding, fire safety, and health and safety training.

Agency staff were required to be trained to the same level as permanent staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply this. Senior staff told us they discussed safeguarding incidents in monthly quality meetings and then this cascaded down to the local teams through their team meetings. Team meeting agendas had safeguarding as a standing agenda item, so this meant that information was shared effectively to the teams.

All staff received training specific to their role on how to recognise and report abuse. Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Although leaders reported challenges in booking staff onto face-to-face safeguarding training, staff did know how to identify safeguarding incidents and told us they would raise these with the service's safeguarding lead, or their manager, and record it as an incident on the incident reporting system. This electronic system automatically sent the safeguarding referral to the correct people within the organisation.

Staff liaised with GPs and social work teams when patients were at risk of abuse. Within the district nursing teams, safeguarding referrals were discussed three times per week at staff handover meetings.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Community health services for adults

Cleanliness, infection control and hygiene

During the previous inspection in March 2017, we identified that some areas of the services at Caterham Dene Hospital were not clean. At this inspection, this had improved.

Staff used infection, prevention and control measures to protect patients, themselves and others from infection. Staff followed infection control principles including the use of personal protective equipment (PPE) and regular hand washing. Staff also wore face masks to reduce the risk of spreading Covid-19. We observed that staff cleaned equipment after each patient contact.

Staff told us that they had sufficient PPE and that there were always enough supplies for them during the height of the pandemic, despite national shortages. Staff were aware of the provider's infection prevention and control policies.

Environment and equipment

The South Tandridge district nurse team base was not suitable for its intended use. Staff could not maintain the confidentiality of patient information. The base was situated within a shared multi-agency office. This meant that colleagues working for other organisations such as local authority and police teams could overhear telephone conversations that staff had with patients. This did feature on the provider's risk register and there was a plan to re-locate the team to a more private part of the building in the near future.

Staff carried out safety checks of specialist equipment. The service had suitable facilities to meet the needs of patients and their families. Staff had access to suitable equipment to help them safely care for patients.

Staff kept equipment and the premises visibly clean. Systems were in place to ensure equipment was checked and cleaned.

Staff could obtain specialist equipment for patients when they needed to, by ordering this through patients' GPs. We looked at the equipment available for each team, including doppler scanner, blood glucose machines, thermometers, pulse oximeter, syringe pumps, blood pressure machine and weighing scales. Equipment held by staff was serviced and calibrated twice a year

Defibrillators and first aid equipment were available at each team base. Checklists were in place to help staff monitor them.

Staff in each location carried out fire drills every six months. Records were kept of any learning from the drills, such as delays in responding to the alarm.

Staff managed clinical waste safely. There were clinical waste bins at patient's houses and clinical waste was left at the location rather than returned to base unless specifically indicated.

Assessing and responding to patient risk

Staff completed risk assessments for each patient and removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately.

Community health services for adults

Staff completed risk assessments for each patient on referral, using an assessment tool on the online records system. They reviewed this regularly, including after an incident or if their health deteriorated. Staff knew about and dealt with any specific risk issues including risk of falling, sepsis, and pressure ulcers. A track and trigger system for escalating concerns about deteriorating patients was in place at the leg ulcer clinic.

Staff shared key information to keep patients safe when handing over their care to other teams. We observed detailed handover meetings between staff, including all necessary key information to keep patients safe. All district nursing teams had daily telephone handover calls and face to face handover meetings for the whole team three times a week.

Staff completed comprehensive risk assessments for all patients. Staff used a range of risk assessment tools which were built into the electronic notes system. which identified when to assess skin integrity to help the prevention of pressure ulcers. Staff recognised when patients were at higher risk of sepsis and when the patient needed to go to Caterham Dene hospital.

Staff had specific training in identifying and managing sepsis and left sepsis information leaflets in people's homes.

During the last inspection in March 2017, we identified that patients at high risk of developing pressure ulcers were not always reassessed within the appropriate timeframe. During this inspection we found that all patients considered to be at high risk of pressure ulcers were seen within the timeframe set out in the provider's policy. District nurse records showed that nurses assessed risks using recognised tools, such as skin integrity assessments and frailty scores. Staff photographed patients' wounds and shared the pictures with the team at staff handover meetings and with the tissue viability team, to help track how pressure ulcers were healing. The organisation had implemented a lower limb pathway, based on National Institute for Health and Care Excellence (NICE) guidance which supported the treatment and escalation of lower limb care.

District nurses sought support from others in the organisation about how best to treat individual patients and the interventions they should provide. For example, district nurses were able to seek support from colleagues working at the local mental health NHS trust if needed. They also had experience in supporting adults with a learning disability to ensure they took the best approach to support the patient's individual needs.

There were clear guidelines to support staff who were lone working. Staff used an instant messaging application to enable a safe network that identified when staff had safely completed their visits.

Staffing

There were nursing and support staff vacancies across all the district nursing teams. The teams were managing this with the support of long term contracted agency staff, some of whom had been in post for over three years. With these long-term agency staff in place the service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm.

Patients told us they were aware which staff were agency staff and were familiar with them. Patients felt the agency staff were as kind and competent as the permanent staff.

Team leaders regularly reviewed staffing levels and skill mix, and prepared staff rotas six months in advance to ensure all gaps were well covered.

Agency staff told us they were given a full induction when they started with the organisation and received a local induction once they joined the team.

Team leaders accurately calculated and reviewed the number and grade of registered and non-registered nurses needed for each shift. The team leaders could adjust staffing levels daily according to the needs of patients.

An average of 25% of posts in adult community services were vacant between October and December 2021. Leaders had increased the size of some of the teams at the beginning of 2022 and not all the new positions had been recruited to yet. Leaders were managing the staffing challenges, and this featured on the organisation's risk register. There were recruitment plans in place with 54 new starters across the organisation starting between July and September 2022.

The organisation was part of the NHS 'flex for future' programme. This is a national plan to support organisations to develop ways to support flexible working. A dedicated project team aiming to improve staffing in both clinical and non-clinical roles had been introduced.

The district nurses held caseloads within their geographical areas which aligned with the primary care networks. This helped with continuity of care and ensured visits could be scheduled closer together and so cut down on the amount of travelling time between visits.

Caseloads were manageable. The district nurse teams had an estimated 323 - 700 patients on their caseloads at any one time.

District nurse visits were scheduled using an electronic system that was colour coded to aid prioritising of high priority visits and to avoid overallocation of staff. The system took account of mileage and travel times when making allocations. On each shift the team leader or nominated deputy would manually adjust the schedule to ensure as many visits as possible could be carried out.

Quality of records

District nurses completed care plans for each patient according to their needs. These were printed with clinical interventions. When care plans were changed on the electronic records system, paper copies were given to patients at their next visit.

All district nurses used tablet computers. This meant that staff could access records and test results in patient's homes and did not have to return to base to update care records.

All care records we reviewed were completed to a high standard. They were accurate, holistic and contained detailed information about visits/appointments, physical health checks, plans for dietary needs, health promotion, and support with self-management of conditions. Care records covered reviews of patients' social circumstances, and psychological reviews.

Other health care providers such as the local GP practices and other community services accessed the same records system.

There were no duplicate records systems which helped minimise the risk of clinical information being lost.

Medicines

Staff followed systems and processes when safely prescribing, administering, recording, and storing medicines. Most medicines were prescribed by patients' GPs and stored in their own homes. Medication cards were stored in patient's homes and returned to the team base when completed so they could be uploaded to the records system.

Nurses who were non-medical prescribers were able to prescribe medicines in line with national guidance. When needed, nurses would administer medicines and dressings which meant they did not need to wait for a GP to prescribe some treatments.

Staff told us that where possible they attempted to arrange all syringe driver appointments to be undertaken by two nurses, to ensure the risk of errors was minimised.

Incident reporting, learning and improvement

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses appropriately.

The organisation had just introduced an online incident reporting system in the month before the inspection.

Team leaders investigated incidents and shared lessons learned with the whole team and the wider service. Staff followed the duty of candour and apologised and gave patients honest information and suitable support when things went wrong.

Staff knew what incidents to report and how to report them, using the online system and in line with the provider's policy. Staff discussed recent incidents and what could be learnt from them at monthly team meetings, weekly multi-disciplinary team meetings and daily handover meetings.

The most common reported incidents were pressure ulcers, and staff were clear about how to report these according to severity. When an incident report was completed regarding a pressure ulcer the severity was graded and tissue viability nurses and managers were automatically contracted to look at the incident. We reviewed 12 incident reports across the district nursing teams and we saw evidence that changes had been made because of feedback, including improved recording of handover meetings as a result of an incident following a patient getting admitted to hospital with a serious wound.

Team leaders investigated incidents thoroughly, looking for themes. Patients and their families were involved in these investigations. Team leaders supported staff after any serious incident and staff accessed debriefs after significant incidents including expected deaths.

Safety thermometer

Staff collected safety information and shared it with staff, this included information about pressure ulcers, venous thromboembolism, falls and urinary tract infections. Leaders continually monitored safety performance including frequency of pressure ulcers, staff harassment incidents, slips trips and falls, patients who had not been seen for a long time and completion of risk assessments.

Patient safety tools were being used and completed appropriately. For example, Waterlow scores which give an estimated risk for the development of a pressure sore in each patient and falls assessments.

Community health services for adults

Is the service effective?

Good 

Evidence-based care and treatment

The organisation had processes in place to ensure protected characteristics under the Equality Act were considered when making care and treatment decisions.

Staff provided care and treatment based on national guidance and evidence-based practice. Managers told us they checked to make sure staff followed guidance through individual managerial supervision and organised peer group supervision.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff had access to policies on the staff intranet.

The organisation had given staff tablet computers to enhance the delivery of effective care as staff were able to input records in patients' homes and check on the most up to date patient records and clinical tests.

District nurses completed care plans depending on individual assessed patient needs and these were easily available on their tablet computers. Treatment of wounds was adapted on an individual basis as the wound healed. Pain assessments were carried out at every appointment by the tissue viability team.

District nursing teams were able to prescribe dressings in line with national guidance for nurse prescribers.

Staff completed a quality improvement project where they developed their own information leaflets for the services which had a clear and well-presented design to support in patients understanding of what each of the specialist teams could provide.

The organisation had taken the lead in the development of a lower limb pathway, based on NICE guidance which supported the treatment and escalation of lower limb care.

The provider had developed a Covid-19 rehabilitation team to support patients with their long-term recovery from the illness. The team had access to physiotherapists, occupational therapists, speech and language therapists, dietitians, and rehabilitation assistants.

Nutrition and hydration

Staff were aware of patients' specialist nutrition and hydration needs. They used special feeding and hydration techniques when necessary.

Specialist support from staff, such as dietitians, was available for patients who needed it. We saw evidence of food and fluid charts in use when we visited patient's homes and patient care records included references to checking on patients' food and fluid intake and recommending changes when needed.

Community health services for adults

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported patients with communication needs using suitable assessment tools and gave additional pain relief to ease pain. Staff had developed a procedure for teaching and supporting patients and carers to administer their own pain relief in exceptional circumstances and when safe to do so.

Staff told us how they used non-verbal signs to monitor patients who could not verbally communicate. Patients received pain relief soon after it was identified that they needed it or when they requested it.

Some patients had access to syringe drivers for symptom control, specifically when patients were coming towards the end of life. Staff told us they would visit patients who were on syringe drivers daily. Pain relief was administered and recorded accurately.

Patient outcomes

The service monitored key performance indicators (KPIs) to ensure it delivered care in a timely manner. These included numbers of referrals, total numbers of patients on caseloads, total number of face-to-face contacts, patients with personal individualised care plans, the total number of did not attends appointments. This was then reviewed with team leaders in their individual managerial supervision. We could see that KPIs were routinely met and normally exceeded especially around face-to-face contacts which was maintained and exceeded, most notably through the covid-19 pandemic.

Staff monitored the effectiveness of the lower limb ulcer pathway by monitoring the speed at which patients' ulcers fully healed.

Competent staff

Staff were competent for their roles. Team leaders appraised staff members work performance and held daily handovers to provide clinical support and team development.

Staff reported feeling well supported in their roles and staff described that they attended supervision sessions with their line managers to support their development and clinical practice.

Staff discussed their individual training needs with their line manager and spoke positively about learning and development opportunities within the provider organisation. We met numerous staff carrying out masters level training and specific clinical training outside of the organisation that would help improve and advance their clinical skills.

Band 6 nurses were encouraged and funded to undertake the specialist district nursing course every year.

Staff were experienced, qualified, and had the right skills to meet the needs of patients. Staff had access to a wide range of statutory, mandatory and specialist training including in catheterisation, motivational interviewing, caseload management, enteral feeding, positive behavioural support, and vaccination.

The organisation gave all new staff a full induction tailored to their role when they started work and supported staff to develop through yearly, constructive appraisals of their work. Information provided by the organisation showed that appraisals were happening regularly and in line with the organisation's policy.

Community health services for adults

Staff did not routinely receive training in managing patients with a learning disability or autism. This meant that when the organisation was supporting these patents, they had to seek guidance from the mental health team. Staff felt it would be more effective if they all had a baseline level of training to support this group of patients.

Managers identified poor staff performance promptly and supported staff to improve. Managers made sure staff attended team meetings or had access to minutes when they could not attend.

Staff in all the teams felt able to raise any concerns or questions they had with the team leaders. Less experienced staff were supported to develop their skills, and staff said they were never asked to perform interventions that were beyond their limit of competence.

Multidisciplinary and partnership working

Staff held regular effective weekly multidisciplinary meetings to discuss patients and improve their care, these meetings had a structured agenda and minutes were recorded and uploaded on to the electronic record system. Staff worked across health care disciplines and with other agencies when required to care for patients. The district nurses worked with a hospice provider to deliver end of life care. Prior to the covid pandemic, the local hospice provider had also attended the district nurse multidisciplinary meetings.

Staff referred patients for mental health assessments when necessary if they showed signs of mental ill health or depression, first community had a team of mental health liaison nurses available to support in addressing mental health or learning disability needs and referring on to the appropriate mental health services with thin the local NHS mental health trust.

The intermediate care team met together weekly with the community geriatrician to discuss more complex and challenging cases. The district nurses described effective multidisciplinary and integrated team working. They referred patients on to other specialist teams as needed, and worked closely with first community podiatry team, sometimes carrying out joint visits to patients.

