Gloucestershire Health & Care NHS Foundation Trust

Inspection report

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Ratings

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

Our findings

Our reports

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

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

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

Overall summary

What we found

Overall trust

We carried out this unannounced inspection of the mental health and community health services provided by this trust as part of our continual checks on the safety and quality of healthcare services. We announced some of the core services at short notice due to the nature of the services. As part of the inspection we also looked at whether the trust overall was well-led.

The 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust came together to form Gloucestershire Health & Care NHS Foundation Trust in October 2019. The Trust continues to provide the mental health services it ran before the two trusts came together. It also provides the community-based physical health services previously run by the acquired trust. The ratings of services previously acquired by another trust do not carry over to the new trust. Ratings for the community health services from previous inspections are shown on our website page for the former Gloucestershire Care Services NHS Trust (cqc.org.uk/provider/R1J).

Gloucestershire Health and Care NHS Foundation Trust provides community, physical health, mental health and social care to the population of Gloucestershire. They employ over 5000 colleagues working in the community and at just under 200 sites across over 100 different clinical services and support services. The Trust provide services to a population of approximately 637,070 people widely spread across a geographical area of some 1,024 square miles.

Gloucestershire Health and Care are a Foundation Trust, which means they are not directed by the government but are accountable to the local community through their members and governors who live and work in Gloucestershire and beyond.

The Trust is registered for the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning

Our findings

- Personal care
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury.

Services inspected:

We inspected the following two mental health core services and five community health core services:

Acute wards for adults of working age and psychiatric intensive care units (PICUs).

- This core service had not been inspected since 2016 and was previously rated as outstanding.
- Gloucestershire Health and Care NHS Foundation Trust provide specialist assessment and treatment for adults of working age on four acute admission wards and one PICU ward in Wotton Lawn hospital.

Wards for people with a learning disability or autism.

- This core service was last inspected in 2018 and was previously rated as requires improvement.
- Berkeley House is a service for people with learning disabilities and autistic people who may be informal or detained under the Mental Health Act 1983. Accommodation is arranged into seven individual flats. At the time of the inspection one person was under 18 and four were aged over 18.
- We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.
- The service was able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.
- Right support: The provider was developing a model of care that ensured people's stay was not prolonged to enable them to live successfully in the community with support and prevent admission to hospital.
- Right care: People's care was individualised, planned and delivered in a manner that met their needs. People's care promoted their dignity, privacy and human rights.
- Right culture: Staff were supporting people with their transition to live successfully in the community. They were respectful to the people they supported.

Community health services for adults.

- This core service had not been inspected since the two trusts came together. At the last inspection in 2018 with the previous trust this service was rated as good overall.
- The adult community services provided community-based care and treatment for people with various needs. The integrated community teams (ICTs) worked with specialist services to meet independent care and treatment needs for people within Gloucestershire.

Our findings

- ICTs included registered nurses and healthcare assistants to deliver district nursing across the county.
- Specialist teams included the diabetes team, tissue viability service, complex leg wound service, lymphoedema service, telecare, wheelchair services, physiotherapy, occupational therapy, reablement, rapid response team, podiatry, home first, bone health service, musculoskeletal physiotherapy and cardiac rehabilitation teams.

Community health services for children and young people.

- This core service had not been inspected since the two trusts came together. At the last inspection in 2015 with the previous trust this service was rated as good overall.
- Services provided include school nursing, health visiting, public health nursing, children's community nursing, a complex care team, a children in care team, occupational therapy, physiotherapy, speech and language therapy, and school aged immunisations.
- Teams provided care and treatment from community-based clinics, hospitals, children's centres, schools, and in children and young people's homes.

Community health inpatient services.

- This core service had not been inspected since the two trusts came together. At the last inspection in 2015 with the previous trust this service was rated as good overall. A focused inspection of the safe domain was carried out in 2018 and rated as requires improvement.
- The trust has seven community hospitals with inpatient wards, located at Cirencester Hospital, Dilke Memorial Hospital, Lydney and District Hospital, North Cotswolds Hospital, Stroud General Hospital, Tewkesbury Community Hospital and Vale Community Hospital.

Community end of life care.

