HCRG Care Services Ltd

St Martins Hospital

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

HCRG Care Services Ltd provide services within the Bath and North East Somerset (BaNES) area. Services are provided in the local community which includes impatient services and community adults and children's services. Headquarters for the services were based at St Martin's hospital in Bath.

St Martin's hospital was previously registered under a previous entity. This was the first inspection for this service under this provider.

We undertook this inspection as part of our inspection programme and inspected the following three community core services.

Community Hospital - Inpatient Ward

There are two community hospitals serving the population of Bath and North East Somerset. Sulis Inpatient ward is located at St Martin Hospital and can admit up to 29 patients into bays or individual side rooms.

The aim of the inpatient service is to enable people to regain health and wellbeing through rehabilitation and recovery.

The community hospital inpatient service is part of an onward pathway of care for patients following a period of acute hospital care:

- active rehabilitation for individuals who have suffered a trauma or illness, to facilitate their ongoing independence and return to their normal place of residence as quickly as possible
- intensive and specialist rehabilitation for individuals following a stroke and are unable to return home directly from the Acute Stroke Unit
- palliative and end of life care for individuals who chose not to die at home.

Patients praised regular staff but commented that staffing levels were low, which limited the amount of time spent with them. They said the staff had encouraged patients to be independent but there was little time from staff to support them with regaining lost skills. Other patients were understanding of staff's commitment to deliver good care but were concerned about their skills to meet their individual needs.

Patients feedback on their experiences of care related to the lack of staff on the ward, lack of activities and reablement. They were not aware of having a care plan or the arrangements for their discharge. Some patients commented on the poor frequency of physiotherapy and occupational therapy programmes to facilitate their discharge.

Generally, patients said the meals were of a good standard.

We rated it as requires improvement because:

- The target for mandatory training in key skills such as Basic Life Support, Moving and Handling and Fire awareness was not met.
- Checks of the equipment held in resuscitation trolley were not robust
- Staff assessed risks to patients, but assessments lacked evidence of escalation where high risks were identified.

Summary of findings

- Care plans did not detail patients' preferences on how their needs were to be met. Their care plans were not developed on all areas of need or on their discharges. Action plans did not provide guidance to staff on how assessment needs were to be met or reviewed where assessments had identified further monitoring where potential deterioration was identified.
- Medicine systems were not fully safe. There were gaps in the recording of medicines administered. Staff did not always record the reasons for not administering medicines.
- Whiteboards with patient's details were in full view of patients and visitors to the ward.
- Although steps were taken to recruit and retain staff high levels of agency staff were used to maintain basic staffing levels.
- Staff did not feel valued by the organisation due to the lack of resources and staff shortages.
- Patients gave feedback about staff's lack of willingness to assist them.

However:

- Staff were committed to delivering good standards of care and their feedback related to the shortfalls with staff vacancies and meeting the needs of patients.
- Staff treated patients with compassion and kindness and took account of their individual needs and helped them understand their conditions.
- Patients and relatives felt confident to approach staff and managers with concerns.
- Managers investigated concerns and made recommendations on how to improve the service for patients.

Community Health Services - Adults

St Martin's Hospital is within the Bath and North East Somerset (BaNES) area and provides community health and care services for adults. The adult community services delivered in a person's home or in a nearby local care setting.

We rated this service as outstanding because:

- Services were tailored to meet the needs of individuals and were delivered in a way to ensure flexibility, choice and continuity of care. Individual needs and preferences were central to the planning and delivery of tailored services. Patients could access services in a way and at a time that suited them.
- The involvement of other organizations' and the local community was integral to how services were planned and ensured that services met people's needs. There was good interaction between the local GPs and the services provided.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Comprehensive strategies in place ensured the delivery and development of the desired culture. Leaders had a shared purpose, strove to deliver and motivate staff to succeed.
- While the service had staff vacancies, they used regular bank and agency staff to maintain care for patients that kept them safe.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- The service used systems and processes to administer and record medicines safely. The service recorded safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Team leaders monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included patients with complex needs.

Summary of findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service provided care to meet the needs of local people, took account of patients' individual needs, and ensured people were able to give feedback. People could access the service when they needed it and received the right care in a timely way. It worked with external agencies and organisations to plan care.
- Leaders were knowledgeable about quality issues and had the experience and capability to ensure that the strategy could be delivered. Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.
- Governance and performance management arrangements were proactively reviewed and reflected best practice. There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
- Leaders actively reviewed complaints and how they were managed and responded to, and improvements were made as a result across the service.

Community Children and Young Person

St Martins hospital is a registered location for HCRG Care Group, providing community health services for children and young people across Bath and North East Somerset.

We rated the service as good because:

- Staff understood how to protect children, young people and their families from abuse and the service worked well. The service-controlled infection risk well. Staff assessed risks to children and young people, acted on them and kept good care records. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care and had access to good information.
- The service responded to health matters affecting children and young people in society. They worked with partner agencies to educate and equip families to provide and maintain healthier lifestyles for children and young people.
- The service provided interventions aimed at the prevention of risky behaviours and promotion of healthy relationships. The service worked alongside partner agencies to promote positive outcomes for children, young people. Routine perinatal screening and additional listening visits undertaken in partnership with external organisations and midwives promoted better outcomes for families and newly born children. Referral to appropriate specialist services as part of this intervention ensured mothers were better equipped to provide warm and nurturing care to their children and young people.
- Staff treated children and young people with compassion and kindness, respected their privacy and dignity and took account of their individual needs. They provided emotional support to children and young people, families and carers.
- The service planned and provided care in a way that met the needs of local people and the communities it served. It also worked with others in the wider system and local organisations to plan care. Staff made reasonable adjustments to help children, young people and their families access services. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of findings

- Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders operated effective governance processes, throughout the service and with partner organisations.

However:

- In some services children and young people had to wait for treatment longer than the provider's target timeframe. For example, some people had to wait longer than the target treatment time of 18 weeks for the community paediatrics.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Outstanding ☆	St Martin's Hospital is within the Bath and North East Somerset (BaNES) area and provides community health and care services for adults. The adult community services delivered in a person's home or in a nearby local care setting. We rated this service as outstanding because: • Services were tailored to meet the needs of individuals and were delivered in a way to ensure flexibility, choice and continuity of care. Individual needs and preferences were central to the planning and delivery of tailored services. Patients could access services in a way and at a time that suited them. • The involvement of other organizations' and the local community was integral to how services were planned and ensured that services met people's needs. There was good interaction between the local GPs and the services provided. • The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Comprehensive strategies in place ensured the delivery and development of the desired culture. Leaders had a shared purpose, strove to deliver and motivate staff to succeed. • While the service had staff vacancies, they used regular bank and agency staff to maintain care for patients that kept them safe. • Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. • The service used systems and processes to administer and record medicines safely. The service recorded safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.

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- Team leaders monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included patients with complex needs.
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- Leaders were knowledgeable about quality issues and had the experience and capability to ensure that the strategy could be delivered. Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.
- Governance and performance management arrangements were proactively reviewed and reflected best practice. There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
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Summary of findings

Community health inpatient services

Requires Improvement

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- Whiteboards with patient's details were in full view of patients and visitors to the ward.

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- Patients gave feedback about staff's lack of willingness to assist them.

However:

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Community health services for children, young people and families

Good 

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- Staff provided good care and treatment. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of children and young people, advised them and their families on how to lead healthier lives, supported them to make decisions about their care and had access to good information.

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Summary of findings

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Summary of this inspection

Background to St Martins Hospital

The service is regulated for the following activities:

- Personal care
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

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

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

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Before the inspection visit, we reviewed information that we held about the service. The Community Inpatient Services inspection was unannounced. We announced this inspection for Community Adults and for Children and Young Person prior to the inspection visit to ensure we were able to visit a range of community locations.

How we carried out this inspection

Community Inpatient Services – Sulis Ward

This inspection included:

- We spoke with the registered manager and Head of Community hospitals
- toured the environment and checked the clinic rooms
- spoke with 10 patients and three family members
- spoke with the ward manager and three nursing staff including a registered nurse and health care assistant as well as the ward administrators
- spoke with the two occupational therapist and one physiotherapist
- reviewed seven care records and seven treatment records
- reviewed a number of meetings minutes and
- looked at a range of policies and procedures related to the running of the service.

Adult Community Services delivered in a person's home or in a nearby local care setting which include audiology, falls, heart failure, respiratory, Parkinson's and related conditions and musculoskeletal.

This inspection included:

Summary of this inspection

- We spoke with eight specialist nurses
- A medical lead who is a Consultant cardiologist by background
- Two service leads
- Chief pharmacist
- Head of Operations
- Reviewed three care records
- Attended a Musculoskeletal clinic
- Reviewed electronic performance data for the various services

Community Services - Children and Young Person

Teams provided care and treatment from community-based clinics, children's centres, schools, and in children and young people's homes.

Services offered by the provider were:

- Family nurse partnership
- Health visiting
- Looked after children's service
- School nursing
- Children's community audiology
- Bladder and bowel
- Children and young people training for carers to support a child or young person with a specific medical need.
- Children's community nursing
- Children's continuing care
- Community paediatrics
- Learning disability health service
- Speech and language therapy.

During the inspection, the inspection team:

- Spoke with 35 members of staff including service directors, heads of service, children's registered manager, regional head of quality and patient safety, professional and clinical leads, school nurses and health visitors.
- Spoke with 9 family members
- Visited the environment of premises where care and treatment were provided
- Reviewed 10 care and treatment records
- Attended and observed clinics facilitated by staff.
- Reviewed a range of policies and procedures and other documentation related to the running of the service.

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

Outstanding practice

- The Community Services- Adults: The district nursing team were working alongside GPs within their phlebotomy clinics. This was in response to identified themes and trends of care requirements needed in the local communities.

Summary of this inspection

- The Community Services- Adults had a community wellbeing hub which was co-located alongside the care coordination centre. The hub provided a "one-stop-shop" wellbeing service for adults and their families. The hub worked with other organisations to quickly respond to changing service pressures such as hospital admission avoidance. They had recruited a team of volunteers to support the delivery of emergency food parcels and two course meals.
- The Community Services- Adults: District nurses had proactively worked alongside GPs to provide blood tests to patients to help reduce waiting times. This incentive had been praised by GPs for their different approach to supporting patients in the community.
- The Community Services - Children and Young People: Staff took account of children, young people and their families' cultural, religious and personal needs and preferences. The service had a lead for the Roma, Gypsy, Traveller and boater communities. This meant they were able to provide care and treatment to these communities where cultural and living arrangements proved to be a barrier to access care and treatment. For example, the lead worked as the named health visitor for boater families to ensure continuity and provision of care, treatment, assessments and immunisations during the families' travel to new locations. This also included arranging for other specialist teams to be available for treatment when required.
- The Community Services - Children and Young People: School nurses worked closely with partner agencies to deliver a service called 'clinic in a box'. This service provided children and young people aged 13 to 16 years old with early access to sexual health advice, health promotion, contraception and treatment via schools and other agreed local outlets, such as youth centres. This supported the reduction of unwanted pregnancies and reduced risky behaviours. This service was awarded the 'Nursing times National Nursing in the Community award in 2021.