When people were discharged there were clear mechanisms for sharing information with the local GP in a timely way as referral letters to the GP and handover information used the same electronic system as the GP services.

Health promotion

The organisation took steps to involve patients and carers in monitoring their own health and had implemented procedures to enable them to manage their health and wellbeing and maximise their independence.

The long-term conditions team working in the pulmonary rehabilitation service had developed comprehensive support for all potential patients with guidance on how to increase physical activity and reduce anxiety related to the condition with wellbeing advice and physical exercises.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Community health services for adults

Staff supported patients to make informed decisions about their care and treatment. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. When patients could not give consent, staff made decisions in their best interests, and they considered the patient's wishes, culture and traditions, and recorded this in the electronic record. The district nursing teams would also seek the support of the mental health team for guidance in these cases.

Mental Capacity Act training was covered within the equality, diversity and human rights training.

In addition, on every visit the staff recorded that consent was collected from the patient for them to carry out the schedule of care. The electronic record system had this as a standard action and had to be completed in order to move on within the record.

Is the service caring?

Good 

Compassionate care

Staff treated patients with compassion and kindness and were passionate about delivering care to patients. Staff were discreet and responsive when caring for patients, respecting their privacy and dignity. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed home visits where district nurses spoke kindly and respectfully to patients in consultations at their homes.

We spoke with 12 patients following the inspection and all patients felt overwhelmingly positive with the care they had received. Staff took time to understand the personal, cultural, social and religious needs of the patients and took these into account when visiting the patients. Patients told us staff went the extra mile and were always pleasant and chatty and the visits did not feel rushed.

Staff proactively obtained feedback about the experiences of people using the service. It was recognised that sometimes it was difficult for house bound patients to deliver the friends and family test as a posted document so had arranged for a senior member of the administration team, independent to the clinical teams, to routinely gather feedback from each patient on the telephone.

Staff followed provider policies to keep patient care and treatment confidential. Staff told us consideration of people's privacy and dignity is embedded in everything that they did. They would only speak about patients' care to carers and family members if patients gave consent.

At handover meetings, staff discussed the psychological and emotional needs of patients, their relatives and carers. Carers assessments were completed when required.

Emotional support

Community health services for adults

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff supported patient's relatives, particularly in understanding their complex health conditions. Staff emphasised that this support was incredibly important because many patients and relatives reported feeling isolated because of the Covid-19 pandemic.

Staff told us they took extra time to listen to patients and support their emotional wellbeing and this was reflected in the patient feedback.

Staff completed training on breaking bad news and demonstrating empathy when having difficult conversations. Staff told us they also had training in having challenging conversations, which helped them to be confident in having difficult conversations with patients especially around end of life care.

Understanding and involvement of patients and those close to them

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

Staff communicated with people with protected characteristics and gave examples of their work with a local learning disability care home where clients had communication needs. Nurses worked alongside mental health specialist colleagues and the staff within the service to ensure care plans and interventions were provided in a way that was clear and understood by patients.

The organisation had developed and implemented a process where carers supporting patients in receipt of end-of-life medication could be risk assessed and trained to administer medication safely. This was carefully risk assessed as to the suitability of the patient and carer and agreed with the multi-disciplinary team before a comprehensive program of training and assessing was done with the carer to ensure it was carried out safely. Feedback about this approach was very positive as it meant that patients didn't need to wait any time for potential pain-relieving medication,

During the last inspection in March 2017, we identified that staff did not always know how to access the translation services. At this inspection, this had improved. Staff were able to access interpreters using the language phone line when required and all staff were aware of this system. When appropriate, staff used close family members to support with discussions about care plans and clinical interventions.

Staff clearly recorded each patient's social circumstances and preferences so these could be taken into consideration when delivering care. For example, some patients liked the nursing staff to liaise with a neighbour or carer prior to visiting, or to use a particular door rather than the front door.

The feedback from people receiving care was that they felt listened to, respected and had their views considered.

The organisation had also been using the 'I want great care' feedback system. This is an online secure independent system that lets patients leave meaningful feedback on their care, say thank you and help the next patient. The feedback from this system fed into the clinical governance and gave live feedback on how people felt about the care they were receiving.

Community health services for adults

Is the service responsive?

Good

Service delivery to meet the needs of local people

Staff planned and provided care in a way that met the needs of local people and the communities it served. Staff worked in collaboration with colleagues working for other providers in the local healthcare system to plan care. The urgent community response team was recently created during 2021 to respond to higher risk care needs within a deadline of two hours. The team was available seven days a week and worked from 08.00 until 20.00 every day. The team was made up of professionals from different disciplines including three nurses and three therapists who were able to put in place clinical interventions that lasted up to 72hrs and then transferred on to the intermediate care team or the district nurses to follow up with a comprehensive discharge summary detailing treatment and ongoing plans.

The provider also implemented a successful Gypsy Roma and Traveller health team to work specifically with this part of the local community. This team had successfully done outreach work, particularly around the roll out of the Covid-19 vaccination programme. This team had also provided drop-in clinics in the Guilford area alongside colleagues working in other local health and social care organisations, to improve access to services.

The teams had an estimated 323 -700 patients on their caseloads at any one time.

District nurse visits were scheduled using an electronic system that was colour coded to aid prioritising of high priority visits and to avoid overallocation of staff. The system took account of mileage and travel times when making allocations. On each shift the team leader or nominated deputy would manually adjust the schedule to ensure as many visits as possible could be carried out.

Staff adapted their approach during the Covid-19 pandemic and managed to maintain a consistent level of face-to-face visits as pre-pandemic. The staff were committed to providing their services to already isolated individuals. Alternative telephone and video conferencing appointments were made available to patients which helped reduce pressure on other parts of the healthcare system, such as inpatient services.

Referrals into community services were handled effectively and a multi-agency approach to ensure people were getting the right care in a timely manner. District nursing teams triaged calls using a traffic light system and colour coded schedules of care based on the amount of time the patient needed with staff. These were allocated to a staff member using the electronic notes calendar function. This meant that all staff were able to see their responsibilities and patient allocations for each day remotely.

All services in the adult community pathways had clear admission criteria and well-presented and information leaflets which had gone through the communications team and patient representatives to ensure they were easy to understand.

District nursing teams and the urgent and intermediate care team had no waiting times and were able to provide the right care at the right time. Senior leaders reviewed the number of people waiting, average waiting times and longest waiting time for all services. This was done using data that was exported from the patient record system. This meant that leaders could act to resolve any issues leading to extended wait times in particular areas.

Community health services for adults

The provider developed a Covid-19 rehabilitation service for people experiencing long Covid. The service was developed in response to a recognition that people were experience enduring symptoms before national commissioning guidance was released. The Covid-19 Rehabilitation team named finalists at the UK Social Enterprise Awards.

Meeting people's individual needs

All services were easily accessible to people with mobility needs.

Patient's individual needs were recorded within their electronic care records. Records were person centred and holistic and included patients' wishes when appropriate.

Staff recorded the location where patients who were receiving end of life care wished to die, and staff worked hard to ensure they met these wishes. Leaders observed a key performance indicator (KPI) to ensure these wishes were captured for all appropriate patients.

Staff were aware of the Accessible Information Standard (AIS). The Standard sets out a consistent approach to identifying, recording, flagging and sharing the communication needs of patients. This was particularly important for patients living with a disability, impairment or sensory loss. All information for patients, such as leaflets, were reviewed by the provider's communication team to help ensure the information was easily accessible to all people.

Learning from complaints and concerns

There were systems in place for people using the services to give feedback and raise concerns about care received. All 12 patients and carers we spoke with said that they were comfortable doing this and had only positive feedback for the staff supporting them. They felt able to complain and that staff would address their concerns quickly.

A senior administrator was responsible for making follow up calls to patients to gather their feedback.

Any learning from complaints was discussed with staff during team meetings.

When complaints were received directly to the services an incident report was completed using an incident reporting system. This meant that there was an audit trail which senior managers could oversee.

Is the service well-led?

Good 

Leadership

Leaders had the skills required to effectively run the services. They understood and managed the priorities and issues the services faced. Staff told us the senior leaders were always visible and were approachable for patients and staff.

Staff knew how to contact senior managers and the chief executive officer and gave examples of when they had done so. All staff were aware of the "five minute ward to board" approach that the organisation had developed, and staff had contacted members of the senior leadership team. One staff member described how the chief executive officer had visited the team in the previous month to check in on them and had thanked them for their work during the pandemic.

Senior managers supported staff with their duties during periods of short staffing during the pandemic and supported the team to continue to deliver care. All staff received a thank you package as a way of the organisation acknowledging their work.

All feedback from staff was overwhelmingly positive about the support and guidance they received from the leadership team.

The leadership team had supported staff member's professional development. At several locations we were able to meet with nurses who were being supported in their training to develop into the band 6 district nurse role. Staff felt that leaders supported their career development.

The clinical team leader at South Tandridge district nurse team was being supported to develop their independent nurse prescribing skills. Staff were mentored during their leadership, which they found useful. They also attended placements in other teams to broaden their experience.

Staff also explained how they were supported to undertake research projects and additional study. For example, one district nurse at South Tandridge district nurse team had allocated study time to complete research into end-of-life care planning as part of a master's degree. They were also supported to set up conversations with nurses working across the organisation to understand their experiences of end-of-life care planning, with an aim to putting support in place for staff to formulate these care plans in future.

Senior managers we spoke with had developed staff internally in a "grow your own workforce" initiative to support the recruitment and retention of staff including registered nurses. The organisation had links with local universities to provide associate nurse apprenticeships and the organisation had five members of staff in the process of completing the district nurse additional training.

Vision and strategy for this service

The organisation had a clear vision which was to "rejuvenate the wellbeing of the community", staff were aware of the vision and were able to discuss with the inspection team what this meant for each of their services.

Each service had a clear strategy which was aligned to the overall organisation strategic approach, which was "People-System-Organisation". In practice this meant that the organisational strategy was to put people first including patients and staff, then to support the needs of the wider system before the needs of the organisation.

Culture within the service

All staff we interviewed, both individually and in the four focus groups that we held, felt respected, listened to and valued. The staff felt that leaders treated them as equals and that there was an open culture and they felt able to approach members of the senior leadership team if they wanted to provide feedback.

Community health services for adults

Despite the pressures of the Covid-19 pandemic, we heard from most staff that the area they felt most proud of was the way they had continued to provide a high-quality service and that morale remained high throughout.

No staff reported bullying or harassment at work and many staff had worked within the organisation for many years. Some staff had returned to the organisation because they felt the organisation was very supportive and that morale was high.

The organisation was taking steps to continuously recruit and offered many incentives to work within the organisation. More recently there was a steering group developing the flexible working approach and leaders hoped this would attract some of the long term contracted agency staff to secure permanent employment with the provider.

Governance

Staff at all levels were clear about their roles and accountabilities and were aware of key performance indicators. The provider had developed dashboards, which gave clear information about service performance in line with these KPIs.

Board papers demonstrated that the board had oversight of adult community services quality and performance measures such as complaint management and compliance with key performance indicators. The organisation had an audit committee which ensured that there was an effective internal audit function established by management that provided appropriate independent assurance to the Board.

Staff did not record whether managerial supervision had taken place in line with the organisations policy. Therefore, leaders did not have oversight of whether staff were receiving their regular supervision. However, staff all received annual appraisals, and this was documented by the organisation.

The services held weekly multi-disciplinary team meetings where patients were discussed, and daily nursing handover telephone calls and three times a week a face-to-face handover. This was structured with staff describing what actions were carried out for each patient, for example what referrals were made, and which observations were carried out. This was an opportunity for all staff to contribute in the care for each patient, these handovers were documented, and the minutes were stored on shared files so could be accessed by all relevant staff. The service also held monthly team meetings

A programme of annual audits was in place for all services which was based on four key areas, external audits, internal audits, service driven audits and clinically driven audits. Local leaders learnt from actions identified in audits and shared outcomes with their teams.

Management of risk, issues and performance

The provider held locally managed service risk registers which were regularly reviewed, and improvements made. These fed into a corporate risk register which covered all services

Engagement

The services held team meetings regularly and staff confirmed that there was good teamwork and engagement. We reviewed team meeting minutes for the integrated care and assessment treatment service (ICAT), which demonstrated that line managers updated their staff with information such as but not limited to, service updates, waiting lists, incident reports, audits, compliments and complaints and feedback from individual clinics.

Community health services for adults

The organisation was in the process of developing better ways to improve patient engagement, but they recognised this had been slow due to their primary focus of maintaining high quality care throughout the pandemic.

Innovation, improvement and sustainability

Staff aimed to improve the experience of patients. For example, staff had developed a lower limb pathway, based on NICE guidance, which supported the treatment and escalation of lower limb care. This helped aid the diagnosis of leg ulcers and use compression hosiery kits as a first-line management for venous leg ulceration. This improved patient safety and patient experience, released nurses time and increased the effectiveness of care.

Staff identified that specific treatment was needed for conditions such as musculoskeletal problems, fatigue, shortness of breath, severe pulmonary or respiratory problems, decrease in mobility, and upper limb weakness following Covid-19 infection. They had developed the long-Covid pathway in January 2021 in line with updated guidance published by NHS England.

Community urgent care service

Outstanding ☆

Is the service safe?

Good ●

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. The majority of staff (90%) had completed most of their training online.

The mandatory training was comprehensive and met the needs of patients and staff. Staff completed a structured induction and mandatory training programme which included infection prevention and control, health and safety, moving and handling, data security, equality and diversity, conflict resolution, safeguarding and life support. All clinical staff received the highest level of life support training. Healthcare workers and administrative staff received basic life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received a monthly report from the learning and development department showing training compliance for individual staff. Managers used this to alert staff to any training requirements and managers received email notifications when staff booked onto required training.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Clinical staff completed advanced level 3 safeguarding training suitable for designated safeguarding leads. Reception staff completed level 1 introductory safeguarding training. Clinical staff also received domestic violence awareness training and 'Prevent' anti-radicalisation training. Staff knew how to contact the child safeguarding lead for advice. They sat within the provider's safeguarding team.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff routinely checked for safeguarding notes on the electronic patient record system to alert them to any concerns. Staff knew how to complete an information sharing form and send it to the provider's safeguarding team and the patient's GP, and how to complete and submit a safeguarding alert to the multi-agency safeguarding hub at the local authority. Staff explained the types of incident they would escalate as a safeguarding concern.