- This core service had not been inspected since the two trusts came together. At the last inspection in 2015 with the previous trust this service was rated as good overall.
- End of life and palliative care is provided 24 hours a day and seven days a week across community services including community hospitals and community-based services.
- The children's community nursing team supports children and young people with end of life, palliative care and complex needs. Where required, they are able to draw upon support from the district nurses who also care for adult patients.
- The trust has developed specific expertise to support end of life care through their:

Integrated care teams, and specifically district nursing colleagues.

Community rapid response teams.

Specialist palliative care occupational therapy.

Expertise within community hospitals inpatient services.

Children's community services.

Our findings

- The trust works collaboratively with the palliative care team based at the local NHS acute trust and with local hospices.

Sexual health.

- This core service had not been inspected since the two trusts came together. At the last inspection in 2018 with the previous trust this service was rated as good overall.
- The trust provided a comprehensive sexual health service across the county. This included an integrated sexual health service, HIV treatment and psychosexual medicine. The trust also provided a pregnancy advisory service and Sexual Assault Referral Centre (SARC), but these services were not included as part of this inspection.
- Services were delivered from two main bases, Hope House and Milsom Street Centre. Staff delivered services at other locations within the community but many of these had been closed during the Covid-19 pandemic.

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

Services we did not inspect

We did not inspect the community dental service at this time. The service was rated as good during the previous inspection when services were provided by Gloucestershire Care Services NHS Trust. We do not currently have any concerns about this service and will continue to monitor in collaboration with our primary medical services team.

Overall rating

Our rating of the trust stayed the same. We rated them as good because:

We rated effective, caring, responsive and well led as good, safe as requires improvement.

We rated seven of the trust's services as good and none as requires improvement. **In rating the trust, we took into account the current ratings of the ten services not inspected this time**.

The trust had a high quality, compassionate leadership team with the skills, abilities, and commitment to lead the provision of safe, high-quality services. They recognised the training needs of managers and staff at all levels, including themselves, and worked to provide development opportunities for the future of the organisation. Senior leaders visited parts of the trust and fed back to the board to discuss challenges staff and the services faced.

The board and senior leadership team had a clear vision and set of values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles. Staff understood the vision and values, and how to apply them in their work. Staff were clear about their roles and accountabilities. The trust had a clear strategy document in place, and this was directly linked to the vision and values of the trust.

The trust board had a good oversight of the challenges facing the services and wider health economy. They were an influential partner in the developing Gloucestershire Integrated Care System and understood the importance of

Our findings

addressing health inequalities in the system. Services planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. We saw evidence of positive feedback from patients and carers across all the sites we visited. People could access the service when they needed it and did not have to wait too long for treatment.

The trust board and all working in the trusts' services had a clear patient centred focus. They made sure to include and communicate effectively with patients, staff, the public, and local organisations. The trust leaders had worked hard to improve the culture throughout the organisation, and to support staff, both through the pandemic and beyond, in the recovery phase. Staff felt respected, supported and valued and were focused on the needs of patients receiving care.

There had been some positive developments through the pandemic, including the trust response to managing the infection, prevention and control agenda, and supporting the wider system. The approach taken by the trust had been welcomed by partner organisations and highly praised. The trust was committed to improving services by learning from when things go well and when they go wrong, promoting training, research and innovation. We saw evidence of a commitment to quality improvement and innovation in the services we inspected. Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. Leaders promoted and supported continuous improvement and staff were accountable for delivering change.

The trust had a clear structure for overseeing performance, quality and risk. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. Services controlled infection risk well. Staff assessed risks to patients and acted on them. Services managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve services.

Services provided good care and treatment based on national guidance and evidence-based practice. Managers made sure staff were competent. Staff worked well together for the benefit of patients, protected their rights, advised them on how to lead healthier lives, supported them to make decisions about their care, and gave them access to good information.

Staff treated people with compassion and kindness, respected their privacy and dignity and understood people's individual needs. Services were inclusive, took account of patients' preferences and their individual needs. People had their communication needs met and information was shared in a way that could be understood.

The trust benefitted from having good quality leadership, and effective governance processes helped the services to keep people safe, protect their human rights and provide good care, support and treatment.