Areas for improvement

Community Inpatient Ward

- The service should ensure that with patient's name and details of checks and progress are not in full view of visitors, staff and other patients.
- The service should consider developing a dementia friendly impatient environment.
- Rehabilitation care plans should be developed on how patients were support to regain independence and skills including discharge plan.

Community health services – Children and Young People

- The provider should continue to review staff workloads, taking action to ensure they are manageable.
- The provider should ensure excessive treatment waiting times are addressed, and actions are taken to review the safety of people waiting.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Community health inpatient services	Requires Improvement	Requires Improvement	Good	Good	Good	Requires Improvement
Community health services for children, young people and families	Good	☆ Outstanding	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Outstanding

Community health services for adults

Safe	Good
Effective	Good
Caring	Good
Responsive	Outstanding
Well-led	Outstanding

Are Community health services for adults safe?

Good

Mandatory Training

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

Staff completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Training figures showed the service achieving 85% compliance which was on par with the provider's target.

Managers monitored training and alerted staff when they needed to update their training. For example, tissue viability courses and manual handling training were provided by the tissue viability and physiotherapy teams. Team leaders encouraged staff to be responsible for their own training and staff were able to access and book themselves onto arranged training through the organisations "MyLearning" page.

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 had access to the safeguarding policy and reporting flowchart/guidance for the local authority safeguarding team to ensure appropriate actions were taken in response to any allegation or incident of abuse.

Staff received safeguarding training which included Prevent awareness. Prevent is a government led programme which aims to safeguard vulnerable people from being drawn into terrorism. Staff also received training on child sexual abuse and exploitation, female genital mutilation and modern slavery. Training figures showed staff achieving between 77% and 95%.

Team leaders confirmed it had been a challenge in accessing safeguarding adults' level 3 training and bespoke training sessions had been introduced to accommodate staff's needs.

Staff demonstrated how they recognised adults at risk of or experiencing abuse or harm and made safeguarding referrals if they had any concerns. Staff worked with other agencies to protect patients.

The safeguarding lead and champions provided support and guidance to staff. They helped staff to become more involved in the safeguarding process.

The safeguarding champions network meeting minutes for July 2022 included updates on the forthcoming Health and Care Act 2022, actions from referrals and appropriate autism and learning disability training.

The senior leadership team reviewed all safeguarding concerns and ensured these were submitted and discussed with the local authority during regular engagement meetings.

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

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. Staff kept equipment and their work area visibly clean.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff contacted patients and carers prior to visiting them in their home to ascertain whether additional risks were present such as Covid-19 symptoms.

We observed staff following infection control and hygiene procedures which included regular hand cleaning and the appropriate use of PPE. Staff told us how they cleaned equipment after each patient contact.

Staff explained how they followed protocols to safely dispose of clinical waste following visits to patients' homes.

Environment and equipment

When providing care in patients' homes staff took precautions and actions to protect themselves and patients.

Clinic rooms where specialist teams provided treatment had enough suitable equipment to help them to safely care for patients. Staff carried out regular safety checks of specialist equipment.

The service had suitable facilities to meet the needs of patients' families.

The environment and clinic rooms were clean, bright and tidy. There were systems and processes in place to ensure equipment was appropriately calibrated and repairs were carried out periodically for equipment used.

The service had a process for ensuring all electrical equipment was appropriately tested every 18 months. We found no issues or concerns during the inspection.

Assessing and responding to patient risk

Outstanding ☆

Community health services for adults

Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff triaged patients upon receiving referrals and prioritised patients according to the level of risk. For example, the tissue viability nurse provided support in assessing patients who may need a specialist review. The learning disability team met weekly and reviewed all referrals which were prioritised on a risk and needs basis.

Staff told us they completed comprehensive risk assessments for each patient during their initial appointment. All patients had a pressure ulcer prevention care plan and a Waterlow score assessment. The Waterlow score gives an estimated risk for the development of a pressure sore.

Staff demonstrated how they worked as a team to assess and respond to patient risk. For example, the occupational therapy team worked with older people and adults with disabilities to maintain their independence while supporting them to stay in their own home or to move into other accommodation.

The learning disability service used a case management system designed to prioritise the appropriate risks and meet the changing needs of adults.

Staff told us they ensured patients attending clinics were fully informed of the reasons for their attendance alongside any proposed treatment. They explained how they would give patients the opportunity to address any concerns.

Staff knew about and dealt with any specific risk issues such as falls and pressure ulcers. These were clearly documented, and we saw plans to address ongoing treatment needs.

Care records were individualised and outlined specific risk issues. For example, staff recorded how to enter the patient's home when they were unable to answer the door and considerations were outlined when dealing with behaviours that challenged.

Staff used the National Early Warning Score (NEWS2) to assess physical deterioration in adults. Care records showed staff identified concerns, acted on them and made appropriate referrals to other specialist services and emergency services when required.

The IAP (Inclusive Activity Programme) was used within the learning disability service. The IAP programme equipped staff with the skills to engage disabled people and those with long-term health conditions to be more physically activity through encouraging choices and inclusion.

Staff told us there were no physical interventions used within the learning disability service. Staff had received positive behaviour management (PBS) training and each person had a positive behaviour support (PBS) plan if required. Staff used verbal de-escalation as required. The psychology team were working with staff to support patients by monitoring their stress levels and how these affected mood and cognition.

Staff said they could access specialist mental health services should they have any concerns about a patient's mental well-being.

Staff shared key information to keep patients safe when handing over their care to others. The service used a digital system where staff could access and update all information relevant to patients. This ensured information was available to others taking over any care needs.

The service had a lone worker policy. Staff ensured their whereabouts were known. Arrival and departure times were communicated to team members who could contact the service or emergency help if necessary.

Staffing

While there were staffing shortages, the service ensured they 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.

Workforce wellbeing, recruitment and retention was an organisational priority for 2022/23. There was a recruitment strategy and the services were actively recruiting both internationally and at local job fairs. Workforce plans in place were reviewed monthly with service leads and head of operations.

Staff attended daily safety brief handovers to ensure they had up to date information to manage any identified concerns.

While there were staffing shortages, the service had enough staff to keep patients safe. Managers told us staffing could, at times, be a challenge due to vacancies. We saw vacancies ranged from 4% in the falls service to 25% in audiology. Regular bank and agency staff were used to maintain consistency and continuity. Team leaders calculated and adjusted staff visits according to the needs of the patient.

Team leaders told us they were actively recruiting to increase staffing levels. The service was promoting a “Golden Hello” with a monetary incentive and “More People Like You,” a referral scheme for colleagues into substantive and bank posts.

The Training and Learning Enterprise team were focused on supporting direct apprenticeships and had identified 20 potential posts across the organisation which included community adult services. They were working with several agencies and organisations to support local people into these posts, including local colleges and students graduating with Health and Care diplomas.

For June 2022 the overall sickness percentage was 6% which was above the organisational target of 4%. Trends reviewed showed Covid-19 at 3% and the remaining 3% included stress, anxiety and depression alongside physical health conditions including surgery. It was identified that stress, anxiety and depression were not work related but a culmination of several other factors.

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.

When patients were referred, discharged, transferred and/or transitioned between teams, services and organisations they had all the information needed for their ongoing care. There were no delays in staff accessing patient records and all information was shared appropriately in line with the service’s protocols.

Patient notes were comprehensive and included all the relevant information to manage the patient’s care and welfare. All staff could access them easily.

Records were stored securely.

Outstanding ☆

Community health services for adults

Medicines

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

Patients were mostly prescribed medicines by their GP which were collected or delivered directly to patients. Electronic prescribing had been implemented within the community teams which staff told us had led to a more efficient, safe and improved prescribing process.

The organisation employed a pharmacist who was responsible for the oversight of medicines including patient group directives.

Services we visited did not store controlled drugs. Emergency medicines were stored in line with manufacturers' directions with access restricted to authorised staff.

here were some nurse prescribers within the integrated community teams and across the specialist services. Some staff were also able to administer medication through the use of a patient group direction (PGD) within their clinical competence. PGDs are written instructions to help staff supply or administer medicines to patients, usually in planned circumstances. The PGD audit for 24 May 2022 provided assurances that the service was compliant with the PGD policy and the teams had implemented actions to address any deficits such as missed recordings of expiry dates and allergy status.

Staff demonstrated good awareness of "just in case" medicines. These are medicines prescribed in advance for symptoms that might happen in the future. Providing medicines in advance meant there were no delays in getting medicines that might be needed quickly to alleviate symptoms.

The service had identified incidences regarding the management of insulin including delays and missed doses. These were reported in the medicine optimisation group meeting minutes for May 2022. The service was working with the medicine management team to improve performance. To mitigate the risk a new insulin delegation standard operating procedure had been implemented as well as the creation of two different coloured forms to support the management of insulin. Staff and managers reported this was very helpful and had reduced the number of incidences. We did not find any issues or concerns within the records seen.

The service had a process which encouraged Band 3 and 4 staff to administer medicines if they had a national vocational qualification or equivalent.

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. 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.

All staff knew what incidents to report and how to report them. Staff reported serious incidents clearly in line with the organisation's policy and used an online incident reporting system to do this.

Outstanding ☆

Community health services for adults

The organisation was preparing for the introduction of the new Patient Safety Incident Response Framework (PSIRF). They had adopted the SBAR ((Situation-Background-Assessment-Recommendation) technique, a communication tool designed to support staff sharing clear, concise and focused information. This replaced the root cause analysis system and had been rolled out across the services. We saw examples of incident reports which were concise and informative.

Staff understood the duty of candour and gave patients and families a full explanation when things went wrong. Patients and their families, where applicable, were involved in these investigations. We saw that duty of candour was reported in all incidents seen.

The heads of services and clinical leads reviewed and investigated incidents thoroughly to identify themes. Learning was obtained from meetings and shared with staff through team meetings and dedicated face to face meetings if appropriate.

Staff attended monthly “close the loop” meetings which focused on reflection, improvement and the monitoring actions and outcomes. It was noted that the top reported incidents were falls, pressure ulcers and medicine issues These were recorded on the risk register with mitigation plans in place.

Safety alerts were discussed at the monthly quality and safety meeting and cascaded to service leads for action as appropriate. Safety alerts were also recorded on the business unit log and corporate database.

Are Community health services for adults effective?

Good

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

National Institute for Care and Health Excellence (NICE) guidance was cascaded to service leads with implementation monitored by compliance advisors. For example, the musculoskeletal team were reviewing their standards to align with recent NICE guidance and evidence-based practice.

To support the NHS to achieve its recovery priorities, Commissioning for Quality and Innovation (CQUIN’s) were reintroduced for 2022/23. The CQUIN framework supports improvements in the quality of services and the creation of new, improved patterns of care. Managers confirmed they were participating in the 2022/23 CQUIN framework. The service was participating in four CQUINs namely; flu vaccinations, the completion of the Malnutrition Universal Screening Tool (MUST), pressure ulcer risk assessments and lower limb wounds.