Staff followed safe procedures for children visiting the unit. Although the service only provided treatment to adults, staff were aware of and followed procedures to keep children safe if they presented at the service.

Community urgent care service

Cleanliness, infection control and hygiene

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

All areas were clean and had suitable furnishings which were clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly, and staff cleaned equipment after patient contact. Contracted cleaning staff carried out regular cleaning and there was a daily and weekly cleaning programme on display. There was an infection prevention and control lead who carried out regular audits with managers.

Staff followed infection control principles including the use of personal protective equipment (PPE). The door to the minor injuries unit (MIU) was locked to enable reception staff to question arriving patients about possible Covid-19 symptoms before granting access. Staff and patients had access to face masks and hand sanitising gel. The risk of infection for reception staff was reduced by the use of plastic screens. Seating for patients in the waiting area had been rearranged to meet the requirements of social distancing.

Environment and equipment

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

Staff carried out daily safety checks of specialist equipment. Staff checked the emergency trolley and equipment daily and they recorded these checks. Equipment had up to date electrical testing stickers to show that it was safe and fit for its intended purpose.

The service had suitable facilities to meet the needs of patients and the service had enough suitable equipment to help them to care for patients safely. Staff had easy access to emergency equipment which was kept next to the main waiting area in the centre of the unit. At the time of the inspection a programme of environmental works was underway to improve the quality of the environment. This involved installing new air conditioning units and a new medicines storage unit to provide easy and safe access for staff.

The MIU had internal and external closed-circuit television which was monitored by reception staff. All consulting rooms had safety alarms and two doors to allow staff to exit safely in an emergency. Staff reported that they felt very safe at work.

Staff disposed of clinical waste safely. They used colour-coded bags for waste.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident. All patients reported to reception when they arrived. The reception staff entered the patient's details onto the electronic records system and noted any concerns for the attention of clinical staff. Assessment nurses reviewed these records before completing an initial face to face clinical triage assessment with the patient. Triage

is designed to assess the seriousness of a patient's condition and to make plans for their ongoing care. National Health Service England's (NHSE) core standards for urgent treatment centres (including minor injuries units) require that triage takes place within 15 minutes of a patient's arrival, but the service agreed a target with their commissioners of 20 minutes for triage. Staff completed triage within 20 minutes in 96% of cases.

Staff worked as a team to ensure patients were triaged within the target timeframe. Staff monitored the patient records system so all were aware of the patients waiting for triage. Emergency nurse practitioners (ENPs) assisted the assessment nurses with triage if the service was busy, to avoid any delay in assessing patients. Prompt triage helped staff to quickly identify patients at risk of deterioration.

Although the service was for adults only, staff triaged children who presented at the service to ensure they were safe to be signposted to other services which could meet their needs more appropriately.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used a recognised tool called the national early warning score (NEWS2) to identify patients at risk of physical health deterioration. Staff performed clinical observations such as blood pressure, heart rate and respirations. The results were recorded and contributed to a patient's total score. Staff repeated these observations at prescribed intervals and compared the patient's scores over time. Score changes can indicate that a patient's condition has deteriorated, and that treatment should be escalated. Staff had received training on NEWS2 and sepsis awareness and were aware of the possible warning signs and the sepsis treatment pathway.

Staff knew how to escalate treatment appropriately. Reception staff and assessment nurses knew to call on more senior ENPs if they had any concerns about a patient. There is no emergency department on the MIU site. Staff described the procedure if a patient deteriorated. They called for an ambulance to take the patient to the nearest emergency department. Staff described how they kept the patient safe while waiting for the ambulance, including the procedures for monitoring the patient's pain levels and giving appropriate pain relief.

Staff shared key information to keep patients safe when handing over their care to others. Staff described the process if a patient needed to be transferred by ambulance to an emergency department. The local emergency department was provided by an acute NHS trust which used a different computer system. This meant that the emergency department could not access MIU patient records. To ensure key information was shared, the MIU staff printed out all the patient's clinical notes and gave them to the ambulance crew. Staff also phoned the emergency department to discuss the patient before they arrived to help make sure the emergency department staff were prepared.

When staff completed a patient's treatment, they sent information electronically to the patient's GP to keep the GP informed and alert them to any necessary follow-up. Staff obtained patient's consent to sharing information with their GP, and we saw patient records which confirmed this.

Shift changes and handovers included all necessary key information to keep patients safe. Staff had a daily morning meeting for all staff including reception staff. Staff discussed any clinical issues from the previous day and information about patients who were expected to return to the service that day. Staff also discussed practical staffing matters to ensure the service ran efficiently and safely.

Community urgent care service

Staffing

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. There was a range of registered nurses working in various specialist roles who were supported by healthcare assistants. The staffing establishment, the number of staff shown as whole-time equivalents (WTE), for registered nurses was 8.8 WTE. There were 2.5 registered nurse vacancies. The establishment for healthcare assistants was 2 WTE and these roles were fully staffed.

The number of nurses and healthcare assistants matched the planned numbers and the service had low rates of agency nurses. Staffing rotas showed that there was always enough staff. Managers and clinical staff confirmed that the service was fully staffed. Managers said that any unallocated shifts were mostly covered by permanent staff picking up extra shifts or by bank staff. Requests for staff to pick up available shifts were made using an instant messaging application. Staff said this system worked well and limited the number of shifts when agency staff were needed.

The service had low vacancy and turnover rates. Managers confirmed that they were recruiting for two ENPs for which they had already shortlisted candidates, and otherwise were fully staffed.

The service had low sickness rates. Managers received data from the human resources department about staff sickness rates and information about whether individual staff needed meetings with managers following sick leave to ensure staff received any necessary support. Managers reported that most recent staff sickness was due to Covid-19.

Managers limited their use of agency staff. They tried to use staff who were familiar with the service. Managers made sure all agency staff had a full induction and understood the service. Managers used one agency to provide agency staff and tried to use agency staff who were already familiar with the service. Leaders ensured new agency staff had received suitable training before they came to work at the service and that they attended a comprehensive induction.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Patient notes were comprehensive, and all staff could access them easily. Staff also had access to GP's records which provided details of a patient's history. Agency staff had the same access to the service's record system as permanent staff.

We looked at 13 records including five for children and found all were accurate and complete.

There was a triage assessment template which prompted the assessment nurse to collect the required patient information such as medical history, medication and allergies. Records contained relevant information about safeguarding, Covid-19, domestic abuse, mental capacity and patient consent. There were notes to highlight the needs of vulnerable patients or patients with additional communication needs.

Records showed the time when a patient arrived in the service, when they were assessed, when they were treated and whether they were being referred to other services such as the onsite x-ray unit or a service provided by another provider elsewhere.

In line with NHSE guidelines, the service's target for patients to complete treatment was within four hours of arrival. The record system recorded a patient's current length of time in the service and used colour coded notes to highlight the patient's progression within the four-hour treatment window. This enabled staff to monitor the patient's treatment in real time, to ensure all patients were treated as quickly as possible.

Records were stored securely. All records were stored on the electronic system and all members of staff had a personal log-in to be able to access the records. All staff received mandatory training in information governance and data security.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Six of the nine ENPs in the service were nurse prescribers, who had completed an accredited prescribing course and were authorised to prescribe medicines. The other ENPs administered medicines safely under patient group directions (PGDs). PGDs are written instructions which allow healthcare professionals to supply and administer medicines to pre-defined groups of patients without the need for a personal prescription. All PGDs were up to date and signed.

The resuscitation trolley had appropriate equipment and supplies available and all were up to date. The trolley had tamper proof seals and records showed it was checked daily and weekly.

Staff completed medicines records accurately and kept them up to date. The lead pharmacist and managers conducted regular audits of supplies, medicines, PGDs and records.

Staff stored and managed all medicines and prescribing documents safely. The clinic room and medicines cupboards were clean, tidy and well-organised. Staff kept the air-conditioned clinic room, medicines cupboards and medicines fridge securely locked. They monitored temperatures daily.

Prescription pads were locked away securely and had monitoring forms for completion by the nurse prescriber to protect against lost or stolen prescriptions.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff asked for patient's consent to view their GP's records. This allowed them to check a patient's prescribed medicines.

Staff learned from safety alerts and incidents to improve practice. Clinical guidelines were up to date and easily available. Specific National Institute for Health and Care Excellence (NICE) prescribing guidelines were readily available for ENPs.

Managers joined a provider clinical practice group every month. The group reviewed the clinical guidelines used in the MIU to ensure compliance with current NICE guidelines, and the group reviewed the MIU's standard operating procedures to keep them current.

There was also a provider clinical effectiveness group every month which managers attended. The group discussed changes in clinical standards and practice. Managers passed on information and lessons learnt in this group to all staff during the MIU's own monthly team meeting and by email to all staff.

Incidents

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

Staff knew what incidents to report and how to report them. Staff showed a good understanding of what incidents were and described the process to report them.

A new electronic incident reporting system had recently been introduced and staff had received training on it. All staff had personal log ins to give them access to the system. Staff entered details of the incident on the system and the system then automatically shared that information with managers and the provider's patient safety and quality team, to make the investigation faster and easier.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. The duty of candour is a duty that relates to openness and transparency and requires healthcare providers to notify patients (or other relevant people) of certain safety incidents and to provide reasonable support to that person. Staff gave an example of a recent incident that involved a joint investigation with another provider. They described the action taken and the lessons learnt from the incident.

Staff received feedback from the investigation of incidents, both internal and external to the service. Managers attended the provider's monthly clinical effectiveness group when service leads from across the provider discussed incidents. Managers also attended a regular review board when serious incidents from the organisation that provided the emergency department were reviewed. Managers gave staff feedback from all these meetings at monthly MIU team meetings. Full details of the meetings were emailed to all staff. Learning that was relevant to the MIU was also discussed at daily meetings.

There was evidence that changes had been made as a result of feedback. Staff described a recent investigation and the lessons learnt from it. Managers had reviewed relevant processes and as a result clinical staff did additional training on falls and fracture identification.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers investigated all incidents. The provider's incident officer supported managers to ensure the provider's policy was followed when investigating. The MIU's senior manager reviewed all investigations and reports before they were completed.

Managers debriefed and supported staff after any serious incident. All MIU staff met for a meeting every morning and there was also a monthly meeting when staff discussed incidents. Managers provided additional support to staff who needed it and staff told us that they felt well supported.

Community urgent care service

Is the service effective?

Good

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers attended regular provider meetings to keep updated with national guidance, changes in clinical standards and to share best practice. They regularly updated the service's policies and procedures, and informed all staff of any changes, to ensure care and treatment followed current national guidelines.

The MIU provided care and treatment for patients with less serious injuries such as sprains, fractures and wounds. The service did not routinely deal with complex conditions or conditions likely to require hospital admission such as cardiac chest pain. However, the service had protocols in place for the treatment of cardiac chest pain to guide staff if a patient with this condition presented at the service. This ensured appropriate medicines and care were given while alternative arrangements were made for the patient's urgent treatment.

Patients were assessed using evidence-based tools such as NEWS2 and the red flag sepsis pathway.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Assessment nurses assessed patients' pain levels during triage using a recognised pain score method. They recorded pain scores on the patients' records. Staff reassessed patients' pain levels during their stay in the service, to identify if a patient's condition had deteriorated, and they gave pain relief when needed.

Staff identified patients with additional communication needs and had access to a communication book developed by the Surrey Learning Disability and Autism Partnership Board. The book contained pictures which could be used to aid communication with patients including pictures of happy and sad faces to help patients describe their pain levels.

Patients received pain relief soon after it was identified they needed it, or they requested it. Staff prescribed, administered and recorded pain relief accurately. Assessment nurses gave milder pain relief like paracetamol during triage if needed. Stronger pain relief was given by ENPs if the patient needed it. We reviewed 13 patient records. These all showed that staff had recorded pain scores and that patients received pain relief promptly.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Community urgent care service

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service met its 20-minute target for triage in 96% of cases. Data showed that there was only one month in the previous 12 when the 20-minute target was missed and more recently waiting times had been under 15 minutes. Senior managers reported that the service met the four-hour national standard for treatment in 100% of cases.

Competent staff

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

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

Managers had access to a computerised learning and development dashboard. It was colour coded to highlight staff who had outstanding training requirements, so managers could more easily monitor training compliance.

The service had a range of nursing staff at different bands suitable for their roles. The wound dressing clinic was staffed by band 5 nurses, the assessment nurses were band 6 and the ENPs were band 7.

Two thirds of the service's ENPs were also nurse prescribers. Nurse prescribers had completed a specialist prescribing course recognised by the Nursing and Midwifery Council.

Managers recognised that there was a national shortage of ENPs, which meant that recruiting them was challenging. To combat this, managers had recently developed a two-year training programme for assessment nurses to progress into the ENP role. Assessment nurses who followed the programme were called trainee nurse practitioners. They did additional training including modules on advanced clinical assessment, minor injuries and illnesses, and nurse prescribing.

Clinical staff did additional training in NEWS2 and sepsis awareness, radiation protection training relating to the onsite x-ray department, fracture identification training, advanced child and adult safeguarding, and domestic violence awareness training.

Staff had not received any training in mental health, learning disabilities and autism. This meant that they were not appropriately skilled to meet the complex needs of these patients, including communication needs. Leaders reported that staff needed to rely on patients' carers to assist them when managing patients with additional needs. The absence of specialised staff training in mental health, learning disabilities and autism introduced a risk that patients with additional needs who attended the service might not receive appropriate and/or safe care and treatment.

Managers supported staff to develop through yearly, constructive appraisals of their work. Appraisals resulted in the production of a personal development plan for staff, which set out objectives and training requirements for the rest of the year.

Managers reported that all staff appraisals were up to date. Senior leaders analysed appraisal completion data for the adult services directorate as a whole, which the MIU is part of. Eighty-five percent of adult services staff had received an annual appraisal, compared to a provider target of 95%.