However:

While there was a clear strategy document in place, work still needed to be done to embed this in practice. Not all staff felt the trust was truly integrated following the merger. Much of the work to integrate the trust had taken place through the pandemic so face to face contact had been somewhat limited and there was still work to be done to engage some staff fully. This included issues with the IT systems. The trust was aware of these and was working on a simplicity project to address these issues. The information systems within teams were not all integrated, meaning relevant information could be held in separate systems and difficult to find. While outcomes data, quality improvement opportunities and evidence-based policies and procedures were reviewed within the clinical governance framework, we were not assured how this information was shared with staff.

The end of life community teams did not all monitor the effectiveness of their service by completing end of life audits.

Our findings

While there were systems and processes to safely prescribe, administer, record and store medicines in the acute and PICU (psychiatric intensive care unit) wards for adults of working age, staff did not follow national guidance for the physical monitoring of patients after the administration of rapid tranquilisation. The service also did not have processes to manage the risk and wellbeing of patients who may be prescribed antipsychotic medicines over the BNF maximum recommended dose.

The acute and PICU wards did not have personal emergency evacuation plans for patients who may need assistance to evacuate a building or reach a place of safety in the event of an emergency.

How we carried out the inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

Before the inspection visit, we reviewed information that we held about the services and asked a number of other organisations for information.

During the acute wards for adults of working age and psychiatric intensive care unit inspection, the inspection team:

- visited four acute wards and one psychiatric intensive care unit. We looked at the quality of the ward environment and observed how staff were caring for patients
- visited three clinic rooms and reviewed 16 medicine charts
- interviewed five managers and the matron for the service
- spoke with eight patients and nine carers or relative of patients
- spoke with 17 staff including a consultant, two doctors, three psychologists, a physical health nurse, nurses, health care assistants and therapists which included, physiotherapists and occupational therapists
- reviewed 15 care and treatment records
- observed a medical ward round, a multidisciplinary team meeting and a bed management meeting
- observed a patient's community meeting
- visited the therapy centre within the service.

Our findings

During the wards for people with a learning disability or autism inspection, the inspection team:

- visited Berkeley House
- spoke with the ward manager and two deputy managers
- checked the clinic room
- spoke with one person and three relatives
- spoke with three staff including nursing staff and support workers
- spoke with the clinical director and transformation lead
- spoke to an independent support worker
- reviewed four care records and four treatment records
- reviewed a number of meetings minutes and looked at a range of policies and procedures related to the running of the service.

During the community health services for adults inspection, the inspection team:

- spoke with 35 members of staff including, but not limited to: service managers, the operations manager for urgent care and speciality services, community nurse leads, community managers, physiotherapists, band 5, 6 and 7 registered nurses, nurse prescribers, occupational therapists, the patient flow staff team and triage nurses
- reviewed 13 care and treatment records
- reviewed incident reports
- observed two patient podiatry appointments, one bone clinic patient appointment and a wheelchair assessment team patient appointment
- reviewed team meeting and governance meeting minutes
- attended a senior leadership network meeting
- looked at a range of policies, procedures and other documents related to the running of the service.

During the community health services for children, young people and families inspection, the inspection team:

- spoke with 46 members of staff including: service directors, heads of service, occupational therapists, physiotherapists, speech and language therapists, children's community nurses, children's support workers, school nurses, health visitors, and children's nursery nurses
- spoke with 11 children, young people or families
- reviewed 23 care and treatment records
- attended and observed ten sessions facilitated by staff, including team meetings, handovers, health assessments, clinics and home visits
- toured the environment of three premises where care was provided
- looked at a range of policies, procedures and other documents related to the running of the service.

Our findings

During the community inpatients inspection, the inspection team:

- visited all four wards at four community hospital sites, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 18 patients who were using the service
- spoke with three carers or family members of patients using the service
- spoke with the managers for each ward
- interviewed 14 staff including consultants, staff nurses, healthcare assistants, occupational therapists, physiotherapists, pharmacists, hotel services staff and social workers
- reviewed 28 care records of patients
- attended two multidisciplinary team meetings and a ward handover
- carried out a specific check of medication management and administration records on all wards
- looked at policies, procedures and other documents relating to the running of the service.