Nutrition and hydration

Staff regularly checked if patients were eating and drinking enough to stay healthy and help with their recovery. They worked with other agencies to support patients who could not cook or feed themselves.

Staff were aware of patient's specific nutrition and hydration needs. All new patients had either a MUST or a Patient Led Assessment of Nutritional Care (PLANC) assessment completed. PLANC is an assessment tool used for palliative patients. We found no issues or concerns with the completion of these assessments.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff updated and recommended changes as and when required. Care records included documented checks of food and fluid charts that were being used within patients' homes.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

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.

The service had recognised that staff were using a variety of tools to measure pain. To alleviate confusion a new pain management tool had been created which had recently been cascaded across the services. The tool was based on the Abbey Pain Scale which is an instrument designed to assist in assessing pain in patients who are unable to clearly articulate their needs, for example, patients with dementia, cognition or communication issues. Service leads told us an audit would be scheduled to review its effectiveness and confirm it was being used correctly.

Patient outcomes

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

Outcomes for patients were positive and consistent. Integrated care teams discharged patients from caseloads when they were receiving treatment by other specialist teams or no longer required district nursing care.

Managers and staff carried out audits to check improvements. All teams participated in regular audits on various aspects of the services provided. For example, care records and medicine management records were regularly checked by managers. We saw the audit results with identified actions where applicable.

Managers and staff carried out audits to improve care and treatment. The tissue viability nurses (TVNs) completed a deep dive from April to June 2022, due to an increase in pressure ulcers. The results outlined that the pressure ulcer increases were equally spread throughout the district nursing services with no themes identified. The TVNs continued to support the teams with any concerns identified.

The organisation used a digital performance programme that showed of performance data within team caseloads. We observed reductions in treatment waiting times and reduced timescales for patients accessing different services. This evidenced improvements in efficiency and effectiveness across the services. Managers said the system was invaluable in providing daily updates which enabled them to identify and address concerns quickly.

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 ensured staff, including bank or agency staff, had the right skills, qualifications, and experience to meet the needs of the patients in their care. Staff received any specialist training required for their role. Staff had the opportunity to discuss training needs with their manager and were supported to develop their skills and knowledge. Staff told us of additional training they had either undertaken or were in the process of completing. These included; physical assessment and clinical reasoning (PACR) training, non-medical prescribing (NMP) and the special professional qualification (SPQ) for district nurses.

Managers identified the training needs of their staff so they could develop their skills and knowledge. For example, independent living skill training was being undertaken by the occupational therapists, focusing on sensory skills and dementia in older populations with learning disabilities.

Staff told us they had access to new learning opportunities which included; autism and learning disabilities awareness and pressure ulcer prevention and management. The musculoskeletal team attended in house training where individual staff delivered bespoke training. The most recent topic had been scapular thoracic pain (shoulder strain or sprain).

Staff had access to new learning opportunities which included; autism and learning disabilities awareness and pressure ulcer prevention and management.

Team leaders were proud of the "grow your own" approach to developing staff. Across the service staff were undertaking apprenticeships specific to their role.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals and supervision of their work. The appraisal window opened on 1 April 2022 and continued until the end of June 2022. The appraisal compliance at the time of the inspection was 85%. Staff we spoke with said they had received regular supervision and appraisals.

Managers made sure staff attended regular team meetings and gave information to those who could not attend.

Managers recognised poor performance, could identify the reasons and dealt with these. The 2022/23 workforce report for April to June 2022 showed there had been no fitness to practice issues.

Managers received automatic notification of staff who were nearing their revalidation date which allowed them to monitor and support registrants. Revalidation was also discussed at appraisal.

Multidisciplinary working

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

Service leaders held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff told us patients could be represented by advocates where necessary and were able to signpost them to the advocacy service if required.

Community health services for adults

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. Staff could access other specialists as needed, including for example, speech and language therapists.

Patient's care pathways focused on all aspects of the person's care needs. Treatment and progress were monitored with input from patients and families, where appropriate.

The teams had effective working relationships with other relevant services and teams outside the organisation. Staff engaged with them early regarding the patient's plans, progress and discharge.

The teams had developed an effective working relationship with the local GP practices.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on units.

Staff assessed each patient's health when accessing the service and provided support for any individual needs to live a healthier lifestyle.

Staff had attended training for "Making Every Contact Count (MECC)." This is an approach to behavioural changes that uses day to day interactions. The MECC method is to support people in making positive changes to their physical, mental health and well-being. Areas identified included; smoking cessation, improving the person's diet, increasing physical activity, weight loss and reducing alcohol consumption. We saw leaflets on display to support this.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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.

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff described and knew how to access further information and got advice when required.

When patients could not give consent, staff made decisions in their best interests, considering patients'' wishes. Care records showed consent being obtained from patients and when patients had fluctuating capacity. There were clear protocols, contacts and arrangements documented to ensure best interest decisions were being undertaken appropriately.

Outstanding ☆

Community health services for adults

Are Community health services for adults caring?

Good

Compassionate care

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

Staff explained how they were responsive when caring for patients. They described how they would discreetly ask personal questions in a way which made them feel valued as individuals.

Staff took time to interact with patients and those close to them in a respectful and considerate way. Staff outlined how they would care and respond to patients attending clinics. Compliments seen said staff were "kind", "considerate" and "looked after them well." Staff explained how they would sensitively manage difficult and challenging conversations.

We observed patients related well to the nurses and were placed at ease when attending a musculoskeletal clinic. Nurses responded well to the needs of the patient which they said was vital to the patient's treatment and recovery.

Staff kept patient's care and treatment confidential. They followed robust confidentiality procedures that were evidenced from looking at healthcare records.

Emotional support

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

Staff gave patients and their families help, emotional support and advice when they needed it. Patients and those close to them were actively supported to be a part in their relative's care. Staff were fully committed to working in partnership with the families.

Staff explained how they supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff did not undertake specific training on breaking bad news but demonstrated how they would provide empathy when having difficult conversations, for example in safeguarding meetings.

Staff understood the emotional and social impact that some patient's conditions had on their wellbeing and those close to them. The service could signpost patients to other services for support if necessary.

Staff explained how they would respect the personal, cultural, social and religious needs of patients and how they may relate this to their care needs.

While staff did not routinely engage with advocates, they recognised that some patients may need to have access and were able to link with the advocacy service and support networks.

Outstanding ☆

Community health services for adults

Staff ensured that the communication needs of patients were understood. Information was available in many formats which included pictorial, easy read or sensory where possible. The service was able to supply people who did not speak English as their first language with leaflets printed in their own language. People's individual preferences and needs were always reflected in how care was delivered. All patients, where appropriate, had a hospital passport and health action plan.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Managers carried out regular observations of staff practice, to ensure a kind and respectful approach throughout the service. Patients were always treated with dignity by all those involved in their care, treatment and support.

People were enabled to make choices for themselves, and staff ensured they had the information they needed. Information was provided in individual easy read, the use of big lettering and simplified versions to help the person to understand.

Staff communicated with patients in a way they could understand. The learning disability team used creative materials to develop communication packages for people who use the services to address social, psychological and emotional wellbeing.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The friends and family test showed that over 80% of people said the service they received was very good. The service did not involve parents and families in the design or development of the service, but they were working on ideas for progressing this with their colleagues.

Staff supported patients to make advance decisions about their care.

Are Community health services for adults responsive?

Outstanding ☆

Service planning and delivery to meet the needs of the local people

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

Managers planned and organised services, so they met the changing needs of the local population. Locality staffing arrangements were implemented to meet identified themes and trends within local communities. For example, the district nursing teams were working alongside GPs within the phlebotomy clinics, due to increased number of blood tests required. The GPs had praised the district nurses for their different approach in supporting the community while reducing waiting times.

Outstanding ☆

Community health services for adults

The service had an urgent community response team that aimed to meet the needs of the local people. The team was made up of a group of clinicians that nurses and other hospital staff could call upon to provide expertise for those patients whose condition was deteriorating. Referrals came from GPs, district nurses, other agencies or via self-referral.

The service had a defined care coordination centre staffed by health and care professions focused on improving the efficiency and quality of patient pathways by bringing existing services together. The care coordination service was made up of a single point of access for the management of referrals and a care control hub which incorporated clinical triage and scheduling.

Co-located alongside the care coordination centre was a community wellbeing hub. The hub was available to the public, private and third sector organisations. It provided a "one-stop-shop" wellbeing service for adults and their families. The hub worked with other organisations to quickly respond to changing service pressures such as hospital admission avoidance. The hub had received over 18,000 calls and recruited 2,000 volunteers to support in the delivery of emergency food parcels and two course meals.

While the service did not have a separate end of life service, the end of life facilitator oversaw this service. Staff we spoke with had a good understanding of how to care for the dying person and explained how they would meet the physical comfort, mental, emotional and spiritual needs of the patient. We saw completed ReSPECT forms. The ReSPECT process creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices. All ReSPECT forms seen had involved the patient and their families.

Physiotherapy staff had been given the opportunity to look at new ideas to improve the service and were developing a new website so patients could access more self-advice such as healthy lifestyle and exercises. This would be accessible via social media and the local hospital.

Facilities and premises were appropriate for the services being delivered. There was appropriate disabled access for people attending appointments. All clinic rooms seen were appropriately equipped.

Team leaders allocated the next day's work based on the patient's individual care needs. Staff told us they had approximately up to 12 visits per day.

Managers monitored and took action to minimise missed appointments and reacted to cancelled appointments. We saw patients being offered appointments earlier than originally scheduled. This meant patients were able to receive treatment from speciality teams earlier and reduced wait time for other patients.

An urgent community emergency response team project had been set up to deliver a two-hour response, centred around avoiding hospital admission and enabling people to live independently for longer. This allowed patients to get faster access to a range of health professionals such as physiotherapy, occupational therapy and medicine prescribing and reviews which relieved the pressure on emergency services. Figures seen showed the response rate being 85% within the two hours.

Meeting people's individual needs

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

Managers met regularly with external providers to discuss availability and requirement of care packages for people who needed them. For example, the district nursing team, overseen by the tissue viability nurses, provided support to GP practices.

Patients were mostly seen in their own homes and staff were flexible with appointment times to meet patient preferences where possible. The district nurses operated a twilight service from 5pm to 10:30 pm and an overnight service from 10pm to 8am. The district nursing service visited patients who required urgent appointments and delivery of care during this time.

Patients attending clinics were asked if they would like to have a chaperone. They would re-book an appointment if a female patient did not wish to see a male staff member or try and swap with another colleague.

The musculoskeletal/reablement team was undertaking a pilot which looked at how the patient was "Keeping well, keeping active, keeping happy." The pilot looked at; what works for me, things I want to change or improve, this is what my therapist will do and what I know will help and agree to do. This pilot was in its infancy and continued to be a work in progress.