Managers did not always support staff to develop through constructive clinical supervision of their work. The provider called clinical supervision 'reflect and learn'. Although access to these clinical supervision sessions had steadily

improved since they were re-introduced in March 2021, further improvements were needed to ensure staff could access them. During March 2022 59% of staff working within the provider's bed-based care group (which included the MIU) had accessed clinical supervision within the past three months. Staff who had managed to attend a reflect and learn group session explained that they took a complex case to the group for discussion and that they found the sessions helpful.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers held team meetings each morning for all staff to address issues relating to that day's service and to discuss any clinical issues from the previous day. Once each month there was a formal team meeting which included all matters which could impact the service, such as staff leave, service updates, audit results, incidents and complaints, lessons learnt, recruitment updates and computer system issues. Staff not on shift were encouraged to join the meeting virtually from home and the provider paid them for their overtime. Managers produced meeting minutes after each meeting and emailed them to all staff. This helped ensure all staff, even those unable to attend the meeting, stayed up to date with all necessary information.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers recognised that staff had difficulty completing online mandatory and additional training. The service had desktop computers which were needed during service hours for patient work. It was difficult for staff to easily access a computer to do their online training. The provider and managers solved the problem by providing every member of staff with a personal laptop. As a result, staff accessed online training from home and the provider paid them for their overtime.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff were required to attend one to one supervision time with managers every six to eight weeks when ongoing training needs were discussed. Staff reported that the provider and managers supported their training and development needs. An assessment nurse, for example, was encouraged to complete specialist courses in the management of minor injuries and in interpreting x-rays. This training enabled them to broaden their skills and it supported their career development.

Managers made sure staff received any specialist training for their role. A healthcare assistant had undertaken specialist training in plaster casting and dressing wounds. The provider was in the process of introducing chaperone training for healthcare assistants. A chaperone accompanies a patient during a consultation or examination, if the patient so requests. Healthcare assistants who acted as chaperones had not previously received training for the role.

Multidisciplinary working

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

Staff worked across health care disciplines and with other agencies when required to care for patients. Managers and staff had good working relationships with partner organisations with the shared goal to manage patient access to emergency care and to divert patients from local emergency departments to other more appropriate services. When patients needed to be transferred from the MIU to an emergency department, staff worked closely with the ambulance staff and phoned ahead to the emergency department to ensure receiving staff were fully briefed on the transferring patient.

Community urgent care service

Staff explained how they had developed a strong working relationship with the acute hospital trust that provided the onsite x-ray service. This had improved patient access to x-rays. MIU staff and trust staff worked together when the x-ray machine was unavailable due to maintenance work and liaised with other local x-ray units to manage the situation for patients.

Staff also attended a meeting with trust staff to discuss incidents at their emergency department and shared learning.

The service had close relationships with the burns units in two acute hospitals and offered telemedicine with them. Telemedicine involves a clinician at one site consulting with a patient or colleague at a distant site using a computer or smartphone. Staff took photos of patients' burns and submitted them electronically to the burns unit staff, who then provided advice. This meant that patients received swift access to specialist advice and treatment.

Staff had close links with local GPs including those who provided the onsite out of hours GP service. The MIU's patient records system linked to the GPs' record system. With a patient's consent, staff accessed the patient's GP records to review the patient's history and, on discharge, staff provided an electronic update to the GP. This made joined-up care easier.

Although the service was located close to the local mental health trust office, staff did not have access to mental health liaison or specialist mental health support.

Seven-day services

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

Service was open every day from 8am to 8pm. The x-ray department was available every weekday from 9am to 5pm and 10am to 5pm on weekends. The wound dressing clinic was also open every day from 8am until 12pm.

Health Promotion

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

The service had relevant information promoting healthy lifestyles and support on the notice board in the waiting area.

Consent and Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. We viewed 13 patients' records, and all showed that staff had obtained the patients' consent.

Is the service caring?

Good

Community urgent care service

Compassionate care

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

Staff were discreet and responsive when caring for patients. Reception staff were aware that the Covid-19 screens at reception made it difficult for patients to speak quietly and privately with staff. Staff ensured that the radio was playing in the waiting room to provide some background noise, which gave some privacy for patients when they discussed personal details with staff. Staff assessed and treated patients in private consultation rooms with closed doors.

Staff took time to interact with patients in a respectful and considerate way. We observed positive staff and patient interactions during the inspection. Staff spoke to patients in a polite and respectful manner.

Patients said staff treated them well and with kindness. One patient reported that they had visited the service on several occasions and staff had always been welcoming and made sure they understood their treatment and any planned follow up with their GP. We saw a recent patient survey with overwhelmingly positive results for dignity and respect. Patients commented on how friendly, kind and empathetic the staff were. They praised how staff listened to them and explained their treatment. Staff had received boxes of chocolates and biscuits, and thank you letters, from grateful patients. Managers put the letters on the staff notice board for all staff to see.

Staff followed policy to keep patient care and treatment confidential. All staff had personal log ins for computers and laptops. Staff described the provider's information governance and confidentiality policy. Managers performed regular audits and spot checks to monitor if staff locked their computers when not in use to prevent unauthorised access and to check that computer screen positions did not allow confidential information to be read by unauthorised people.

Understanding and involvement of patients and those close to them

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

Staff talked to patients in a way they could understand, using communication aids where necessary. Staff had access to a communication book with picture symbols which helped them communicate with patients who had additional communication needs. Staff described the value of involving patients' carers whenever possible to help support patients with additional needs.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Reception staff gave a feedback form to patients when they arrived and asked them to complete the form before they left the service. There was a feedback box at the door for completed forms to be left anonymously. Patients could also give feedback using an online webform. Reception staff sent feedback forms to the provider's quality team, who provided results to managers. Patient feedback was posted on the staff notice board and also on a 'You said, we did' board in reception.

Is the service responsive?

Outstanding ☆

Community urgent care service

Service delivery to meet the needs of local people

People's care and support was planned proactively in a way that met the needs of local people and the communities served. Leaders worked with others in the wider system and local organisations to plan care.

Leaders went above and beyond when considering how the service could best meet the needs of the local population. They did this in collaboration with colleagues at other local providers and with commissioners. A unique wound dressing clinic had recently been set up by staff and commissioners had agreed to fund this permanently. This service was developed because staff proactively completed audits that revealed improvements were needed in the care of patients' wounds in the community. The number of patients needing wound care was increasing, which placed a burden on local GP surgeries. Productivity audits in the MIU showed that ENPs were spending a lot of time dealing with wound care patients, taking them away from clinical work which required their level of expertise. Staff working at the MIU made a proposal to commissioners for a new wound dressing clinic, which commissioners agreed to fund. The service was staffed by registered nurses, which freed up the service's ENPs for other clinical work. Staff had heard that the clinic reduced pressure on local GP surgeries as it was open every day. Staff received positive feedback from patients who valued the continuity of care provided by the clinic team, and the seven-day service.

Staff worked jointly with colleagues in several local organisations (including acute hospital trusts, ambulance trusts, GPs and local authorities) on an urgent and emergency care transformation project. As part of this project, plans were in place to imminently expand the services offered in the MIU.

Plans involved GPs working directly within the MIU, treating both adults and children, making the service accessible to a wider pool of patients. Staff would assess and treat patients with more complex conditions, so they would not have to be transferred to emergency departments, reducing the burden on those services.

Staff had also considered how the service could respond to people's individual needs and preferences by developing the scope of the service. This involved increasing the range of diagnostic testing available which in turn prevented the need for many patients to travel further for these tests. Equipment had been ordered for point of care testing. Point of care testing is diagnostic testing carried out at the time of the consultation with the patient. Such testing provides instant results, and benefits patients by allowing for immediate, informed clinical decisions about a patient's treatment. The increased scope of the service reduced the chance that patients would have to travel further for diagnostic and screening services so helped promote their wellbeing and quality of life.

The transformation project also included technical improvements to enable the MIU to offer pre-booked appointments in addition to the current walk in service, to increase flexibility and choice for patients. Patients would be able to arrange an appointment via phone or online contact with NHS111.

The plans to develop the service would benefit the local population and would help to reduce pressure on the local urgent and emergency care services. Staff at all levels described their commitment to the transformation project because of the benefits it would have to the local population. They described additional training they were receiving to help them build their professional skills in readiness. For example, one ENP had received extensive training in interpreting x-ray images. Additional training for clinical staff in the treatment of children was planned, and leaders had already planned training for staff on the new booking system for pre booked appointments.

The service also collaborated with local GPs. Managers monitored data for referrals to the MIU from local GPs. If the data indicated changes in referral trends from a particular GP surgery, managers worked with the surgery to identify and resolve any issues.

Community urgent care service

Facilities and premises were appropriate for the services being delivered. The MIU had enough rooms and facilities for the needs of the service currently and for its imminent expansion. There was already a room available for the additional point of care diagnostic testing, with some equipment in place. There was an x-ray department provided by a local acute trust and conveniently located down the corridor in the MIU.

Staff were clear about how to safely manage patients who presented at the service experiencing acute mental health difficulties. Staff said they would call an ambulance to take the patient to the local emergency department which had a mental health liaison team available. If it was not an emergency, staff said they would contact the patient's mental health team, if they were already receiving help. Staff could also refer patients to the provider's website which had mental health advice and links to support services.

Meeting people's individual needs

Staff had outstanding skills and an excellent understanding of their local population, values and beliefs that may influence their decisions on how to deliver care, treatment and support. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Reception staff knew how to access telephone translation services if people needed language support. There was a member of staff available who could use sign language.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff were alert to patients' individual communication and language needs. If a patient with additional needs attended the service, staff assessed and treated them urgently to minimise any distress caused by waiting. Staff had access to a communication book with picture symbols which helped them communicate with patients who had additional communication needs.

There was a reduced-height desk at reception for easy access for people in wheelchairs, and the reception desk was fitted with a hearing loop, which is a special type of sound system for use by people with hearing aids.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times were in line with national standards.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

The service was commissioned for adult patients, who were triaged within the target time of 20 minutes. If children attended the service, staff said that they were triaged as a priority and within 15 minutes to make sure they were safe to be signposted to a more appropriate children's service. The triage nurse monitored the patient records system closely to keep track of waiting times. ENPs also monitored the records system and if the service experienced a busy period, ENPs would also carry out triage to prevent delays. Staff described with pride the value of teamwork to meet triage targets and avoid delays for patients, which ensured patients were assessed quickly and safely.

The Department of Health's standard is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in an MIU. Managers reported that this standard was consistently met.

Community urgent care service

Leaders monitored the progress of patients through the service using the electronic records system. Patients' details were highlighted in orange if they had been waiting two hours for treatment, and in red if they had been waiting three hours. Managers said that the colour coding assisted them in effective monitoring of waiting times. If they saw patients' details turn red, they made urgent enquiries with staff to be aware of the current situation in the service, and to make any necessary staffing changes so patients' treatment was not delayed, and treatment targets were met.

At the time of the inspection, only walk in consultations were available to patients. Pre booked appointments arranged through the NHS111 phone and online service were about to be introduced. This would provide patients with more flexibility as to when they accessed the service.

Staff did not monitor the number of patients leaving the service before being seen for treatment. It is important that patients do not leave the service without being seen in case they are at risk of their health deteriorating.

Learning from complaints and concerns

People's feedback was valued, and issues were dealt with in an open, transparent and honest way. It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

The service clearly displayed information about how to raise a concern in patient areas. There were posters in the waiting area which explained the complaints procedure. The reception staff gave out feedback forms to all patients when they arrived in the service and asked them to complete them before they left. The provider's website gave details of the complaints procedure and the NHS friends and family test, which collected feedback on the quality of the service.

Managers investigated complaints and identified themes and a policy was in place to support them in doing this. Managers could seek advice from the provider's complaints manager when needed. They gave examples of both formal and informal complaints that had been received. They described how they managed and investigated the complaints, including how they contacted the patients involved. Senior managers were routinely involved in the resolution of complaints. The draft outcome letter was sent to the provider's chief executive for approval before it was sent out to the person who had complained.

Patients received feedback from managers after the investigation into their complaint. Managers were aware of the duty of candour, which is a professional responsibility to be honest with patients when things go wrong. Managers contacted patients to discuss their complaints and apologised when the investigation highlighted a failure in the service.

Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints and learning were discussed and shared with staff in the daily and monthly MIU meetings. We saw minutes from the most recent team meeting which confirmed that complaints are a regular agenda item and that no complaints had been received recently.

Staff could give examples of how they used patient feedback to improve daily practice. Managers gave an example of a complaint that had been jointly investigated with the acute trust who ran the x-ray department, and how lessons learned included some additional training on fracture identification. Patient feedback had recently been received about the lack of a television in the waiting area. Managers had arranged for a television to be installed and it was awaited.

Community urgent care service

Is the service well-led?

Outstanding ☆

Leadership

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

The two service managers were qualified ENPs with relevant skills and experience, which enabled them to run the service well. They reported that senior leaders supported them well.

Leaders worked on shift with their colleagues and supported clinical staff when they experienced pressures. Staff spoke highly of their leaders and confirmed they were approachable and available for support when needed. Staff knew who the most senior leaders in the organisation were and reported that they visited the service from time to time.

Leaders had developed a training programme to support assessment nurses to progress to band 7 ENP roles after two years' training.

Vision and Strategy

The vision and values were imaginative and person-centred and were developed in partnership with people and staff. This made sure people were at the heart of the service. The service had a strategy to turn its vision into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders worked with multiple stakeholders and local providers on a transformation project for local urgent and emergency care. Leaders were imminently expanding the services offered by the MIU as part of the transformation project. A GP would work within the service every day and they would treat children as well as adults. Increased diagnostic testing would become available. These measures meant that the MIU could treat patients who presented with more complex conditions, avoiding transfers to the emergency department. This was an integral part of the local health strategy.

Culture

Staff had developed and sustained a positive culture in the service encouraging staff and people to raise issues of concern with them, which were always acted upon. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff morale was high, and staff showed great enthusiasm for their work. All staff we spoke to reported that they were happy working for the provider, that they were well supported by leaders and that all team members got on well together regardless of role or seniority. Staff spoke proudly of how the team had worked together and supported each other during the Covid-19 pandemic.

Community urgent care service

Staff felt recognised for their positive contribution. They reported that they had received thank you letters from patients, and that thank you messages had been written in the staff newsletter. Members of the local community had donated food items to staff who worked through the national lockdowns during the pandemic.

There was a provider wellbeing group, and staff felt that senior staff supported their mental wellbeing. Staff said that leaders produced flexible staffing rotas to help accommodate their family responsibilities, which they found helpful. Staff valued the steps that leaders took to show their appreciation, such as a birthday day off, wellbeing packs, free tea and coffee, free parking and an awards ceremony to recognise achievements.