During the community end of life inspection, the inspection team:

- visited Cirencester, Tewkesbury and George Moore hospitals
- visited integrated community nursing teams in Cheltenham and Tewkesbury, the rapid response teams, the out of hours' nurses team at Edward Jenner Unit and staff at the children's community nursing team in Cheltenham
- spoke with the end of life lead, the deputy director of nursing, other members of the senior management team, clinical leads, matrons, managers, hospital and district nursing staff, domestic staff, administrative staff and call handlers
- spoke with 10 patients, nine carers and 10 staff
- reviewed 16 care records and six prescription charts
- observed three home visits and two team meetings.

During the sexual health services inspection, the inspection team:

- visited Hope House and Milsom Street Centre and looked at the quality of the environment
- spoke with 12 staff including clinical leads, service managers, senior nurses, health advisors, nurses, health care assistants and receptionists.
- spoke with four patients who were using the service
- reviewed records relating to 13 patients' care and treatment
- observed how people were being cared for
- observed a multi-disciplinary team meeting reviewing patients' care
- looked at a range of policies, procedures and other documents relating to the running of the service.

Our findings

What people who use the service say

Acute wards for adults of working age and psychiatric intensive care units:

Most patients said staff treated them well, listened and treated them with respect. They said nurses looked after them and there were enough people to help if they needed anything. However, some patients said they found it difficult to interact with staff due to the high turnover.

Carers and family members said staff were “really helpful” and provided a level of care which was “thoughtful and considerate.” However, most said that communication with the hospital could be improved.

Wards for people with a learning disability or autism:

We are improving how we hear people’s experience and views on services when they have limited verbal communication. We have trained some CQC team members to use a symbol based communication tool. We checked that this was a suitable communication method and that people were happy to use it with us. We did this by reading their care and communication plans and speaking to staff or relatives and the person themselves. In this report, we used this communication tool with one person to tell us their experience.

We used one person’s preferred method of communication to seek feedback. When one person was shown the bedroom card they said “safe”. This person smiled when holding the staff card and gave a “yes” response when holding the call for help card. This indicated the person felt safe and received appropriate care and treatment from staff.

Three relatives praised the staff for the kind and compassionate care shown to their family members. They told us they were involved in the care planning process and felt confident to approach the staff with concerns.

Community health services for adults:

Feedback from patients from March 2022 from the friends and family test (FFT) returned as being 100% positive.

Comments from patients and carers included comments stating satisfaction with the kindness and re-assuring care provided by staff. Patients also stated they felt staff gave them time and did not rush their appointments. Feedback we viewed from a family member stated that their mother was very happy with the care they had received and if they were happy then he was happy.

There were thank you cards pinned up all around office spaces we visited. The common theme of thank you messages included appreciation for kindness and compassion from staff.

Community inpatients:

The patients we spoke with said that staff were friendly, respectful and provided them with individual treatment to meet their needs. Patients found the service easy to access and did not have to wait a long time to receive the support they needed.

Community end of life care:

Our findings

Patients and carers told us:

“Nurses have made the experience as good as it could be. They are so attentive, supportive, knowledgeable and caring.”

“Nurses are fantastic. I always get a response quickly with a positive outcome. I have complete confidence in the (district) nursing team. They just know what to do.”

“The nurses explain what they are doing at every stage and why it might be of benefit but ultimately they leave the decision up to me.”

“I can't fault them, they are very caring.”

“The nurses are amazing. You can see it in their faces that they just want the best for us.”

“They give us plenty of time to make decisions. They offer an amazing service.”

“They give excellent care to my (relative) and our family. Staff are so kind and respectful. We are always involved if there is a change to my (relative's) medication and decision making.”

“Nurses are very approachable - I know I can ask them anything.”

“The treatment has been absolutely outstanding. We are gobsmacked at how good the care is.” “They keep us informed and have given us leaflets about what to expect. The nurses talk frankly but do it kindly and at a level we can understand.”

“Nothing is too much for this (nursing) team. The staff are wonderful and clever.”

Sexual health services:

Overall patients were very positive about the service.

People said staff were friendly, respectful and provided them with individual treatment to meet their needs.