The therapy team had piloted a scheme using a lateral turning system. This is a piece of equipment designed to keep patients moving by automatically turning them at regular intervals day and night thus reducing pressure damage when stationary in their bed. Staff explained how this equipment had successfully prevented a patient's admission to hospital.

The reablement team were currently trialling a preventative telecare system that could highlight potential deterioration in the service user's health. The system gave patients a voice by assessing, gathering and providing objective information on how well they were managing their own independence at home. To maintain patient confidentiality, the service had created a standard operating procedure including data protection, regulatory compliance and strict cybersecurity standards.

The occupational therapy team were carrying out a six-month project which began in May 2022. The team were looking at ways of decreasing packages of care by reviewing the patient's functionality, through equipment usage. The aim of the project was to trial pieces of equipment at an early stage of rehabilitation with a view of improving orientation and mood. The occupational therapists were looking at capturing the data in line with the Care Act Assessment. The Care Act Assessment was to be used to decide what care and support a patient may need to help them live their day-to-day life.

Access and flow

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

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. All patients were sent a letter to advise them they had been referred and were on the waiting list.

The organisation's digital performance programme was able to provide daily updates regarding waiting times. Data showed the service was meeting its waiting times. For example, the falls service had achieved 96% of patients being seen within six weeks while the heart failure services had seen 92% of patients with two patients waiting between five and six weeks. Staff within the musculoskeletal teams saw all urgent patients within two weeks.

Community health services for adults

The reablement service and the multidisciplinary teams worked well to support flow through discharge to access (D2A). D2A is about supporting people to leave hospital, when safe and appropriate to do so enabling them to continue their care and assessment out of hospital.

Managers monitored the number of patients whose discharge was delayed. Across the urgent community response team there were nine patients waiting for D2A. Six lived in rural areas where ongoing care needs were difficult to the accessibility of the locality and the other three were waiting for placements. Staff told us the commissioners were very supportive in trying to find additional care agencies and suitable placements.

During our visit we observed staff identifying the treatment required in line with the patient's care plans. Staff were able to arrange follow up appointments and we saw good liaison between services to ensure timely follow up appointments were arranged, thus reducing waiting times.

The musculoskeletal (MSK)/reablement team piloted a scheme during Covid-19 looking at new ways to offer treatment. This resulted in the team accepting GP and community referrals for those not needing daily therapy, who could be treated within three to four sessions. The outcome of the pilot showed a positive impact on the waiting list decreasing from 44 days to 30 days.

Staff said patients and carers had responded well to being offered a telephone or video call as part of their treatment. Most people did not require specialist occupational or physiotherapy skills and could be supported by a supervised therapy assistant. Staff told us they continued to review how they could improve their involvement with patients in the community.

The heart failure team had successfully managed to secure funding for two new echocardiogram machines from the organisation's "Feel the difference Fund." Each year, HCRG Care Group sets aside money to fund projects designed, developed and implemented by colleagues delivering services across the country as part of their commitment that everyone feels the difference. Staff explained how this had greatly reduced waiting times with patients not having to wait for hospital appointments for the procedure.

Managers worked to keep the number of cancelled appointments to a minimum.

The services were working in collaboration with the local ambulance service to look at ways they could be contacted to provide support and possibly prevent admission to hospital. Service leads said this continued to be a work in progress, but they were making inroads into the awareness of what the community teams could provide.

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. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Staff understood the policy on complaints and knew how to handle them. Patients received information on how to give compliments or complain about the services.

Managers investigated complaints and identified themes. Clear records of all complaints were kept, including actions taken to resolve the complaint and any learning or changes made because of the complaint.

Outstanding ☆

Community health services for adults

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw evidence of feedback given to staff during team meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. We saw evidence of feedback given to staff during team meetings. The service used compliments to learn, celebrate success and improve the quality of care. For example, we saw compliments received for the twilight nurses, respiratory service and the reablement team which outlined their compassion, their professionalism and how they always accommodated the patient's individual needs.

The services were looking at how they could increase patient involvement. The teams had worked with people living with a learning disability and were asking for feedback in different ways. For example, they were asking people how they wanted their day to be and were designing a programme around this.

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Are Community health services for adults well-led?

Outstanding ☆

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues and service faced. They were visible and approachable in the service for patients and staff to assure the delivery of high-quality person centred care. They fully supported staff to develop their skills and take on more senior roles.

The service was led by a South West regional director who was supported by a head of operations and the head of community and specialist nursing, head of therapies and reablement, head of care coordination and wellbeing and the head of social care. The leaders demonstrated high levels of experience and appeared compassionate and inclusive of all staff. There was a registered manager in post who was fully aware of the registration requirements for the service. There were service managers in post who oversaw the daily running of the services.

Leaders had a shared purpose to deliver and motivate staff to succeed. Comprehensive strategies in place ensured delivery and development of the desired culture. Leaders showed strong collaboration and support across all services and a common focus on improving quality of care and patient and staff experiences. Leaders were visible and approachable.

Leaders understood the challenges to quality and sustainability, and identified the actions needed to address them. For example, leaders were regularly reviewing and tendering for contracts. This was to ensure continued staff recruitment in order to provide a sustainable service.

Staff felt well supported by their managers and were comfortable and confident in approaching them if they had any concerns. Managers we spoke with confirmed they received continuous support to enable them to do their role.

There were clearly defined roles and responsibilities within the leadership teams. All managers knew what was expected of them which was supported by the senior leadership team including the director of operations. Managers were able to attend a mentorship and coaching programme to support better communication.

Staff were able to access training to complement their role. They said their manager supported them to develop their skills and take on more senior roles.

Staff were clear about their roles and responsibilities. Specialist leads managed their own teams. For example, occupational therapy leads managed occupational therapists.

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 organisation's vision and values were on display. Staff were able to demonstrate their knowledge of the trust's vision of "We Care, We Think. We Do." They were also able to say how they would "change lives through transforming health and care." All knew where to find the information on the organisation's intranet. Staff were aware of the patient focussed values of the service. This was demonstrated in the clinics we attended.

The strategy and supporting objectives were challenging and innovative while remaining achievable. For example, the tissue viability team was responsible for the pressure ulcer prevention strategy for Bath and North East Somerset community services. They supported community teams in the provision of safe care and preventing avoidable harms.

A new medicine strategy had been completed for 2022/2025. The aim of the strategy was to focus on patient safety.

Leaders were clear on how well the different services had developed during the Covid-19 pandemic and all said that while access and flow was on occasions challenging, they had turned the corner, and this was improving.

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.

There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work. The service provided opportunities for career development.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff reported feeling encouraged and motivated by the managers, describing them as supportive and valuing their contributions. All staff showed passion and commitment to providing high quality care.

Staff felt respected, supported and valued which was reflected in the staff survey. Staff felt proud to work for the organisation and felt they were valued. During our inspection the attention to detail when working with patients was evident. Staff explained the importance of compassion, care and candour for the patients and relatives in their care.

Staff were positive about each other and their teamwork, and stated they had close working relationships and always supported one another.

The provider promoted equality and diversity in its work. Staff felt able to raise concerns without fear of retribution. The service's training programme ensured that leaders and managers had embedded equality, diversity, inclusion and safeguarding into the training programme. This ensured patients were treated with integrity and dignity.

Staff said morale was good. They told us there was a positive culture where staff felt able to share their views without fear of reprisals.

Staff understood the whistleblowing process for raising concerns and felt comfortable in approaching their manager or clinical lead.

Staff were aware of the role of the Freedom to Speak Up Guardian and those of the local champions. They knew how to contact them. Managers encouraged learning though a culture of openness and transparency. Staff said they were able to raise concerns with their team leaders, service manager or senior leadership team and would be listened to if they did.

Staff praised the development opportunities available to them. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

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.

Governance and performance management arrangements were proactively reviewed and reflect best practice. 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 had a clear systematic governance process to continually improve the quality of services provided to patients. These arrangements were clear and operated effectively. Staff understood their roles and accountabilities.

The governance framework provided oversight of quality and safety performances. There was a clear performance management reporting structure which looked at operational performance including a review of incidents, staffing, infection control, education and training. The service undertook numerous quality audits, and information from these which assisted in driving improvement and gave staff ownership of things which had gone well, and action plans identified how to address things which needed improvement.

The community teams and specialist services we spoke with were able to describe the governance processes within their services. Meetings had a set agenda which looked at governance and quality.

Monthly quality and safety meetings had a standardised agenda which looked at areas such as; the actions log, safety alerts, quality improvements and updated National Institute for Health and Care Excellence (NICE) guidelines. The service had up to date policies for staff to follow. These were reviewed during the quality and safety meetings.

The quarterly medicine optimisation governance committee meetings provided good oversite of medicine issues across the community services. Areas reviewed included; updates on policies, learning from incidents and medicine risks. The agenda was mirrored in the two-monthly medicines management group meeting minutes. These were cascaded to staff to provide education, training and learning.

The service monitored all incidents and complaints and had a framework to identify themes. The complaints log was designed to enable managers to have oversight of whether they responded within appropriate timeframes. The complaints also included sections for lessons learnt and how learning was shared. We saw evidence of lessons learned shared in meeting minutes.

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.

Leaders we spoke with understood the issues, risks and challenges faced by the service and had a plan of action to mitigate those risks.

The digital data used by the service helped the operational and team leads to identify areas highlighting trends. They were able to view up to date statistics across community services and quickly identify themes which may impact on patients.

The operational registers were merged in January 2022 into one BaNES (Bath and North East Somerset) register. The register contained risks such as; staffing levels, inability to complete training and information technology (IT) issues. We saw this was regularly reviewed with actions in place to mitigate the risk. Each risk had a proposed date for completion which ranged from September 2022 to March 2023. All new risks were reviewed by the senior management team representative prior to being submitted to the board and commissioners. We saw the management of risks were reviewed during the monthly quality and safety meetings.

The management team discussed the risk register at monthly governance meetings. All action plans were monitored through monthly learning from events meetings, and internal service meetings, including closing the loop forum.

The service had a business continuity plan in the event of loss of electricity, floods or adverse weather etc. This plan was available to all staff and included clear contingency plans. Staff were aware of the plan and knew where to find it.

Information Management

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

Staff could find the data they needed to understand performance, make decisions and improvements. The information systems were integrated and secure.

All staff had undertaken data security and awareness training as part of their mandatory training. Staff we spoke with understood their responsibilities around information governance and risk management.

Staff had access to work mobile phones, so contact details and personal information was not compromised. Staff also had access to laptops with personal login details so they could update patient information when visiting patients in the community.

All staff had access to systems that made sharing patient information possible. Poor Wi-Fi access in some rural areas hindered the ability of staff to update and upload patient records during community visits.

The service was in the process of centralising staff and systems data after re-branding to HCRG Care Group. Staff could access policies and procedures and receive information on the organisation's intranet.

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

Engagement

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

Constructive engagement from people who used services and staff was welcomed and seen as a vital way of holding services to account. Leaders and staff actively and openly engaged with patients and staff to plan and manage services.