Senior leaders recognised the importance of clinical supervision for staff. They had re launched and publicised the clinical supervision programme called 'reflect and learn' after Covid-19,and encouraged staff to undergo training as facilitators.

In addition to clinical supervision, staff had formal one to one time with leaders every six to eight weeks. Staff reported that they were also supported by leaders with daily and monthly staff meetings, and that leaders had an open-door policy which encouraged staff to approach them at any time.

There was continuous communication between staff whilst on shift to ensure that patients were assessed and treated without delay. Staff pulled together during busy periods to make sure everyone was supported.

Staff spoke positively about the opportunities for extra training and career progression. Two ENPs had been sponsored by the provider to attend a national urgent care conference. Assessment nurses had become trainee nurse practitioners and were working towards promotion to band 7 ENPs. Staff said it was a good training environment to work in with students from several universities working in the service.

Staff reported feeling comfortable discussing issues with leaders who were approachable and had an open-door policy to encourage staff to raise issues. Staff felt that comments and suggestions were welcomed. Some staff, for example, planned to give feedback at an upcoming team meeting about the height of the Perspex screen at the reception desk, which they felt hindered their ability to hear patients.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The service worked in partnership with other organisations to make sure they were following current practice and providing a high-quality service. They strived for excellence through consultation, research and reflective practice. Leaders had monthly meetings with external providers to monitor and progress the urgent and emergency care transformation programme and the resulting extension of the MIU. There were robust governance frameworks in place to provide oversight of quality and safety. Leaders took part in a monthly clinical effectiveness meeting led by the provider's chief nurse, which had oversight of clinical standards, NICE guidance, policies and performance targets.

Leaders had easy access to audit results on a computer dashboard so they could monitor required actions effectively. Senior leaders played an active role in the resolution of complaints and they reviewed incidents, including trends and lessons learned. Leaders fed back results and actions to staff at regular staff meetings.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers planned a programme of audits 12 months in advance. Regular audits were carried out covering infection prevention and control (IPC), hand hygiene, x-ray results from the onsite x-ray department, the wound dressing clinic within the MIU, patient records and medicines management.

Managers had access to a computer dashboard showing the results of all audits. They used the audit results to produce action plans for required service improvement work. They actioned the action plans, and progress was monitored by the provider's quality improvement team.

Managers used information from the audits to improve care and treatment. They reported how action was taken following a recent IPC audit which revealed some omissions in the cleaning regime. An action plan was developed with the cleaning team to include additional deep cleaning. Staff increased the frequency of cleaning audits to monthly, and IPC compliance was raised to 96%.

Management of risk, issues and performance

Leaders monitored the performance of the service. For example, they analysed data showing whether patients had been seen within the required 20-minute timescale. Data was tracked over time so leaders could monitor the performance of the service.

Although leaders had access to reliable data for service performance targets such as the 20-minute triage target and the four-hour treatment target, no data was collected relating to patients who left the service without being seen. Patients who leave prior to assessment or treatment are a safety concern because staff do not know the seriousness of their condition. As data was not collected, leaders did not know if this was a rare or frequent occurrence.

Although leaders had access to electronic staff records, there was no dashboard or data available to readily show if staff had received regular clinical supervision, one to one supervision or an annual appraisal. Some data relating to clinical supervisions and annual appraisals was collected and analysed centrally by the provider, but it was not specific to staff in the MIU. It related instead to larger cohorts such as bed-based care and adult services. We saw no data that related to staff one to one supervision with leaders.

As a result, leaders could not easily monitor whether staff in the MIU had received their required supervisions and appraisals in accordance with provider policy.

Leaders had embedded a comprehensive audit programme and had easy access to electronic audit results and action plans, so they could monitor the progress of required actions.

Leaders had a good understanding of the top risks to the service and described how staff worked to mitigate these risks. The top current risk was that the service would have to close for four hours for deep cleaning if a patient with Covid-19 symptoms attended the unit. An external door to one treatment room had recently been installed to enable patients, who could not guarantee their Covid-19 status, to visit the service without jeopardising the rest of the unit, whilst still enabling the patient to be treated. Other risks on the risk register related to poor cleaning standards and undiagnosed fractures on x-rays. Leaders had put measures and audits in place to reduce and monitor these risks.

Community urgent care service

Information Management

The information systems were integrated and secure. Patient information was managed appropriately, and staff were able to access GP records to receive and share up to date patient information. Staff shared test results, photos and x-rays digitally with other providers to speed up access to specialists. A new system was being installed to allow the service to connect to NHS111 so the service could accept pre-arranged appointments for patients.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients and to place patients at the heart of everything they did.

The provider's website provided details of the different ways in which people could give feedback. Feedback about the MIU was consistently positive.

The urgent and emergency care transformation project was a collaboration of over 20 local providers and healthcare organisations. Leaders were actively involved in the project, designed to provide more efficient, joined up care for patients and to benefit the wider population with improved access to emergency care.

Learning, continuous improvement and innovation

The service had a track record of being an excellent role model, actively seeking and acting on the views of others through creative and innovative methods. All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.

All the staff we spoke to were committed to improving the service. They were proud of the wound dressing clinic which was a quality improvement project following an audit. Leaders and staff spoke positively about the imminent extension to services and the benefit to patients. Staff reported how leaders encouraged them to continue training and how there was a positive learning environment in the MIU.

Community health inpatient services

Good

Is the service safe?

Good

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it. Mandatory training included safeguarding level 2, fire safety, infection prevention and control, moving and handling and basic life support.

Most of the staff had completed the training as required. Overall, across community health inpatient services 76% of staff had completed moving and handling and 80% for basic life support in December 2021. The provider's training target was 85%.

Both moving and handling training and basic life support training were completed face to face and there had been difficulties providing this training during the Covid-19 pandemic but there were now plans in place to ensure staff could complete these.

Most of the training was accessed online and staff were given protected time to complete this.

Staff felt that the mandatory training met their needs and gave them the skills to do their jobs effectively.

Senior leaders had oversight of training completion rates on a monthly basis for all staff and this was regularly reviewed.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. All staff completed safeguarding level two training as part of their mandatory training.

The service had a dedicated safeguarding lead that staff could access for advice. Staff had training on how to recognise and report abuse for adults and children and they knew how to refer safeguarding concerns to the local authority.

Staff said they felt confident raising safeguarding concerns and understood their role in the process.

Staff explained how they would escalate any safeguarding concerns and how they worked together with other agencies. For example, staff had worked jointly with the local mental health team to support a patient to address a hoarding habit and make their home environment safer for them to live in.

Children who needed to visit their relatives in hospital could do so in a private room away from the main ward.

Cleanliness, infection, prevention and control and hygiene

Community health inpatient services

Staff knew how to prevent infection and had received training in infection prevention and control.

The ward environment and clinical equipment were visibly clean. There was a completed cleaning schedule and each area was deep cleaned weekly. The cleaning schedule also gave directlions to staff about how to clean items correctly.

Clean stickers were placed on all items to indicate when they had last been cleaned.

At the last inspection in March 2017 we identified that the physiotherapy gym was not clean. At this inspection this had improved and the physiotherapy gym was kept clean.

A recent Covid-19 outbreak was well managed and the infection prevention and control lead visited the ward regularly to provide support to staff in meeting infection, prevention and control principles.

There was a Covid-19 status board for patients which was colour coded and this was also contained in the handover documents.

Patients were cohorted in their bays as the ward was recovering from a Covid-19 outbreak. Patients were moved into the day room whilst their bed space was being deep cleaned.

Staff adhered to national guidance and policies and procedures in reducing the spread of Covid-19. All patients were tested on admission and isolated in a single bedroom whilst awaiting a test result or remained isolated following a positive result until considered non-infectious as per national guidance.

There were adequate supplies of PPE for staff and visitors were asked to wear face masks.

Staff followed national guidance for allowing visitors on the ward and the use of PPE.

Environment and equipment

During the last inspection in March 017 we identified that equipment was not stored safely and securely. The safe storage of clinical equipment including wheelchairs and hoists continued to be a challenge during this inspection. The ward had a shortage of rooms for equipment to be stored in, which meant that some equipment had to be stored in the dayroom and the patients' records trolley was in the corridor.

There were several hoists and wheelchairs stored in the dayroom. Senior leaders said this was being addressed and new storage space was being created by repurposing an old bathroom as dedicated storage space for equipment. A refurbishment of the ward was taking place during the inspection and the flooring was being replaced.

Staff had the equipment they needed to meet patients' needs and were able to order specialist items including pressure relieving mattresses and communication aids such as whiteboards.

Equipment was subject to regular portable equipment testing and checks and staff were allocated to check equipment daily.

Patients had access to specialist equipment to aid their rehabilitation and meet their needs including use of a dedicated physiotherapy gym. Staff had access to a hoist and pressure relieving mattresses for patients to use

Community health inpatient services

Staff had access to emergency equipment and emergency medicines on the ward, which were in date and checked regularly. Staff could access a defibrillator, oxygen and suction located on the emergency resuscitation trolley.

Staff had completed their annual fire safety training and day and night staff had taken part in a live fire evacuation drill. Staff were trained to use specialist evacuation chairs to help them move immobile patients in an emergency.

The ward complied with the guidance on eliminating mixed-sex accommodation. Bed bays were male or female only bays with a shared bathroom.

Equipment including bariatric chairs and beds were available for larger patients.

Dementia-friendly signs and pictures supported patients to navigate in key areas indicating toilets.

Some staff reported that the layout of one of the bays was inconvenient this made it difficult to see to patients' needs.

Internet coverage on the ward was sometimes poor which affected patients' ability to connect to the internet.

Assessing and Responding to Risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff assessed malnutrition using the Malnutrition Universal Screening Tool (MUST) and a cognitive assessment tool. However, staff did not always record the results of these assessments clearly. For example, two out of five patient notes we looked at saw food and fluid intakes not totalled correctly and patients' weight not accurately recorded. This meant patients may be at risk of not having their food and hydration needs met appropriately.

Staff assessed whether patients could easily use call bells to call for staff assistance. Staff also assessed whether patients were at risk of slips, trips and falls. Patients at risk of slips, trips and falls were observed closely by staff and sensor mats alerted staff to respond to patients who had fallen.

Staff were trained to safely complete specialist assessments such as bed rails assessments.

Patients with known cognitive issues or at risk of developing them were assessed by an external mental health team using a cognitive screening tool and staff took appropriate action when patients scored above the normal range. Patient risk was discussed at handover meetings between each shift.

During the inspection we reviewed five patient risk assessments and found that patient risks were

appropriately identified and managed. Staff used National Early Warning Score (NEWS1) charts and staff recoded outcomes clearly. This is a physical health assessment completed routinely to help identify potential physical health deterioration promptly.

Staff identified and quickly responded to patients whose physical health had deteriorated.

Staffing

Community health inpatient services

The service had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Although there was currently five whole time equivalent (WTE) registered nurse posts vacant, these shifts were covered by regular agency staff who were familiar with the service. These regular agency staff received a thorough induction to the service.

New permanent staff were supernumerary for two weeks when they first joined the service.

The provider had plans to improve recruitment. These involved considering alternative shift patterns, rolling recruitment adverts and developing a new nursing associate role. One nursing associate was currently employed on the ward. Staff sickness rates across all adult services was 4%.

Staff turnover rate across all adult services was 16% cumulative for the past twelve months. Staffing consisted of nurses, health care assistants, physiotherapists, rehabilitation assistants, nursing associates and occupational therapists.

Managers could increase staffing levels according to patient needs.

Medical staffing

The provider did not employ its own doctors. Instead, a service level agreement was in place with a local General Practitioner (GP) provider. A team of three GPs visited the ward for five to six hours a day six days a week and provided out of hours cover. In an emergency, staff contacted the emergency services.

Quality of records

The ward used a mixture of electronic and paper records. The electronic records system was also used by GPs across the local area and all staff had access to the system. This meant that GPs had easy access to clinical information once patients were discharged from the ward.

We looked at five patient care records. All records were stored securely and easily accessible to staff. Patient risk assessments, routine patient observations, food and fluid charts and pressure care assessments were kept in on paper.

Symbols were also used to identify patients with cognitive issues, falls risk, patients requiring regular checking by staff to ensure basic needs were met and the number of staff needed to safely mobilise the patient.

Medicines

The service had systems and processes to safely prescribe and administer medicines, but these were not always followed effectively by staff. Some medicines were found to be out of date.

Two Glucagon injection kits, which are used in emergency treatment for diabetic patients, had expired in January 2022. This meant they could have been ineffective in an emergency. We also identified some out of date topical creams that had not been disposed of. This posed a risk that these medicines might be used despite being potentially ineffective. These medicines were disposed of promptly during the inspection.

Community health inpatient services

Despite the fact staff regularly checked the clinic room and received support from an external pharmacy company, these issues had not been identified by the provider's own medicines governance assurance process.

Medicines were stored safely. The clinic room fridge temperature was checked regularly and was within normal range. The controlled drugs cupboard was locked and records were correct and up to date.

The emergency drugs were sealed and in date and were checked regularly and this was clearly recorded.

There were no gaps on prescription sheets and known drug allergies were recorded for each patient.

Safety performance

Staff monitored and recorded an appropriate range of safety performance indicators.

These included recognising patients at risk of physical health deterioration and using a routine physical health monitoring tool.

Falls and pressure injuries were reported on and reviewed at weekly governance meetings where staff could identify any themes or trends.

The service made appropriate changes to care for patients with complex needs after identifying potential safety concerns. For example, safe 'bay watch' ward area equipped with sensor mats and a member of staff always present helped mitigate the risk of falls.

Incident reporting, learning and improvement

Staff understood their responsibilities to report incidents.

A new electronic incident reporting system was recently introduced and staff had received training in how to use it.

Staff said there was a no blame culture and everybody worked together to reflect and learn from incidents. Learning from incidents helped shape future training and development needs. Serious incidents and root cause analysis reviews were carried out after incidents and these were seen as opportunity to learn and improve patient care. For example, a patient was discharged home based on their wishes, but their needs changed rapidly, and their health deteriorated, and they were readmitted to hospital. Staff reviewed and made changes to the discharge planning process following this incident.

Staff were offered debriefs following serious incidents and these were included in reflect and learn sessions.

Is the service effective?

Good 

Evidence-based care and treatment

Community health inpatient services

Staff provided good care and treatment based on national guidance and evidence-based practice. Staff used an appropriate assessment tool to help prevent patients developing pressure sores.

Staff had access to pressure relieving mattresses that helped reduce the risk of pressure sores developing. One patient required their position to be changed every two hours and this was documented in their care plan.

Staff monitored patients' physical health regularly. National Early Warning scores (NEWS) were recorded daily and staff escalated scores that fell outside the normal range to help prevent patients from experiencing harmful physical health deterioration. Staff also recorded changes in patient's weight each week.

Staff used intentional rounding to meet the needs of individual patients. This involved assessing each patients needs in relation to toileting, comfort, pain control, nutrition and hydration, pressure injury care and safety.

Patients' weight was monitored each week and patients were referred to a dietitian if they needed support with their nutrition or hydration.

We observed staff supporting patients with their mobility.

No patients were subject to detention under the Mental Health Act 1983 during this inspection.

Patients' recovery care plans were personalised, appropriately assessed patients' needs and detailed the views of patients, carers and relatives. The care plans addressed patients' personal care needs, mobility and falls prevention.

Staff worked together and developed rehabilitation goals for each patient. These included increasing independence, improving mobility and activities of daily living. Occupational Therapists and Physiotherapists produced joint rehabilitation plans for some patients. For example, increasing mobility and managing stairs.

The occupational therapist also completed home visits to ensure that the patient's home environment was suitable to meet their needs once discharged, such as providing extra equipment.

Pain relief

Patients received pain relief when they needed it. We spoke with six patients and they said their pain levels were well managed by staff giving them medicines as prescribed.

Some patients were given pain medicines before mobilising and this increased their ability to perform tasks with comfort.

The use of controlled drugs for pain relief was regularly reviewed and monitored.

Trained nurses were able to administer paracetamol without a doctor's prescription for temporary pain relief.

One patient with communication needs had a care plan that explained how they expressed pain and staff knew the signs to look for when caring for them.

Nutrition and hydration

Community health inpatient services

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

The ward could accommodate patients with Percutaneous Endoscopic Gastrostomy (PEG) feeds but not patients with naso-gastric feeding tubes.

The service made dietary adjustments for patients' religious, cultural and other needs and staff alerted the catering team to any special needs as identified at initial assessment.

Staff were made aware of patient feeding and hydration needs at mealtimes during handover meetings.

Staff were always available to assist patients with their meals as needed. A comprehensive four step pathway was in place for monitoring nutrition and hydration with clear steps for staff to follow at each stage including referral to a dietitian.

A dietitian visited the ward weekly and regularly advised staff about nutrition. The dietician and the speech and language therapist made recommendations for the use of thickeners to reduce choking risk in some patients.

Staff monitored patient's continence care and monitored constipation and bowel movements using the Bristol stool chart.

Patients' individual dietary needs were clearly documented and understood by staff, especially for patients with communication needs. Staff used a Malnutrition Universal Screening Tool (MUST) in line with professional guidance to assess and improve nutritional care.

Most patients and carers gave positive feedback about the meals provided and there was plenty of choice. However, some patients said the food was not hot enough. This was because food was cooked away from the main ward and heated up when it arrived. This had been escalated during a housekeeping meeting and was being addressed by the provider at the time of the inspection. There were two nutrition champions on the ward who worked to promote nutrition and hydration.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

Staff used the Barthel Index as a recognised tool to measure patient outcomes. The Barthel index consists of 10 variables that are used to measure a patient's daily functioning around activities of daily living (ADL) and mobility, including continence and dressing. Staff scored each variable to assess how each patient's functioning had changed over time.

Senior leaders had oversight of patient outcomes and routinely collected information on patient discharge pathways.

Competent staff

Leaders ensured staff had the skills and experience to meet the needs of patients on the ward.

Staff reported that patients with more complex needs were being admitted to the service because of the ongoing Covid-19 pandemic. This meant they needed to learn more specialist skills to safely care for patients with more complex needs. Additional training was available in speech and language therapy and in supporting patients with their mental health needs.

Staff felt they could access appropriate training and said senior leaders were supportive in their requests. One nursing associate had completed venepuncture training.

Clinical skills updates were available for staff and the senior leadership team who are all clinicians were often visible on the ward and would lead by example.

The provider was yet to introduce mandatory training in caring for patients with a learning disability or autism, which was expected to become requirement later in the year.

Although staff felt well supported in their roles and reported attending supervision sessions with their line manager, leaders did not monitor whether staff had received their required managerial supervision. This meant that potential challenges in completing staff supervision, which gives staff the tailored support they need to fulfil their roles safely, might not be identified promptly,

Staff received clinical supervision in reflect and learn sessions.

Staff received an annual appraisal.

Multidisciplinary working and coordinated care pathways

All staff we spoke with felt that they worked well together as part of a multi-disciplinary team (MDT). Staff described good opportunities for joint working, learning from each other and being able to challenge decisions constructively with colleagues.

Staff reported good working relationships with professionals visiting the ward and other community providers. Staff worked with colleagues in adult social care when planning a discharge package of care for patients. We saw evidence of joint home assessments carried out by professionals from different teams to plan patients discharge.

Health promotion

Patients were identified who may need additional support due to frailty or cognitive issues. Information and advice was provided by staff about health conditions, treatment and outcomes.

Patients were offered advice by staff and could access leaflets on healthy eating and physical activity.

Consent, mental capacity, deprivation of liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent and knew how to support patients who lacked capacity to make their own decisions. For example, staff followed lawful procedures to keep patients safe by restricting their liberty, under Deprivation of Liberty Safeguards (DoLS) legislation.

Community health inpatient services

One patient was subject to DoLS legislation and this was due to expire in the next few days and a best interest review meeting was in place.

Staff completed mental capacity assessments that were decision specific. Staff completed Mental Capacity Act training.

Staff worked closely with mental health teams and used a cognitive assessment tool to identify patients at risk of cognitive decline.

Patients at risk of absconding were placed in a 'bay watch' bay where a member of staff was always present.

Implied consent was sought by staff before giving care and explanations were given.

We observed staff communicating with hand signals with a patient who had learning difficulties and providing an appropriate explanation of the care they were about to give and seeking their consent.

At the previous inspection we had advised that the provider should record and update Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) records regularly and appropriately

We found that (DNACPR) records were appropriately maintained and family were involved in decisions about whether patients should be resuscitated where possible.

Is the service caring?

Good 

Compassionate Care

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

We observed positive and compassionate interactions between staff and patients on the ward. For example, patients were being supported by staff to read newspapers and to dress appropriately to protect their privacy and dignity.

Staff did not always protect the confidentiality of patient information. During the inspection staff left a laptop containing patient information unattended in a communal area. Paper patient records were also left on an unlocked trolley in the communal area. Leaders took immediate action to remedy this during the inspection.

Patients had easy access to a call bell system. A new call bell system had recently been installed and leaders were able to access monthly audit data of response times from this new system to check how long patients were waiting.

During the last inspection in March 2017 we identified that call bells were not answered in a timely way. This concern had been addressed at this inspection and we observed staff responding to call alarms in a timely manner. Most patients told us that staff would promptly respond to their call bell when it was pressed.

Patients reported that they got on well with staff. However, some patients felt that staff were often busy and didn't have enough time to interact with them.

Community health inpatient services

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment. Family members had been involved in developing care plans and preparing plans for discharge

We saw evidence of relatives being contacted by staff to update them on patient care. This was recorded in patient notes. A permission to share information with others form was also completed in some patients' records.

Staff provided phones for patients to use to keep in touch with their relatives.

One patient with a learning disability had a 'This is Me' document in place. This provided staff with information about their preferences, needs and communication styles. A note on the handover form advised all staff this was in place and asked all for staff to read it before caring for this patient.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress.

Patients described staff as kind and caring and that they were always helpful.

Staff understood patients' personal, cultural and religious needs. Relatives told us that communication was very good with staff.

We saw staff encouraging a patient with communication needs to drink fluids and they were offered a choice of drinks and staff took time to wait for their reply. We observed staff providing support to patients who required this whilst mobilising.

Is the service responsive?

Good 

Planning and delivering services that meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served.

The discharge team at the local acute hospital worked closely with staff on the ward to ensure patient referrals were appropriate and information was shared effectively.

Staff reported changes in the cohort of patients with more complex needs and co morbidities including cognitive impairment and learning disabilities becoming more apparent over last few months. The staff had adapted to these patients with more acute needs by increasing staffing levels as needed on the ward and working closely with other visiting professionals.

Staff discussed patients' progress at daily handover meetings. Discharge, pain management and physiotherapy goals were discussed at the weekly multidisciplinary team (MDT) meeting.

We observed a handover meeting, where important information was discussed such as patient risks, mobility status and any actions required to work towards discharge. Patients were supported by staff to attend follow up appointments at the acute hospital and we saw evidence that transport had been arranged for this.

Meeting the needs of people in vulnerable circumstances

Managers told us that they could access interpreters when required. The service made reasonable adjustments for patients with a disability. For example, staff used picture cards and signs to communicate with patients who were experiencing cognitive difficulties. One patient was unable to verbally communicate and used hand gestures to communicate.

Staff used whiteboards to communicate with patients who had a hearing impairment.

Staff facilitated contact with relatives for patients during Covid-19 outbreaks when visiting was restricted on the ward. Staff used mobile devices to set up video and telephone calls for patients and relatives.

Easy read versions were available of some information leaflets.

Access to the right care at the right time

There was no waiting list for admission to the ward at time of the inspection.

In January 2022 there were 18 patients experiencing a delay to their discharge with a total of 145 days spent on the ward when medically fit for discharge or transfer. Staff worked with community providers to organise packages of care for patients due to be discharged and delays in this process were the main reasons for delayed discharge. Some patients also required specialist placements and these were not always available in a timely way. The average length of stay in January 2022 was 25 days per patient.

Most patients were referred to the service by the local acute hospital trust. A discharge liaison team at the acute hospital provide worked closely with ward staff to decide whether patients were suitable to be admitted to the service.

The service had exclusion criteria in place. This meant that staff identified the types of patient who they could not safely provide a service to. For example, the service was not commissioned to deliver treatment to patients who required a naso-gastric tube, intravenous fluids or piped oxygen.

GPs supported staff with advice as needed when they considered whether to accept referrals to the service.

Patients' discharge started to be planned after they were first admitted to the service. The range of multi-disciplinary professionals who worked with the patient and other agencies such as social care and family members were involved in discharge planning.

The local community hub worked with the ward staff to allocate community care and nurses. The community hub coordinated patient care and services that were put in place in the community for patients as they were discharged. This included nurses and social care staff.

Patients requiring end of life care could be cared for on the ward and side rooms were available to ensure privacy and a quiet space for patients and their relatives. Emotional and bereavement support was also available for relatives

Community health inpatient services

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. Patients complaints included the quality and temperature of the food. Some patients mentioned not having therapy sessions as often as they wanted.

Patients and carers were given an information leaflet on how to provide feedback and make a complaint if they wished to do so. Patients and relatives said they would complain to the matron in the first instance but did know there were other ways to complain.

There was a 'You Said We Did' box on the ward to encourage ideas and feedback from patients.

Is the service well-led?

Requires Improvement 

Leadership of the service

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

Leaders were approachable. Staff reported that leaders were visible on the ward and would help with patient care as needed.

The matron did a daily tour of the ward speaking with all patients and staff and their office was based on the ward.

Leaders said the provider had supported them to develop in their leadership roles. Some staff had attended a leadership courses and received coaching as part of their development.

Relatives reported that they could contact the matron easily.

Service vision and strategy

Most of the staff we spoke with felt that the organisation's values were reflected on the ward and that providing the best care for patients was their motivation. Staff demonstrated these values and showed empathy when providing high quality care to their patients.

Staff described wanting to do the best for patients and their colleagues.

The vision of the organisation was first rate people delivering first rate care for first rate value to rejuvenate the local community.

Culture within the service

Staff felt supported, respected and valued. They described the service as a good place to work with a supportive and caring culture.

Staff were supported to learn lessons when things went wrong without being made to feel blamed.

Staff said they had good support with the expectations of their roles within the team and staff also understood other peoples' roles.

The service promoted equality and diversity in daily work and provided opportunities for career development. For example, healthcare assistants had been supported to complete nursing associate training within the organisation.

The service had an open culture where patients, their families and staff could raise concerns without fear. Staff told us that they knew how to raise concerns if needed.

All staff we spoke with said that they felt valued and supported and morale was high within the team.

Managers recognised the impact Covid-19 had on staff and staff wellbeing resources had been put in place and staff who had used them reported a good experience. For example, an Employee Assistance Programme (EAP) was in place and staff were offered counselling and support.

Governance, risk management and quality measurement

The provider's systems for assessing and monitoring the quality and safety of the service were not always effective. We identified medicines that were out of date that had not been identified as being unsafe to use by any internal assurance process. We also identified two patients whose food, fluid and weight had not been correctly recorded, *although the nee*d for the malnutrition universal screening tool (MUST) scores to be consistently calculated was identified by the provided in a n audit completed in March 2022.

Team leaders did not routinely monitor whether staff and received their required managerial supervision. This meant that leaders could not be assured that staff were receiving the support the needed to safely carry out their roles.

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Leaders attended weekly governance meetings which included discussions about learning from incidents and complaints.

The clinical leads liaised with the GP practice partners to provide medical governance. The GPs attended weekly governance meetings with clinical leads and were able to respond to the needs of the service in a timely way. For example, GPs increased their visits to the ward during Covid-19 outbreaks.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. For example, leaders carefully assessed the benefits and risks of re-introducing face-to-face therapy sessions for patients during the Covid-19 pandemic.

Community health inpatient services

Leaders identified risks to the service including staff recruitment issues, particularly a shortage of band 5 registered nurses. Leaders were working with HR on a programme of recruitment and incentives for agency staff to become permanent.

Engagement

The provider engaged with patients, relatives and staff through a range of surveys, feedback forms and discussions. The ward was supported by volunteers from a local community group who had helped to furnish the garden area for the patients to use.

Innovation, improvement and sustainability

All staff were committed to continually learning and improving services. The lead pharmacist had taken part in an audit looking at the duration of antibiotic prescribing.

Community health services for children and young people

Good ↓

Is the service safe?

Good →←

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. Overall, 93% had completed their mandatory training.

The mandatory training for children, young people and families included safeguarding, conflict resolution, information governance, fire safety, infection prevention and control, moving and handling, equality and diversity and basic life support.