The service had many forms of staff engagement including an active partnership forum and managers and staff meetings. Team meetings were held regularly, and staff confirmed there was good engagement. Meeting minutes demonstrated that service leads updated staff with information such as available training and feedback from incidents.

To celebrate staff and student's resilience with coming through Covid-19, the organisation held a nursing conference on 25 May 2022. This was a celebration of what they had achieved alongside some learning. The conference was attended by the Chief Nurse from BaNES and the Southwest Regional Chief Nurse from NHS England.

Staff told us they were actively encouraged to feedback any ideas for improvements. During the conference staff attended breakout workshops to look at pathway management in a variety of areas such as; continence, end of life care, tissue viability and frailty.

The senior leadership team were looking forward to rolling out a roadshow for colleagues from July 2022 onwards where staff would be given the opportunity to "ask us anything."

The corporate executive team held "Town Hall" events where they updated staff on key themes such as; pay awards and fuel economy.

Outstanding ☆

Community health services for adults

The service worked closely with external stakeholders such as commissioners and NHS England.

Patients and carers could access information about the service through the provider's website. Patient and carer feedback stated the service was flexible and accommodated the needs of patients.

Staff could access the HCRG Care Group incentives through an app which was readily available. There were pages dedicated to supporting staff with their wellbeing

Staff understood that organising meetings was difficult due to staff shifts and the fact they worked country wide. This meant staff did not live near each other. However, all staff we spoke with felt they could discuss issues with their manager if necessary.

Responses seen from patients was positive with many staff were "excellent" and provided "good care."

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 teams worked together to make improvements in the running of the service. The service had proactively identified opportunities to expand and develop their roles.

Incidents and shared learning were discussed in the "closing the loop" forum and shared with staff. This provided opportunity for discussion of safety and quality issues. Leaders were responsive to concerns raised and sought to learn from them to improve services and performance.

Staff were given the time and opportunity to learn.

District nurses had proactively worked alongside GPs to provide blood tests to patients to help reduce waiting times. This incentive had been praised by GPs for their different approach to supporting patients in the community.

Requires Improvement

Community health inpatient services

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Good
Well-led	Good

Are Community health inpatient services safe?

Requires Improvement

Mandatory Training

Mandatory training in key skills was set by the service. The staff were not up to date with mandatory training

The overall figures for training attended by HCRG staff was above the mandatory training target of 85%. However, St Martins staff's attendance to mandatory training was below the target. The training matrix showed 57% had attended mandatory training.

Staff were not up to date with their mandatory training. The training matrix showed that only 52% of staff had attended Basic Life Support training, 57% had moving and handling and 37% Fire Awareness.

Some staff reported that agency staff were not always trained. For example, moving and handling. The head of community hospital said the booking service for agency staff had clear directives on the skills and competency of agency staff, but it was possible they were not familiar with the equipment used on the ward.

Safeguarding

Staff understood the principles of the safeguarding adults' procedures including the types of abuse.

Safeguarding adults training including PREVENT awareness was mandatory for staff. There were three levels of training available and the level to attend was dependent on the role. Fifty eight percent of staff had attended the training, however, it was below the target of 85%. For example, 40% of staff had attended level 1, 47% level 2 and 52% level 3.

Children's safeguarding training attended by staff was below the 85% target. The level of training depending on their role. For example, for level one 40% of staff had attended and 54% attended level 2

The ward manager gave an example of a recent safeguarding referral, the actions taken and the ongoing support. Steps taken by the ward manager ensured they were safeguarded from abuse and their confidentiality maintained.

Requires Improvement

Community health inpatient services

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

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.

Ward areas were clean and had suitable furnishings. Cleaning schedules were available on the ward for housekeeping staff to follow.

Patients had limited space to gather and socialise with each other or to meet their visitors. Equipment was stored in the day room which limited the social space for patients. There were plans for the day room to change into an area for patients to make meals and socialise with others.

Fire risk assessments were completed by NHS property services and there were regular checks of fire equipment. A fire warden was designated to the wards and Personal Emergency Evacuation Plans (PEEP) were devised on how patients were to be supported to a place of safety in the event of fire.

Infection Control procedures were followed there were hand sanitizers and mask available at the front entrance and around the wards. Staff followed infection control principles including the use of personal protective equipment (PPE).

Environment and equipment

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

Environmental risk assessments were completed by HCRG property services and external contractors checked equipment annually to ensure they were safe for use. The staff were not clear which service to report repairs. For example, landlords or the organisation. There were outstanding repairs to the bathrooms including the female shower in one bay.

The clinical room where patients received care and treatment was kept locked, clean but cluttered. The equipment in the resuscitation trolley was out of date. The staff had not visually checked for several weeks the expiry dates for equipment although they had signed the audits to indicate equipment was within date. The ward manager and head of community hospital took immediate action and ensured all equipment was within date. There may have been an impact on the abilities of medical professionals to save life in an emergency had this not been noted during the inspection.

Patients could reach call bells, but they said a prompt response was not always possible due to low staffing levels on the wards.

Assessing and responding to patient risk

Risk assessments were completed for each patient. The lack of reviews did not always demonstrate the risk was reduced or removed.

Nationally recognised tools were used for assessing patients at potential risk of health deterioration which included National Early Warning Score (NEWS) to assess patients at potential risk of deteriorating health, Malnutrition Universal Screening Tool (MUST) and Waterlow for patients at risk of pressure injury.

NEWS assessments were not consistently completed for four patients which lacked the action taken when the risk of health deterioration escalated. Where there was high risk of health deterioration the NEWS assessment lacked evidence of escalation.

Nationally recognised tools were used for assessing patients at potential risk of health deterioration. These included National Early Warning Score (NEWS), Malnutrition Universal Screening Tool (MUST) and Waterlow for patients at risk of pressure injury.

Waterlow assessments were used by staff to assess patients at risk of pressure injury. Templates were missing guidelines on the scores and the action to be taken. Assessments for four patients in St Martin's assessed at high risk of pressure injury were incomplete. For example, the Waterlow assessment lacked the level of risk or the actions for one patient with a score of 20 due to long standing medical condition, mobility needs, poor skin integrity and continence needs.

Handovers occurred when shifts changed and staff were provided with handover sheets included all necessary key information to keep patients safe. Accompanying risk assessments and care plans were not always in place for needs identified in the handover sheets. Staff said the handover sheets were useful and kept them updated with the current risk.

Staffing

The service operated on established staffing levels and agency and bank staff were used to maintain them.

On the evening visit a nurse in charge and two nurses with two health care assistants were on duty. One agency nurse and one health care assistant were included in the team of staff on duty.

Agency and bank staff were used where vacancies existed. The vacancy rate was 25% and the sickness rate for June 2022 was above the 4% target. Steps were being taken to recruit and retain staff. For example, for internal adverts there were incentives and progression opportunities for both substantive and bank posts. The service was undertaking overseas recruitment for registered nurses and 12 staff had been recruited.

Some staff raised concerns about the skills and competencies of agency staff. A brokerage service was used to book agency staff. The brokerage service ensured the regular agency staff used to cover vacancies were qualified and skilled to meet patients' needs.

Medical staffing

The service had medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

There were vacancies in the therapy team which consisted of Occupational therapists (OT) and physiotherapist. **R**ecruitment was ongoing for vacant posts which arose from the progression of OTs to higher bands.

A GP was on duty daily on the wards and a consultant on call during evenings and weekends.

Requires Improvement

Community health inpatient services

Records

Staff kept records of patients' care and treatment. The records stored securely and easily available to all staff providing care but not always up to date.

Assessment tools were not completed correctly or evaluated for action. Records that provided guidance on how to support patients were not comprehensive. For example, personal care and discharge plans were not developed including information from risk assessments. Monitoring charts such as NEWS scores were not completed and didn't detail actions to mitigate the risks. This meant patients' care and treatment needs may be delayed, and nursing staff not updated on the patient's current needs.

While staff maintained daily records, the reports along with outcomes of assessments and outcomes of procedures were not gathered and used for planning patients care. This meant that staff had to review all notes when seeking outcomes of medical procedures and tests.

Handover notes were detailed but not associated to a care plan or risk assessment. For example, for one patient the handover notes refer to continence needs, textured diet and behaviours that places them and others at risk of harm. Although risks were assessed a care plan on how to lower the level of risk or de-escalate situations were not developed. This meant staff were not provided with guidance needed to consistently meet the needs identified.

Medicines

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

The audits of medicine systems were completed by an internal pharmacist. The audit for March 2022 had identified a number of recommendations and ward staff were to complete an action plan on how recommendations made were to be actioned**.** The findings from the audit was that the medicine procedures known as standard operating procedures (SOP) was not available on the ward and consistent with our findings. We found gaps in the recording of medicines administered although the audits indicated that the standard was fully met.

Prescription charts showed that staff were not administering medicines within the prescribed intervals or at consistent times. The registered manager told us the SOP states that medication could be administered within 2 hours of the prescribed time. Since the inspection site visit the SOP was to be made available on the ward for staff's reference.

The National Institute for Health and Care Excellence (NICE) a national recognised body for good practice guidance was not followed for recording of medicines administered. Staff were not following systems and processes with the recording of medicines administered. We found gaps of staff signatures to evidence medicines administered in three of the six medication charts, codes were not used to explain the reasons for not administering the medicine. This meant there was no assurances that patients have been given their medicines as prescribed

Incidents

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

Requires Improvement

Community health inpatient services

All staff knew what incidents to report and how to report them. There was an electronic system for reporting incidents and accidents. Staff reported to the nurse in charge and during handover staff were updated on changes of care following an accident or accident.

There were closing the loop sessions to discuss incidents. The Quality and Safety team provided feedback on incidents and accidents. The ward manager acknowledged team meetings to discuss learning from incidents were difficult to organise. A whiteboard was used to provide staff on the ward with information about specific incidents which included learning.

Falls were identified as the highest risk for the ward and a working group was taking place looking at the demographic or age of patients, their cognitive abilities, medical presentations.

Are Community health inpatient services effective?

Requires Improvement

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients in their care.

Staff took steps to follow up-to-date policies to plan and deliver care according to best practice and national guidance. For example, NICE Guidance

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs.

However, nationally recognised management guidelines were not consistently followed for patients assessed as at risk of malnutrition. Where malnutrition universal screening tool (MUST) assessments had identified patients as at risk of poor hydration, fluid intake charts lacked detail or evaluation. This meant the outcomes used to inform planning were not up to date or accurate for patients at risk of poor hydration.

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. For three patients of the six care records reviewed were assessed with moderate to high levels of pain. The effectiveness of the pain relief administered was not reviewed or documented.

Patient outcomes

Staff monitored the effectiveness of care and treatment.

Patient's needs were assessed on admission. Admission checklists were based on all areas of patients' physical, emotional and social care needs. Risks identified during the admission process were assessed. Patients preferences was not sought on how their needs were to be met. Care plans were not devised on how staff were to consistently meet the needs identified from the information gathered during assessments for the seven patients records reviewed. Action plans were not reviewed where assessments had identified further monitoring due to potential deterioration. This meant the results from assessments and information gathered were not always used to improve patient outcomes.