Staff did not routinely receive training in recognising the signs of sepsis in accordance with National Institute for Health and Care Excellence guidance (Sepsis: recognition, diagnosis and early management). Despite this, staff could access a flow chart to use for 'recognising the signs of the unwell child' to support them.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they were given time to complete their mandatory training.

Safeguarding

Staff understood how to protect children, young people and their families from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse. All staff received training in safeguarding adults and children at a level appropriate for their role. Staff could access additional training for domestic abuse, training on domestic violence in the Irish traveller community. The service had a safeguarding lead who supported staff with safeguarding concerns and worked closely with partner agencies.

Staff did not receive specific training in Child Sexual Exploitation (CSE) or Female Genital Mutilation (FGM). However, elements of FGM and CSE were included in routine staff safeguarding training. Leaders reported that specialist training in areas including FGM took place during team meetings as needed. For example, the safeguarding children lead had run a session on FGM because this need was identified through staff safeguarding supervision.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave us examples of how they worked with other agencies to protect people at risk of harm.

Staff could access and attend safeguarding supervision at least every six weeks. Staff and managers fed back that this was valued by staff and they found great benefit from this supervision.

Community health services for children and young people

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All staff we spoke with knew how to make a safeguarding referral and felt very well supported by the safeguarding lead.

The record systems used enabled staff to raise 'warning flags' when a child or young person was known to have safeguarding risks, so staff were immediately aware of these risks when they opened the record. However, not all staff set these warning flags on the records of patients who needed them. This meant that where significant safeguarding risks were present, staff would not always be made immediately aware of these. These warning flags were absent on two records we reviewed that should have had them. Leaders took immediate action to remedy this and told us that further training would be given to staff to ensure they were all aware how to raise a flag and to confirm whose responsibility it was to do it.

Cleanliness, infection control and hygiene

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

Premises used to run remote clinics were clean and well-maintained. Staff cleaned equipment used after each patient contact to minimise the risk of infection.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore masks and gloves in line with the provider's policy and national guidelines to reduce the spread of infection, including Covid-19. We observed staff washing their hands regularly. The provider carried out regular hand hygiene audits which showed 100% compliance by staff.

Staff observed the necessary infection, prevention and control measures in line with Covid-19 guidance for healthcare settings at the time of the inspection. This involved observing maximum meeting room capacities.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. When providing care in children and young people's homes staff took precautions and actions to protect themselves and children, young people and their families.

The service had suitable facilities to meet the needs of children and young people's families. Clinics took place in various locations, such as community centres and schools. Most contacts took place in people's homes. Risk assessments were carried out prior to any venue being used.

The service had enough suitable equipment to help them to safely care for children and young people.

Staff disposed of clinical waste safely. Clinical waste was secured in clinical waste bags and disposed of at patients' homes. Sharps were placed in secure sharps bins.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks.

Community health services for children and young people

Staff continually assessed risk. We saw evidence in care records of where risk issues had been appropriately escalated and then proactively followed up by staff.

Staff completed mental health screening tools as appropriate and knew where to signpost or refer people for help with their mental health needs. For example, they referred patients to the child and adolescent mental health team (CAMHS) where this was appropriate.

Staff knew about and dealt with any specific risk issues.

Staff shared key information to keep children, young people and their families safe when handing over their care to others.

Health Visitors had caseloads of approximately 578, although prioritised their work effectively in terms of risk. We had previously identified this challenge during the last inspection in 2017 but this had not improved. Leaders were working closely with commissioners ahead of their contract re-tendering to consider alternative ways of working.

Staff met regularly to discus and allocate new cases. When allocating, staff triaged the caseload in terms of risk. In the inclusion team staff also triaged new referrals on a daily basis and were able to respond at short notice to emerging risks on the team caseload. For example, two staff from the inclusion team scheduled an urgent visit at short notice on the day of the inspection.

Staffing

The service had staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers gave bank, agency and locum staff a full induction.

There were staff vacancies across the children, young people and families teams. The teams were proactively trying to manage this with the support of bank and agency staff, and some of these were familiar with the service. The 0-19 service, speech and language therapies (SALT) and occupational therapy (OT) teams were also upskilling other staff with some extra training to meet the needs of patients and improve waiting times.

Leaders were aware of the staffing recruitment challenges this featured on the organisational risk register. The provider continued to discuss staffing levels and recruitment strategies with commissioners.

Agency staff were given a full organisational induction when they started.

The organisation was part of the NHS flex for future programme. This is a national development plan to support organisations to develop ways of working to support flexible working. The organisation was embracing this approach and had developed a project team to implement change across the organisation in both clinical and non-clinical roles.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.

Community health services for children and young people

Patient records were comprehensive, and all staff could access them easily. The service used an electronic care records system. This meant that staff could access records easily when working remotely. The care records we reviewed were all up to date and comprehensive. Staff clearly documented plans at the end of their progress notes. Staff added a red flag alert to the system if there were any key issues others would need to know about when reviewing the record, or example, if there was a child with child in need status or under a child protection plan. All contacts were recorded on the electronic system.

Records were stored securely on password protected systems. Staff had unique logins for these and received training in data protection.

When children and young people transferred to a new team, there were no delays in staff accessing their records.

Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely.

Staff stored medicines safely. We saw that the provider regularly checked the temperature of the fridges where medicines were stored to ensure medicines were still effective for use.

Staff learned from safety alerts and incidents to improve practice. This had been shared with staff to minimise the risk of this happening again.

We attended a Covid-19 immunisation clinic. School nurses transported these medicines appropriately and completed regular temperature checks. However, one box of Covid-19 immunisations that had not yet been opened were not temperature checked to ensure they were stored at the required temperature to be administered.

Incidents

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

Staff raised concerns and reported incidents and near misses in line with the provider's policy. Staff we spoke with were aware of what incidents to report and how to report these on the electronic system. The provider had recently started to use a new reporting system which was comprehensive and captured actions and lessons learnt well.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. We saw evidence of where staff had contacted families to apologise when things had gone wrong, such as when a family's data had been shared by mistake. Staff learnt from this incident and received additional training.

Community health services for children and young people

Managers were proactive in learning from incidents and any lessons learned were discussed during staff meetings, supervision sessions and in the provider's newsletter that was sent to all staff. Staff we spoke with were able to give examples of incidents that had recently occurred and what action had been taken to minimise the risk of them happening again.

Managers debriefed and supported staff after incidents.

Is the service effective?

Good 

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of children and young people in their care.

The service delivered care in line with the Healthy Child Programme and best practice guidance. The Healthy Child Programme provides families with a programme of screening, immunisations, health and development reviews.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff regularly had updates sent to them or discussed in team meetings when there was any change to guidelines. Staff had access to policies on the staff intranet.

A dedicated inclusion team provided a 0-19 service to children, young people and families from the local Gypsy Roma and Traveller, asylum seeker and refugee communities. The core aim of this service was to address and reduce health inequalities and to provide improved access to bring young people up to speed with the requirements of the healthy child programme. The service also worked with all members of the family to identify potentially unmet health needs. Patients were then signposted to other services to have these needs addressed as necessary and the team kept the family member's GP informed.

The provider had improved its approach to safely managing children whose parents had not completed their under 12-month review parental assessment form. During the last inspection in 2017 we identified that there was no system for identifying children whose parents had not completed this assessment, posing a potential risk that a child with potential developmental delay or other vulnerability might not be identified and supported. Staff now progressed these families through an additional needs pathway which involved a more in-depth face to face consultation so the childs needs could be appropriately assessed.

Nutrition and hydration

Staff gave children, young people and their families education and support to ensure that their nutritional and hydration needs were met.

Community health services for children and young people

Staff supported children and their families to ensure their nutrition and hydration needs were met. This support was given to families at their first contact with the service, when staff offered advice to new mums about breastfeeding their babies. Health visitors and nursery nurses gave advice to parents about weaning their babies. Staff also provided an 'introducing family foods' group session. School nurses gave advice to children and young people of school age. A 'be your best' programme targeted children who were above a healthy weight in primary schools.

Dieticians worked closely with families to assess, make plans and ensure children and young people had the right support, advice, guidance and equipment for their individual needs.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people.

The Healthy Child Programme mandated contacts data showed that for the first two months of 2022 an average of 94% of new baby reviews were carried out within the 14 day target and 93% of eight week reviews happened on time. Fifty-eight percent of one year reviews happened on time and 55% of two year reviews happened on time. Staff explained that they prioritised the early reviews when they were catching up following the Covid-19 pandemic, because the risk of missing the target for these reviews was greater.

The service participated in relevant national clinical audits; for example, the UNICEF breast feeding audit. The inclusion team routinely shared outcomes with commissioners to illustrate the positive benefits of the service. These included a correlation with reduced emergency department attendance with the team's interventions. A correlation could also be drawn between decreased likelihood of maternity complications and contacts with the inclusion team.

Competent staff

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

Managers and staff told us that individual supervision and group supervision was taking place in line with the provider policy. Staff we spoke with were all confident they were receiving some supervision but that this varied in frequency and the provider did not have a system for leaders to monitor whether staff supervision as being completed.

Staff had the opportunity to discuss training needs with their line manager and spoke positively about learning and development opportunities. Staff felt the organisation was dedicated to investing in its staff with many staff carrying out additional training, including specialist training in breast feeding, healthy bladder and stammering. Staff could apply for funding to attend conferences and to complete further academic training. For example, a school nurse was completing additional professional training to become a health visitor.

New staff received a full induction tailored to their role when they started with the organisation. Staff also received an annual appraisal. Information provided by the provider showed that appraisals were happening regularly and in line with the organisational policy.

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

Multidisciplinary working and coordinated care pathways

Community health services for children and young people

All those responsible for delivering care worked together as a team to benefit children, young people and their families. They supported each other to provide good care and communicated effectively with other agencies.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. We saw examples of where staff had worked with partner organisations, safeguarding teams, schools, and other health professionals.

The provider formed part of a collaborative called Children and Family Health Surrey. This was the over-arching organisation responsible for bringing together providers who delivered the 0-19 service across the county of Surrey. The contract was delivered in partnership by First Community Health & Care community Interest Company, another local community health Community Interest Company (CIC) and in part by the local mental health NHS trust. Leaders and other staff worked across these organisations and split their responsibilities accordingly. For example, the associate director within First Community Health & Care C.I.C led on the delivery of the 0-19 contract across the county, whilst their counterpart who was employed by the neighbouring community health CIC led on the delivery of therapeutic services for young people across the county. The inclusion team was hosted by First Community Health & Care C.I.C. and other services such as the developmental paediatrics and audiology were led on by partner organisations. Staff felt that this collaborative approach to meeting the needs of patients using the 0-19 pathway was highly effective.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. Staff were aware of where to refer or signpost children or parents to for support with their mental health needs. Staff received training in mental health and some staff had completed mental health first aid training.

Teams worked closely with other healthcare providers including GPs and specialist hospital teams to ensure the full range of health needs for family members were met. Staff also linked in with charitable organisations and social services to ensure the whole breadth of needs were met by the relevant teams. This included social and accommodation support and access to food and clothing.

The inclusion team also worked closely with local maternity services to identify and keep track of families and young people they could support. Funding was recently agreed to recruit to a midwife role within the inclusion team.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service gave information promoting healthy lifestyles and support to children, young people and families. Information and support around healthy eating, smoking cessation and mental health.

The service ran Personal, Social, Health and Economic Education (PSHE) and health promotion in schools to educate school age children on healthier lifestyles and gave education for them to make informed choices regarding health.

The service had been carrying out Covid-19 vaccination in response to the pandemic. The service promoted these to the people they supported.

Staff in the inclusion team thought creatively about how to reach vulnerable groups. Staff reported that they recently worked flexibly during evenings and weekends to attend church services to help support people from the Gypsy, Roma and Traveller communities to access Covid-19 vaccinations.

A vaccine equity coordinator post in the inclusion team had recently been recruited to. The aim of this post was to improve vaccine uptake amongst minority groups in the community. The team had also released a video to educate, inform and answer common questions about the Covid-19 vaccine and boost vaccine confidence within traveller communities.'

Consent

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. When we reviewed care records, we saw evidence of young people or their families consenting to care and treatment.

Staff made sure children, young people and their families consented to treatment based on all the information available.

Mental Capacity Act training was not a mandatory training requirement within this service but was covered within the equality, diversity and human rights training.

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

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance.

Is the service caring?

Good 

Compassionate care

The service had a strong, visible person-centred culture and was exceptional at helping people to express their views so staff understood things from the patient's points of view. Staff and leaders were fully committed to this approach and found innovative ways involve people as partners in their own care. Where necessary, appropriate communication tools were needed to ensure staff made every effort to involve people. Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs. They took time to interact with children, young people and their families in a respectful and considerate way.

All interactions between staff and patients we observed were very supportive. The families we spoke with were overwhelmingly positive about their experience using the service and reported that staff treated them in a kind and

caring manner. We spoke with 12 family members during the inspection. They all told us that staff had treated them with dignity and respect. When we observed interactions between staff and parents/children, staff treated them in a caring and compassionate manner and quickly built a rapport with new families. Staff listened to what they had to say and showed a genuine interest in the child and their wider family.

Staff kept details about patients' care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and considered these needs when delivering care. Staff ensured that individual needs were respected.

Staff provided good continuity of care. Where possible, the same health visitor would see people for their antenatal, new birth and post-natal visit.

Children, young people and families could feed back on the service in a number of ways, including the friends and family test (FFT), which Health Visitors told patients about at every contact. This feedback could be sent by text or in paper format. The CHAT health app also had a feedback mechanism. The 'Capturing the voices of looked after children' was at the centre of everything the Looked After Children health team aimed to achieve. The team endeavoured to promote a culture where looked after children were listened to and able to participate in decisions about their health. The team continued to encourage children to directly feed back about their to help improve the service.

Emotional support

People valued their relationships with the staff team and felt that they often went 'the extra mile' for them, when providing care and support. Staff are exceptional in enabling people to remain independent and have an in-depth appreciation of people's individual needs around privacy and dignity. Staff provided emotional support to children, young people and their families to minimise their distress.

People reported that staff were consistently empathetic, understanding and supportive when working with them. Families reported that staff went the extra mile during periods of family crises and were willing to support the whole family in a holistic way. For example, by making referrals for speech and language therapy for older siblings.

Understanding and involvement of patients and those close to them

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment and were involved in their care.