Patients were not having the number of therapeutic sessions set by and national and local benchmarks structure and processes of stroke care against evidence based standards. Patients admitted following a stroke were not having the 40 mins therapy sessions per day. Therapy staff said shortages meant targets were not met.

Therapeutic activity groups were only taking place during the day and in the evenings, patients had little to do. Activities coordinators will be line managed by the OT team and there will be more purposeful engagement with the changes.

Patient discharges were delayed. The discharge coordinator said there were 15 patient's discharges were longer that the target of 30 days. Delays in discharges arose when a patient stayed in the ward although they were medically fit for discharge. This was largely due to patients waiting for a package of care to live at home or waiting for a placement within a care home.

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.

Some staff raised concerns about the skills and qualification of agency staff. The registered manager and head of community hospital explained some staff vacancies had arisen from progression to different banding. They acknowledged that high levels of agency staff were used. A brokerage service was used to book agency staff and there was a clear directive that only skilled and qualified agency staff were to be booked to work at the hospital.

There were mixed comments about the quality of the induction. While some staff said there was little time to assist with the induction other staff said their prepared them to perform their role. The ward manager said that training was online, but the local ward induction needed to improve.

Annual appraisals were from April 2022 and 84% of staff already had their appraisal session.

Managers receive automatic notification of colleagues who are nearing their revalidation date which allows them to monitor and support registrants to revalidate. They supported medical staff to develop through supervision of their work. Individual clinical supervision was not regular and peer supervision with band six staff had happened to discuss improvements needed to support patient care. It was recognised that more regular supervision was needed.

Requires Improvement

Community health inpatient services

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide good care and communicated effectively with other agencies.

MDT meetings were held on separate days for patients admitted following a stroke and for patients admitted for rehabilitation. There were discussions about discharge, patients with complex needs and family involvement.

A discharge coordinator was in post and attended MDT meeting with medical and clinical staff, but nurses were not attending the meetings regularly which had an impact on discharges.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards/units.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their daily activities.

Nursing staff were not up to date with training in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Only 59% of staff had attended MCA training. There was some confusion on which team was responsible for completing mental capacity assessments for discharge. Occupational therapist staff said they were completing the assessments for discharge due to lack of training between nursing and therapy staff.

Handover sheets listed the names of seven patients where mental capacity assessments were completed. Two of the six patients were identified as having capacity, four lacked capacity, and for one patient the outcome of the assessment was not completed. Three patient's capacity assessment was outstanding or for three patients with cognitive impairments such as dementia and memory loss none was requested.

Staff knew the principles of the MCA regarding seeking patients consent before delivering personal care and the daily decisions they were able to make. For example, patients were given choices and asked if the staff could use their first name.

Deprivation of Liberty Safeguards were granted by the supervisory body (lacking capacity to consent to be there, deprived of their liberty, under continuous supervision and control, For example, not recognising the consequences of not having medical care and leaving the hospital ward without support from staff.

Requires Improvement

Community health inpatient services

Treatment Escalation Plans (TEP) documented the recommendations discussions with three patients about their clinical care in emergency situations, where they were not able to make decisions or express their wishes. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) documented future treatment decisions such as serious illness, acute deterioration or end of life treatment made by health care professionals with three patients and family

Are Community health inpatient services caring?

Good

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. Staff took time to interact with patients and those close to them in a respectful and considerate way. For example, the ward clerk would have patients sit next to them when they became anxious and wanted to leave the ward.

Patients said staff treated them well and with kindness. There were patients who raised concerns about staffing levels and the use of agency staff. They said some staff were not always helpful or willing to assist them. The ward manager was challenging staff's behaviour with the way they engaged with patients.

Patients care and treatment was not kept confidential because whiteboards with details on their admission, tests and nursing procedures and discharge information was in full view of visitors and other patients. The registered manager and head of community hospital gave assurances that patients confidential information will be respected. For example, covering the board or relocating the board.

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

Emotional support

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

Patients and those close to them received help, emotional support and advice when they needed it although their time with staff limited. 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.

The head of community hospital told us how they ensured staff were kind and compassionate towards patients. Staff were praised when their practice was within the values of the organisation. The friends and family test were applied during recruitment and open feedback from patients and relatives.

Requires Improvement

Community health inpatient services

Staff we saw interacting with patients were friendly and approachable. They took time to interact with patients and those close to them in a respectful and considerate way.

Patients knew about the reasons for their admission. However, they were not aware of their care and discharge plans.

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.

Visiting to the hospital was reinstated following the COVID pandemic. Staff made sure patients and those close to them understood their care and treatment.

Patients had support from staff to make informed decisions about their care. Staff talked with patients, families and carers in a way they could understand,

Patients gave positive feedback about the service. Mixed comments were made by relatives about the therapies available to support discharges.

Are Community health inpatient services responsive?

Good

Service planning and delivery to meet the needs of the local people

Transfers of care to Sulis ward were mostly from the hospital trust and not from the local community and were mainly for patients on a discharge pathway. There were eight beds allocated for patients following a stroke, but currently there were 16 patients having had a stroke. The day room had been used in February and March 2022 to accommodate two further patients due to the high demand with transfers of care from the hospital trust. Staff were concerned about them not meeting the aim of the inpatient service regarding specialist rehabilitation for individuals who had a stroke and were unable to return home. This meant patients were not having the rehabilitation time set by national benchmark standards.

Facilities and premises were appropriate for the services being delivered. Patients were admitted to single sex wards arranged into five en-suite bays of six patients and six side rooms.

Meeting people's individual needs

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

Handover notes listed nine patients with additional needs such as depression, anxiety and dementia. Care plans were not developed for patients living with mental health problems, and dementia. The staff were to monitor behaviours that

placed one patient at risk of harm and towards others. The purpose of the chart was to identify the triggers of the behaviour and to develop strategies to de-escalate incidents. A care plan linked to the behaviour chart was not in place. The chart was completed for one day and the language used were punitive. For example, "accusatory behaviour" was used to describe a patient and an expectation the patient responded to their explanations.

Wards were not designed to meet the needs of patients living with dementia. For example, leisure, social interaction, and dementia friendly environment**.** The handover notes identified two patients with a diagnosis of dementia and one with memory loss. The patients in one bay were known to move around the ward and at night a member of staff was deployed to monitor these patients.

Access and flow

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

Managers monitored delays with transfer of care against the service own set targets. Delays with transfer of care occur when an adult patient remains in hospital although they were deemed medically fit for discharge. The service monitored the total number of lost days due to delays in transfer of care. For example, average stay was above the 30 day target and for June 2022 the average stay was 47.9 days.

The discharge coordinator said delays with transfer of care arose when they were unable to finalise arrangements for continuing care in the community. For example, some patients were difficult to place in the community due to their complex needs. Staff raised concerns about the agency staff's lack of competency which impacts on discharges planning because Occupational therapists (OT) were helping nursing staff to deliver personal care.

Discharge plans were missing for the seven patient records reviewed. This included identifying any rehabilitation needs and services needed to support the person to leave the hospital. The discharge coordinator told us that nurses knew the plan for patients to progress to discharge assessment beds, but this was not clearly recorded. We were told that steps were taken to ensure transfers of care were smooth. Discharges were arranged to suit the carers and they ensured the timings of discharge were best for carers**.**

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. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Requires Improvement

Community health inpatient services

Are Community health inpatient services well-led?

Good

Leadership

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

The registered manager leadership style was credible, visible and leads through engagement and coaching. “We” was the terminology used as staff worked as a team. The challenges to the service related to retention and recruitment of staff. These were addressed by creating a clear ladder of progression and accepting nurse students on placement. There was potential for creating more nursing associate roles because progression of staff had created band five post vacancies.

Ward managers were supported by a head of community hospital. The expectations of this role included developing the model of care to more holistic, person centred and reablement of patients.

Local leadership was provided by ward managers although some staff gave feedback that issues were not always addressed when these had been reported.

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. Leaders and staff understood and knew how to apply them and monitor progress.

The registered manager and head of community hospital explained they worked well with ward managers. There was acknowledgment that steps to recruit were being taken but that staff struggled with the timescales and progression of staff to bring about retention. There was to be earlier involvement with families, more effective reablement and meaningful activities such as gardening and pottery.

Culture

Staff did not feel felt respected, supported and valued.

The registered manager and head of community hospital recognised that staff were “unsettled” due to changes with providers. In 20 months, new bids for contracts will have to be submitted. This could potentially result in another provider with their own policies, processes and procedures that staff would need to embrace.

The organisations visions and values were known to staff. Staff told us that morale was low due to ongoing high levels of agency usage along with their concerns over the competencies and skills of agency staff. Staff said some agency staff had little experience of working in hospital environment although they worked in a caring role. Regular agency and bank staff were positive about working on the ward. The head of community hospital and ward manager were taking action to improve morale. For example, listening to staff, to improve communication the MDT office was converted into the

office for allied health care professionals and to improve the presence of the ward manager their office was moved to the ward. The challenges with agency staff were acknowledged and to embed the changes there was gradual progression with the introduction to the model of care. The ward manager gave us their assurances that more robust checks and processes were taking place for booking agency staff.

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.

Managers recognised staffing was the major risk to the service and had put recruitment and retention initiatives in place to attempt to mitigate the risk.

There were monthly management meetings to review learning and how changes in practice were embedded after an incident. There were monthly standing operating procedures clinical leads monthly meetings.

There were changes with the national and local governance structure has challenged the ways of working. The impact was not yet known to the service as there were changes occurring with the introduction of the integrated care system (ICS) a partnership organisation merged with Clinical Commissioning Groups (CCGs). The ICS will have an impact on the health and wellbeing of the local population and although Community Impatient services were members, they were not part of the Integrated Care Board.

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. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The service had a risk register which included missing budgetary targets, staff vacancies, incidents reporting and uncertainty for the future contractual provision of health and social care in BANES community as a result of the contract not being extended beyond March 2024

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. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Paper documents were used on the ward while electronic systems were used across other services within HRCG. Information was documented in progress notes which staff found difficult to read. This meant that information was not widely shared or easily accessed by other internal and external teams that used the same system.

Requires Improvement

Community health inpatient services

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

Engagement

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

While we observed staff consulting with patients during the admission process, managers recognised that patients voice was missing from their plans of care. We were given assurances that a full review of documents would be undertaken.

Learning, continuous improvement and innovation

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

All staff 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. Staff we spoke with were committed to making improvements although they felt the ward was operating short staffed. The service leaders recognised the need to drive improvement across the service. They understood the issues within the service and were committed to improving the quality and safety of the service**.** For example, initiatives on recruitment and retention of staff, review of documents and communication

Community health services for children, young people and families

Good

Safe	Good
Effective	Outstanding
Caring	Good
Responsive	Good
Well-led	Good

Are Community health services for children, young people and families safe?

Good

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update this. Staff accessed individual accounts for an online platform, which provided them access to training, mandatory compliance and informed them when to renew.