Staff spoke with children, young people and their families in a way they could understand, using communication aids where necessary. One parent told us of how a staff member had run a session with the family on Makaton. Makaton uses speech with signs and gestures to help people communicate.

Staff were able to access interpreters using the language phone line when required and all staff were aware of this system. Staff also encouraged family members to support with translation if this was appropriate.

Community health services for children and young people

Staff made sure children, young people and their families understood their care and treatment. Staff explained what their session would consist of to ensure this was understood and consented to before commencing treatment or care.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Staff at the inclusion team recognised that they needed to develop methods of gathering feedback from their patients. This had been a particular challenge because of relatively low literacy rates in the population they served. Staff had started to consider implementing a visual tool to gather some feedback about how satisfied patients were with the service. Staff also explained that they recorded ad-hoc feedback from people using the service to share with the wider team.

Parents we spoke with told us they were involved in their children's care.

Is the service responsive?

Good  

Planning and delivering services that meet people's needs

Staff had an excellent understanding of the social and cultural diversity of the population they served. Services were planned in a way that targeted the diverse needs of the local population. This meant that people have an enhanced sense of wellbeing and exceptional quality of life. Staff worked closely with others in the wider system and local organisations to shape services and plan care.

A dedicated inclusion team provided care and treatment to children and families from vulnerable backgrounds. Staff worked closely with families from local Gypsy Roma and Traveller, asylum seeker and refugee communities.

The inclusion team caseload was approximately 500 at the time of the inspection. However, this caseload fluctuated in size significantly depending on the needs of the local community. For example, at the time of the inspection the inclusion team were preparing for a share increase in caseload size as a new refugee hotel was due to open soon in the local area.

Leaders had made a strong case to commissioners about the benefits of the inclusion team. Commissioners had agreed to fund the team on a permanent basis and it continued to extend its range of support to people from vulnerable backgrounds.

The inclusion team operated across the whole of Surrey. This was a joint venture between First Community and a neighbouring community health provider and all staff worked in partnership across both organisations.

The service also worked with all members of the family to identify potentially unmet health needs. The inclusion team was recruiting to a registered nurse post. The aim of this post was to support adult family members with their health needs.

Once young people's health needs were being met and they were up to date with the requirements of the healthy child programme. Staff only took action to transfer families to the universal services in agreement with families and when it was safe to do so. Managers planned and organised services, so they met the changing needs of the local population.

Community health services for children and young people

Managers utilised local knowledge and information shared to help plan their services. For example, the inclusion team worked with families in refuge or temporary accommodation such as hotels, and patients that were at risk. This team had regular meetings with charitable organisations, the clinical commissioning group (CCG) and social care to ensure that children, young people and families had their health and social needs met.

Professionals said that the service was focused on providing person-centred care and achieved exceptional results. Ongoing improvement was seen as essential and staff had improved the inclusion team offer since the last inspection and were considering ways to expand its reach to diverse communities in the future. The service strived to be known as outstanding and innovative in providing person-centred care based on best practice. Staff welcomed the opportunity to share their good practice in working with hard-to-reach communities with professionals working within other community health organisations nationally.

The provider had been proactive and quickly made adaptations to their ways of working through the Covid-19 pandemic to ensure that there was a prompt response to any factors which may impact service provision. For example, during the early stage of the pandemic staff were required to conduct virtual visits rather than seeing people in person. They recognised that this may have an impact on wellbeing, particularly when new parents would likely be feeling isolated, and so introduced extra contacts with new parents at four weeks post-partum to check in on parental emotional health and do some health promotion work if required. Face to face contacts continued if this was needed to support families at risk or that needed some extra support through this difficult time. For example, supporting children on the child protection register, or children with complex needs.

A dedicated advice line provided prompt access to advice from nursery nurses and health visitors. The service was delivered across the county in partnership with colleagues from a neighbouring community health provider, as part of CFHS. The advice line was used by families and professionals including GPs who wanted to seek professional advice or contact members of the team. The advice line was an innovative way of working that had various benefits. It freed up Health Visitors working within the 0-19 teams to focus on their work and increase face to face time with families rather than handling routine queries that came to them via their duty system. The advice line enabled professionals like GPs to get support and reduced the likelihood of inappropriate referrals to services being made. Families were also promptly signposted to the most appropriate service to meet their needs, such as emergency departments or their GP. Advice line staff took a proactive approach to telephoning parents of newly born babies during the Covid-19 pandemic because they could not attend face to face appointments. Leaders had shared their successes in relation to the advice line at a national professional advisory group so that national colleagues could consider its benefits.

A phone texting service called ChatHealth was in place 11-19 year old children and young people to access support or advice on a range of physical and emotional health and development information. This meant that if any children or young people did not feel they could approach a school nurse face to face, they could access this service for confidential healthcare and lifestyle support from a healthcare professional. The service could also be used to book appointments with the school nurse or to signpost patients to other appropriate services, such as sexual health services.

The immunisation teams supported local immunisation clinics in response to the Covid-19 pandemic to support their local communities, as well as delivering the school-age vaccine programme.

Managers ensured that children, young people and their families who did not attend appointments were contacted. Managers monitored and took action to minimise missed appointments (DNA). The provider collated data on missed appointments. For January and February 2022 DNA rates ranged between 6 and 12% across the teams. The provider attempted to make contact with people who missed appointments, to proactively engage them. We saw evidence of this in the clinics we observed.

Community health services for children and young people

Baby cafes were offered to new mothers during the pandemic. The service was run by staff who needed to shield, and provided advice on infant feeding, online classes and support groups.

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

The provider was proactive in meeting the individual needs of children, young people and families. One parent told us of how their OT had arranged funding for two chairs that had been adapted to their needs to be delivered to a child's school. The child attended the main part of the school for part of the day and spent the other part in an alternative education area. This meant that staff from the school did not need to move the chairs each day.

Staff had good knowledge of other services available locally and signposted people to these, such as the food banks, a charity that helped families access baby or child equipment and gifts and home start which is a local authority run service where parents can access a support buddy.

Staff knew how to access translation services on the telephone, and we observed this in practice. Staff also told us they could secure face to face translators when there was sufficient time to source one before a patient consultation.

Staff supported children and young people living with complex health care needs by using health passports. Health passports included details of the specific needs of patients living with a learning disability. For example, allergies or specific communication aids

Staff understood and applied the policy on meeting the information and communication needs of children and young people with a disability or sensory loss.

Staff were aware of the Accessible Information Standard. The Standard sets out how to identify, record and share information about meeting people's communication needs.

One staff member completed an audit on the types of equipment that could be recycled and how much money could be saved by doing this. This approach meant that families did not wait as long to receive equipment.

Staff had professional links with charities that provided families with clothes, shoes, toys and toiletries.

A staff member in the Gypsy, Roma and Traveller team had worked closely with other agencies during one of the Covid-19 lockdowns to support members of the community to gain access to utilities, refuse collection and to help put families in touch with schools and foodbank charities.

Access to the right care at the right time

People could access the service when they needed it and received the right care in a timely way.

Community health services for children and young people

People's care and support was planned proactively in partnership with them. Staff ensured people were involved in their care and felt consulted, empowered, listened to and valued. Managers monitored waiting times and made sure children, young people and their families could contact the service if they were waiting for extended periods of time and their situation ahd changed.

Patients experienced extensive waits to access paediatric Occupational Therapy and Speech and Language Therapy. The average waiting times during the six months to June 2022 were 32 weeks for children's occupational therapy and 19 weeks for children's speech and language therapy.

Challenges in accessing paediatric Occupational Therapy and Speech and Language Therapy were featured on the service risk register. Leaders had taken measures to address these wait times. For example, an Occupational therapy review had been completed where each patient was assessed to see if they still required support by the service. Some patients were signposted to other services. A systematic review of patients who had been waiting 26 weeks had also been introduced to help staff determine whether patient risks had changes whilst they and been waiting. However, despite these measures there had not yet beena significant decrease in the time people had to wait to access support from an Occupational Therapist or Speech and Language Therapist.

If patients had their appointments cancelled at short notice, managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff supported children, young people and their families when they were referred or transferred between services.

Learning from complaints and concerns

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

Children, young people and their families were given information on how to complain or raise concerns. Parents we spoke with confirmed they knew how to raise concerns should they need to. One parent we spoke with had made a complaint and it had been dealt with effectively.

Managers investigated complaints. We reviewed some complaints received by the service. These had been managed in line with the provider's policy. There were a number of complaints about lack of contact from health visiting services. The manager we spoke with felt this was due to the change in access to face to face contact through the pandemic.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. Information was shared in team meetings and in the staff newsletter.

Is the service well-led?

Good 

Community health services for children and young people

Leadership

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

A service manager for children, young people and families was responsible for the day to day management of the service. They were supported by the associate director for children, young people and families and worked closely together.

Senior leaders were visible within the service. They were readily contactable for staff and patients. Staff consistently told us that they felt well supported by leaders.

Managers and team leaders supported staff to develop their skills. For example, the organisation had supported staff to access further training to progress their career.

There was evidence of career progression within the service, for example a number of staff had been promoted to more senior roles throughout the organisation and leaders supported staff with their career development. For example, an administrator working in the inclusion team was given exposure to patient-facing work that would support them with their ongoing studies in human rights and justice.

There was also a floor to board policy where staff could speak to a board-level director within five minutes should they need to.

Vision and strategy

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

The service's priorities in their business plan made a commitment to knowing the population well, to be inclusive, develop their approach to addressing health inequalities and to look after their people.

The service worked closely with their commissioners to deliver high quality services to the community. Meetings were ongoing with the commissioners to look at improved ways of working and resource allocation to ease the pressure and on current staff and manage increasing demand.

Culture

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

All of the staff we spoke with told us they felt respected and valued within their roles. Morale within the team was generally good but could fluctuate due to the demands, long wait times in some services and high caseloads in the health visiting teams.

Community health services for children and young people

Staff consistently told us they were proud to work for the organisation and felt that they had worked well throughout the pandemic to ensure services still were as accessible as they could be.

Staff told us they felt well supported and valued by leaders. Many of the staff we spoke with described the team as being highly supportive of each other. Staff told us that everyone's opinions, ideas and contributions were equally valued.

Staff told us there was an open culture where they could raise concerns without fear of retribution. All staff we spoke with told us they would not hesitate to raise concerns. They were confident that they would be listened to and action taken. No staff reported bullying or harassment at work.

Staff told us that their wellbeing was supported. During the pandemic managers had utilised remote and virtual meetings to ensure staff still had their 'team' around them. Staff had access to appropriate wellbeing support at work. There were also opportunities for team members to debrief when required.

Staff in the inclusion team attended group sessions with a psychologist working at the local mental health NHS trust for group reflective sessions.

Governance

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A robust governance process existed across the Child and Family Health Surrey group of providers. For example, a joint clinical practice group was in place to ensure consistent clinical approaches were used across the county. Senior leaders from all partner organisations joined a transformation and operations boards. The chief executive officer for each organisation also attended a partnership board. This joint governance helped ensure consistent, high quality interventions were provided across the county.

However, the service had not yet resumed its full programme of routine audits. Leaders explained that routine audits had mostly been put on hold because of the Covid-19 pandemic.

The senior leadership team met regularly to discuss any governance and performance issues. Any key messages were then passed on to staff in their monthly team meetings.

Staff at all levels were clear about their roles and accountabilities and were aware of key performance indicators.

The service did not keep records of formal supervision, this meant that leaders could not monitor whether all staff received the support they required. Staff did not systematically monitor whether families who had recently moved to the local area had been seen in time. Children who had recently moved to the area must be seen within 14 days. This presented a risk that any challenge in seeing new families would not be identified by senior leaders and their particular clinical or safeguarding needs may not be identified in a timely way.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

Community health services for children and young people

The provider maintained a corporate risk register which covered all services. Leaders reviewed risks on a regular basis and actions were in place to manage and mitigate risks. Items such as; OT and SALT waiting lists, health visiting caseloads and Covid-19 were included in the register.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. Data or notifications were consistently submitted to external organisations as required.

Staff collected data to track the performance of the service. Data was reviewed by the clinical assurance group that met monthly. Any decisions and actions needed were discussed and agreed at this group. This data was also shared with commissioners.

Managers notified the CQC of events in line with the regulation's statutory notification guidance.

Staff could access policies and procedures easily and updates to these were notified to staff in the staff newsletter.

Engagement

Leaders and staff engaged with patients and staff. They collaborated with partner organisations to help improve services for patients.

Staff were overwhelmingly positive about their work for the provider. They described a strong sense of teamwork and supportive leaders. The services held team meetings regularly and managers updated staff with information about learning from incidents, audits, compliments and complaints and feedback. The service also sent updates in the newsletter of changes to professional guidance.

Staff gave feedback via a staff survey which in turn helped them shape the service. Eighty per-cent of staff completed the most recent staff survey.

Learning, continuous improvement and innovation

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

The service continuously aspired to improve the experience of their patients by reviewing opportunities and adapting aspects of the service to meet the needs of groups of patients. For example, the service had been proactive in responding to the Covid-19 pandemic. Staff quickly adapted to different ways of working such as virtual contacts with patients while still continuing face to face contacts with families at risk or who were vulnerable. Staff working in 0-19 teams met on three allocated days each year to share innovative practice, learning and continuous improvement initiatives.

Staff in the inclusion team met with both local and national health visiting teams to share the positive work they were doing to identify and address the health needs of vulnerable communities. Colleagues from other parts of the country had contacted the inclusion team to help them develop a case for similar teams to be funded and set up elsewhere to address the unmet needs of minority communities.

Community health services for children and young people

The inclusion team leader worked closely with the University College London homeless network to inform professionals about how to successfully engage with members of the Gypsy Roma and Traveller community. This expertise was gained through successfully engaging with the local community in Surrey. The inclusion team leader also shared their positive experience of improving Covid-19 vaccination update amongst vulnerable communities with a range of local authorities and clinical commissioning groups in other parts of the country.

The inclusion team leader had been nominated for a Health Service Journal award by commissioners. The Nursing Times had also published an article about the positive work of the inclusion team during the early stages of the Covid-19 pandemic, when staff maintained face-to-face contact with families to avoid losing contact with the most vulnerable people in the local community.

At our last inspection the 0-19 team had been awarded the UNICEF award for breastfeeding advice and support. They had continued to receive this award on a yearly basis and their current award was silver level.