The mandatory training was comprehensive and met the needs of children, young people and staff. It was delivered through an online system and through face to face sessions.

Staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. The service had introduced the Oliver McGowan training in learning disability and autism for staff.

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 specific for their role on how to recognise and report abuse. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff took part in quarterly safeguarding supervision sessions. Staff were trained to the appropriate level for safeguarding children and adults applicable to their role, this included up to level two and three. A consultant paediatrician was trained to safeguarding level five and was the designated safeguarding lead for the service.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Equality and diversity were part of the mandatory training.

Community health services for children, young people and families

Good

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There were close links with social care professionals within the local authority, safeguarding leads and named persons across teams provided support with advice and making referrals.

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.

Facilities were clean and had suitable furnishings which were well-maintained.

Staff cleaned equipment after use. Protocols and cleaning products were in place to wipe down surfaces before and after use within clinics and offices.

Staff followed infection control principles including the use of personal protective equipment (PPE).

Staff followed best practice when entering children, young people and families' homes. The

teams assessed infection control risks and identified the appropriate PPE for all home visits.

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 enough suitable equipment to help them to safely care for children and young people. Staff carried out daily safety checks of specialist equipment.

The service had a central system listing equipment stock with calibration status, service intervals and contact details for the company providing equipment repair services. Equipment was regularly serviced and calibrated in line with manufacturer's recommendations.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified and quickly acted upon children and young people at risk of deterioration.

Staff used nationally recognised tools to identify children or young people at risk of deterioration and escalated them appropriately. Nursing staff used the paediatric early warning scoring tool (PEWS). This was introduced following an identified action in the deteriorating patients and identification of sepsis report in April 2022.

Community health services for children, young people and families

Good

Staff knew about and dealt with any specific risk issues. This included the use of tools and assessments to consider home environments, physical health deterioration, domestic abuse and safeguarding issues.

Staff routinely met with the children and adolescents' community mental health teams to discuss children and young people needing access to mental health services.

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

Staffing

While there were staffing shortages, the service ensured they 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 staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

Staff told us they loved their job and felt supported by their teams. Staff ensured service demands were met. However, they told us increased service demands made them feel close to burnout.

Staff discussed staffing issues with managers and were aware of initiatives to recruit more staff. However, this did not alleviate pressure on health visiting teams.

The service had low vacancy rates across speciality services. However, additional workload on educational health care plans (EHCP) had contributed to demands on capacity. This meant waiting lists that resulted from the covid pandemic, were not reducing. However, senior managers had action plans to address these and were working with commissioners to streamline affected services and meet waiting time targets.

Morale across speciality services was good and staff told us they felt well supported by managers and their teams.

Managers made sure all bank and agency staff had a full induction and understood the service.

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.

The service used an electronic care records system, notes were comprehensive and staff could easily access them.

When children and young people transferred to a new team, there were no delays in staff accessing their records. The electronic system allowed for sharing of information across services and staff were able to access relevant notes added by other professionals.

Staff could access electronic records off site when completing home and community visits.

Community health services for children, young people and families

Good

Professional leads and managers undertook periodic audits on the electronic records for their respective teams to ensure completeness and accuracy. Care records we reviewed showed this to be effective as they were clear and comprehensive.

Records were stored securely.

Medicines

The service used systems and processes to safely prescribe medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Paediatric Consultants utilised electronic prescribing to meet demands of the people using the service. This meant children and young people were able to have prescriptions electronically sent to pharmacies most convenient for them and their families in a timely manner.

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 knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy.

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.

Staff received feedback from investigation of incidents, both internal and external to the service. Managers discussed incidents in monthly quality, care effectiveness and safeguarding meetings. Any learning was then cascaded to staff teams.

Staff met to discuss the feedback and look at improvements to children and young people's care.

There was evidence that changes had been made as a result of feedback. For example, information on making referrals had been adjusted to highlight the importance of high risk concerns on forms so they could be escalated without delay.

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations.

Managers took action in response to patient safety alerts and monitored changes.

Are Community health services for children, young people and families effective?

Community health services for children, young people and families

Good

Outstanding ☆

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 followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Managers completed templates with updates to National Institute for Health and Care Excellence (NICE) guidance and referenced where they were and were not being met within the service. Managers reviewed processes to add in NICE guidance to ensure staff were adhering to best practice.

Staff gave parents and carers advice in line with national guidance and had leaflets available for families to keep. We observed staff using the ages and stages questionnaire and the early language identification measure (ELIM). Staff gave advice in baby and toddler clinics regarding feeding regimes, sleeping routines and discussed bowel patterns. We observed an autism diagnostic observation scale (ADOS) assessment by speech and language therapists. This assessment was complex and staff in attendance showed flexibility, compassion and professionalism in their approach to a challenging situation.

Nutrition and hydration

Staff regularly checked if children and young people were eating and drinking enough to stay healthy and help with their recovery.

Where relevant, staff included nutrition and hydration assessment and management within children and young people's care plans.

Staff fully and accurately completed children and young people's fluid and nutrition charts and escalated concerns where needed.

Staff used a nationally recognised screening tool to monitor children and young people at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for children and young people who needed it.

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 service participated in relevant clinical audits and outcomes for children and young people were positive, consistent and met expectations, such as national standards. Staff used the therapy outcome measure (TOM) to assess the impact of intervention across impairment, activity, participation and wellbeing. The family nurse partnership used 'new mum star'. This outcome measure tool is used to support young women as part of the programme before and after they have their babies.

Community health services for children, young people and families

Good

Managers and staff used the results to improve children and young people's outcomes. Managers discussed results from audits at quality care effectiveness meetings (QCES) and developed action plans to improve these where necessary. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Managers shared and made sure staff understood information from the audits.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. Managers and staff used evidence-based tools and assessments to monitor outcomes.

The school nursing service provided the 'FRIENDS' course to targeted schools across the region identified as having higher levels of needs. The course aims to build resilience and develop positive relationship building skills for children in year five. Results from previous cohorts have shown 90% of participants reported increased knowledge about understanding feelings in themselves and others, and 71% of children said they used 'FRIENDS' skills often. The programme was delivered each year and had been recognised by the World Health Organisation (WHO).

The breastfeeding service was accredited by UNICEF baby friendly initiative stage 3.

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 children, young people and their families.

Managers gave all new staff a full induction tailored to their role before they started work. This included HCRG values training, where employees were required to learn about and demonstrate competencies and behaviours aligned to their values of 'Care, Think, Do'.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Most staff told us they received effective and supportive supervision with their managers or team leaders. Supervision attendance was reported as 95%. However, health visitors told us that it was difficult to fully attend these sessions due to their workload.

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

Managers made sure staff received any specialist training for their role. Staff were able to explore areas of interest they felt would be of use to their role and development, they could then apply to undertake the course upon managers approval. Staff told us they were unaware of a time when this had not been authorised.

Managers identified poor staff performance promptly and supported staff to improve. Managers referred to organisational policy and gave examples how they would work in a manner of ways to address performance issues, and support staff to resolve issues and raise performance.

Multidisciplinary working

Community health services for children, young people and families

Good

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 held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. For example, family nurse partnership and health visitors engaged in regular meetings with the Bath midwives Lotus team.

School Aged Immunisation teams worked with schools to organise, and risk assess environments where immunisations were carried out.

Staff worked across health care disciplines and with other agencies when required, to care for children, young people and their families. All services were involved and ensured representation at 'team around the child' meetings, which ensured a multidisciplinary approach. Children, young people and families provided positive feedback on the support they had received through the multidisciplinary approach. For example, families described 'teamwork' and felt parents and professionals had equal voices.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. Teams engaged with community children and adolescent mental health (CAMHS) teams to support multidisciplinary working.

The speech and language therapy team and school nurses supported training for the youth offending service team. The team provided specialist assessments and advice for those who entered the youth justice system, as well as school nursing support to help manage health conditions, the impact of trauma, promotion of healthy lifestyles and access to sexual health advice. This intervention increased the uptake of immunisations and dental health care. Speech and language therapists also gave advice on communication needs, communication passports and advice for pre-sentence reports.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support displayed in locations where care was offered. The service delivered the healthy child programme for children aged 0-19 years.

Health visiting staff received HENRY training. This training includes support and resources aimed at promoting a healthy start for babies and young children. 'Cook it' groups were available to families to attend, and supported families to learn practical skills to provide their children a healthy balanced diet.

Health visitors, school nurses and the children's weight management team provided an evidence-based weight management service. The programme supported healthy eating and physical activity to manage obesity in children, young people and their families. The service provided an educational programme for 5-17year olds above their ideal weight, supporting healthy lifestyle choices. Body image, being active and screen time topics were covered to support family-based behaviour change. Additional interventions included a 12-week free leisure centre support with a parent or carer access and five week funded community based practical cookery skills course for families.

Community health services for children, young people and families

Good

Health visitors provided routine perinatal mental health screening for expectant mothers. One to one listening visits and ongoing referrals to specialist agencies meant there was additional support for new mothers experiencing mild to moderate mental health needs. This service was implemented alongside midwives, children centres and local charities and known as the Bath and North East Somerset perinatal emotional wellbeing partnership (PEWP).

Staff assessed each child and young person's health and provided support for any individual needs to live a healthier lifestyle. We observed staff providing infant feeding, sleep, weight management and active lifestyle advice to families. They signposted to services that were able to assist with achieving a healthy lifestyle and wellbeing, beneficial to children and their families.

Consent, Mental Capacity

Staff had a full understanding of how to support 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 made sure children, young people and their families consented to treatment based on all the information available, and in line with legislation and guidance. This was recorded clearly in children and young people's records. We observed staff gaining parental consent to provide care and treatment to their child where the child was unable to give consent. This was clearly documented in notes taken during the clinic session.

When children, young people or their families could not give consent, staff made decisions in their best interests, taking into account their wishes, culture and traditions.

Staff understood how and when to assess whether a child or young person had the capacity or competency to make decisions about their care.

Staff received and kept up to date with training in the Mental Capacity Act. Staff we spoke to were able to explain Gillick competence and how it is applied. Gillick competence is the principle used to judge capacity in children to consent to medical treatment.

Staff knew how to access policy and get accurate advice on the Mental Capacity Act and Gillick competence.

Are Community health services for children, young people and families caring?

Good

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way.

Community health services for children, young people and families

Good

Children, young people and their families said staff treated them well and with kindness. Families provided positive feedback through the friends and family feedback test. Feedback given across all services included themes of staff showing kindness, compassion and providing support with sensitive issues.

Staff followed policy to keep care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Families told us staff were flexible and stated how they were able to meet their needs. The service used feedback from families to adjust the use of indicators on digital record keeping systems that described level of need, social demographic and other personal sensitive information. Feedback highlighted families not liking having 'tags' placed against their children, young people and families records that could immediately influence a negative assumption.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. During a baby and toddler clinic, we observed staff giving support and advice to a mother regarding her child. They spent time chatting with the mother regarding various aspects such as growth, weight, bowel patterns and feeding. Home visits and a telephone consultation were offered for further support and recommendations to attend a group which looked at practical aspects of parenting.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families', wellbeing. Information within care records showed consideration of the social impact on a families' wellbeing when physical or mental conditions meant care and treatment impacted on day to day living.

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. Staff supported children, young people and their families to make informed decisions about their care. Staff involved children, young people and their families in identifying goals of treatment and developing care plans.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. During a clinic we observed, staff were thorough with ensuring parents understood what was being said and what was happening. They adapted their communication style to support the child being calm and to understand what they were doing. The child's views were sought, and information communicated to them was understood.

Community health services for children, young people and families

Good

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. The service collected feedback from various sources and methods, these included, complaints and concerns, compliments, Family and friends test (FFT), you said-we did and also by working with the local youth council. Feedback from these sources was overwhelmingly positive. Families we spoke to told us they feel their needs are met and staff have increased the families understanding of conditions to better support their children.

Are Community health services for children, young people and families responsive?

Good

Service delivery to meet the needs of local people

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

Managers planned and organised services, so they met the changing needs of the local population. Leaders of the service attended monthly quality, care effectiveness and safeguarding meetings. During these meetings managers shared service developments and local intelligence to support the planning and organisation of services.

During the covid pandemic, the immunisation team utilised vaccination clinics to provide drop ins within areas of lower uptake or higher need.

Facilities and premises were appropriate for the services being delivered.

The service had systems to care for children and young people in need of additional support and specialist intervention. The children's continuing care team provided specialist support to children with a range of complex care and treatment requirements. Individual care plans were completed with families and specialists supported these treatment needs. Training was also provided to families and carers where appropriate, this meant children did not have delays in receiving treatment when families and carers were competent to do so.

Managers ensured that children, young people and their families who did not attend appointments were contacted. Staff contacted families to rebook appointments and understand the challenges on why appointments were missed. Care records showed arrangements were made to assist families where attending appointments was difficult.

The service understood pressure on other departments. Teams worked collaboratively during assessments and treatments when possible. This meant the need to attend more appointments than necessary was avoided. However, the service recognised the need to re-organise elements of care and treatment they had been delivering. One example of this was due to primary care providers referring to the service for assessments that were previously undertaken within GP practices prior to the covid pandemic. This added additional pressure on workload to the service.

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.

Community health services for children, young people and families

Good

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. 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 utilised communication tools and developed alternative resources to ensure these were age appropriate and suitable for children and young people with communication difficulties.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed.

School nurses worked closely with partner agencies to deliver a service called 'clinic in a box'. This service provided children and young people aged 13 to 16 years old with early access to sexual health advice, health promotion, contraception and treatment via schools and other agreed local outlets, such as youth centres. This supported the reduction of unwanted pregnancies and reduced risky behaviours. This service was awarded the 'Nursing times National Nursing in the Community award in 2021.

Further interventions school nurses were involved in included the children missing education service. School nurses worked with the local authority to ensure children and young people with health needs were supported to access education. This meant children and young people were able to continue their learning and inappropriate court action would be prevented for school absences for those with outstanding medical needs.

Staff took account of children, young people and their families' cultural, religious and personal needs and preferences. The service had a lead for the Roma, Gypsy, Traveller and boater communities. This meant that they were able to provide care and treatment to these communities where cultural and living arrangements proved to be a barrier to access care and treatment. For example, the lead worked as the named health visitor for boater families to ensure continuity and provision of care, treatment, assessments and immunisations during the families' travel to new locations. This also included arranging for other specialist teams to be available for treatment when required.

The service had a pathway for unauthorised encampments. The aim was to deliver a health visiting service and improve access to childhood immunisations who did not have consistent access to health visiting. The Gyspy, Roma, Traveller and boater health visitor lead worked with the wider health visiting teams. The service worked collaboratively with the local council and provided an assessment of needs. When required, an enforcement against the camp would pause so appropriate health visiting services could ensure people's health needs were met. This included access to GP support for immunisations and referral to other services such as audiology and speech and language therapy as required.

Access and flow

People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were not always in line with organisational targets.

Due to the coronavirus pandemic the access to services had been impacted by changes including changes to face to face assessment access, home working, and redeployment of staff.

Access to services was available by referral forms specific to the specialist service required. These could be completed by families and by professionals. The service was in the process of remodelling access to services and were proposing to offer a single point of access like the service provided by HCRG in Wiltshire.

Community health services for children, young people and families

Good

The demand for services had risen considerably since the pandemic. Teams continued to provide face to face visits. Feedback from parents was overwhelmingly positive, recognising how staff had gone over and above to meet the needs of their children.

Managers monitored waiting times and discussed findings within management meetings. Staff told us they collaborated with other teams for joint assessments and treatment where possible. Health visitors told us they worked over their hours to visit families. However, service leaders recognised increased service demand was not sustainable and documented plans to address these issues with commissioners.

Service leads implemented strategies to assist with the referral and information gathering processes. For example, there were information forms for families to complete with additional measures in place which mitigated the need to request further information. Other examples included using digital assessment forms to further streamline processes and virtual appointments were offered across the different services where appropriate and agreed with children and families.

When children and young people had their appointments cancelled at the last minute, managers made sure they were rearranged as soon as possible.

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 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 children, young people and their families in the investigation of their complaint.

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Information about how to complain was available on the organisation's website and also within information given to families receiving care and treatment.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Incidents we reviewed showed clear lines of escalation, investigation and sharing of information. Actions were implemented when improvements could be made, and feedback was given in a timely and respectful way.

Managers shared feedback from complaints with staff and learning was used to improve the service. Concerns and complaints were discussed in monthly quality, care effectiveness and safeguarding (QCES) meetings and learning from these discussions was cascaded via service leaders to relevant staffing groups.

Are Community health services for children, young people and families well-led?

Good

Leadership

Community health services for children, young people and families

Good

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 organisation supported leaders to undertake relevant management and leadership training courses at degree level. The organisation had a succession planning document that outlined its objectives and a succession planning template for all critical posts within a team.

Managers understood the priorities and challenges the service faced. Leaders had identified key areas at risk of being overwhelmed by demand out-stripping capacity and were addressing this with commissioners to ensure service delivery could continue and be optimised.

Staff told us leaders were approachable and felt they could openly raise concerns with them.

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 was focussed on its objectives with a clear understanding of how they were going to achieve them. Consideration was given to the length of contract in place for the organisation left to deliver the services before contract renewals were considered. A recent presentation to commissioners highlighted service priorities with an action plan that addressed barriers that hindered the service being able to provide a sustainable service to the population it served. The impact of successful and non-successful implementation of a new strategy. this included having a positive effect on wait times that would decrease as a result of re-organising core service delivery.

Leaders discussed findings collated via an online performance reporting programme, they were able to celebrate successes and identify shortfalls where the service needed an action plan.

Culture

Staff felt respected 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.

Despite an increase in demand for services, the morale in most teams was good and staff felt supported and valued. Staff supported each other well and all teams highlighted this as a positive for their teams. However, health visitors teams told us morale was low due to the increased demands on services. As a result many told us they were working over their hours and felt close to burnout.

We saw staff were attentive to the needs of the children and families they provided care for and families provided overwhelmingly positive feedback across the range of services accessed by children.

Community health services for children, young people and families

Good

Staff told us they felt comfortable speaking with managers about concerns they had without fear of reprisal. However, health visitors told us they didn't always feel concerns they raised would be resolved.

Staff knew how to whistle blow and where to access the whistleblowing policy. Staff knew who the speak up guardian for the trust was and how to contact them.

The service had an up to date lone working policy that staff understood and adhered to.

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 organisation had pathways for services to follow which included urgency, mandatory supporting documentation, clinical acceptance criteria and relevant signposting. This ensured consistency of triage pathways.

Managers held regular quality, care effectiveness & safeguarding meetings (QCES) meetings to discuss topics such as risk management, incidents, audits safeguarding and information governance. Where actions were needed or an agenda item required a follow up, a designated person would be named to take responsibility for that agenda item.

There were clear lines of accountability within children and young people's services, and this included arrangements for safeguarding children and support for looked after children.

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.

Leaders had an audit schedule to routinely monitor and review their performance. Leaders reviewed a quality assurance performance dashboard about the number of referrals coming into the service. Leaders discussed and documented any areas of perceived risk. Staff were able to feed into a risk register. Leaders reviewed the risk register and created action plans to reduce the impact of any identified risks.

Leaders were aware of risks to some of the services they offered, such as the bladder and bowel service, community paediatric medical service, integrated therapies and speech and language therapy. Leaders had formulated a management plan to address these issues and ensure service delivery going forward is timely and meets the needs of the local communities.

A risk assessment was in place for the contracted delivery of the health visiting service due to capacity demands. This outlined increased demand issues due to external factors beyond the service's control. Health visitors told us about the workload pressures they faced. During our inspection leaders reviewed the risk assessment which included mitigations. These mitigations included adjustment to the core service delivery, developed by teams and team leads, movement of other health visitors to support with capacity and initiatives to onboard more staff into the health visiting teams.

Community health services for children, young people and families

Good

Information Management

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

The organisation used a digital performance reporting tool to display data collected from a wide range of sources. Data was accessible to be analysed in a clear and understandable format. Performance trends were easily highlighted so leaders could make decisions and improvements where needed.

Staff had access to a secure digital record keeping system. They could access all information they required, share information with partner agencies and other professionals and be alerted to new information when it became available.

Data and notifications were submitted to external organisations in line with organisational policy and Care Quality Commission requirements.

Engagement

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

Staff were encouraged to engage in the development of their service and implement quality improvement projects. The service held a central resource budget called the 'feel the difference grant'. This was for ideas from practitioners that would support system wide improvement initiatives across the service.

Commissioners had access to the digital performance reporting tool. This allowed commissioners to be sighted on performance issues in real time and promoted transparency as to challenges faced within the service.

Learning, continuous improvement and innovation

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

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

The 'clinic in a box' service was awarded the 'Nursing times National Nursing in the Community award in 2021.

Community health services for children, young people and families

Good

In Bath and North East Somerset, there were recognised gaps in educational outcomes for children and young people in receipt of pupil premiums and their peers. As a result, partner agencies and HCRG Care Services Ltd were launching an initiative to support areas of identified needs. Aimed at closing these gaps in areas of communication and language, one intervention includes a dedicated speech and language therapist will work in partnership with the early years advisory team.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service must ensure medicine systems are safe. The service must ensure they have assurances that patients have medicines as prescribed. Prescription charts must detail the reasons for not administering medicines. Equipment checks of the resuscitation trolley must be robust

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The service must ensure records provide sufficient information and detail to enable staff to support patients. Assessment tools must be completed according to guidance and include evidence of escalation where risks were identified. Patients preferences on how their needs are to be met must be sought. Care plans must be developed from assessments, provide guidance to staff on how to consistently meet the identified needs and reviewed to determine the progress

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service must ensure that staff attend mandatory training including basic life support, to ensure the safety of patients and their needs are met.