Patients had found the service easy to access and did not have to wait a long time to receive the support they needed.

We also reviewed recent results from the Friends and Family Test (FFT) used by many NHS services to gather service user feedback. Ninety five percent of all patients felt they had been treated with dignity and respect and had been involved in decisions about their care and treatment.

Outstanding practice

We found the following outstanding practice:

Community end of life services:

Our findings

Staff completed risk assessments for family members to administer subcutaneous medication for common end of life symptoms. This meant that carers did not have to wait for home visits by a nurse of doctor to respond to breakthrough symptoms, which was especially helpful for them during the evening or out of hours. The risk assessment contained appropriate safety considerations and described the prescribing suggestions for each common symptom.

Managers showed compassion to teams who had lost members of staff over the pandemic. Staff held services for the family members, raised funds for the family to go on holiday, made a plaque for the staff member, attended the funeral and in one case, put solar lights in the hospital garden which matched ones purchased for the family so the deceased staff member could be remembered at work and at home.

Sexual health services:

The service had introduced roles within the teams to provide enhanced support to patients with additional needs. This included the Vulnerable Adults Nursing team (VANS) and a Sexual Assault Referral Centre (SARC) Coordinator. The service was also in the process of implementing a new 'PrEP Engagement officer' to promote 'pre-exposure prophylaxis' (PrEP) medicine for people at higher risk of contracting HIV through unprotected sex or drug use.

The service had been forward thinking and had already established an effective telephone triage system prior to the COVID-19 pandemic. This had allowed the service to respond quickly to the pandemic and had minimised service disruption for people accessing support.

Areas for improvement

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with two legal requirements. This action related to one service.

Acute wards for adults of working age and psychiatric intensive care units

The service must ensure that patients are monitored in accordance with national guidelines following the use of rapid tranquilisation. (Regulation 12 (1) (2) (a)).

The service must ensure that there are personal emergency evacuation plans (PEEP) for all patients who may need assistance to evacuate a building or reach a place of safety in the event of an emergency. (Regulation 12 (1) (2) (a) (b) (c)).

Action the trust SHOULD take to improve:

Ward for people with a learning disability or autism:

Our findings

The service should consider how they protect people's dignity and privacy when all internal staff can access the clinic room during periods when CCTV observations of people were taking place.

The service should consider improving recording of medicines administered.

The service should consider how they provide care and treatment to young people and adults combined at the same location.

The service should consider how patients discharge can be improved.

Acute wards for adults of working age and psychiatric intensive care units

The service should ensure that dedicated female lounges are not used for other reasons in order to meet Department of Health guidelines.

The service should ensure there are processes for the checking of medicine fridges and clinical room temperatures and emergency equipment.

The service should monitor staffs working hours to ensure this does not exceed the working time regulations.

The service should ensure that controlled drug stock checks are consistently completed.

The service should ensure there are processes for the overview and management of antipsychotic medicines prescribed over the British National Formulary (BNF) limit guidelines.

The service should ensure that the involvement of both patients and their relative/carer in their care and treatment are clearly recorded.

The service should ensure they have a process to record feedback from the Independent Mental Health Advocate.

The service should ensure there is adequate oversight of actions and how they are monitored to improve services.

Community health services for adults:

The trust should ensure that IT systems are aligned and easily accessible for all staff.

The trust should ensure checklists of equipment bags are carried out by staff providing care and treatment within the community.

The trust should ensure they have effective information sharing arrangements in place.

Community health services for children and young people:

The trust should ensure that lead professionals for safeguarding are clearly recorded and easily accessible within care records.

Our findings

The trust should ensure there is access to suitable facilities and equipment for teams to provide face to face care and interventions.

The trust should review the health visiting duty role and the processes for staff to carry out this role safely.

The trust should ensure all staff develop comprehensive care plans with person centred goals, informed by robust assessments of the child, or young person's needs.

The trust should ensure that all health visitors and children's nursery nurses have access to regular clinical supervision.

The trust should ensure that all children's community nurses have a good understanding of Gillick competence and how to ensure this is appropriately recorded.

The trust should continue to monitor and implement actions to reduce waiting lists and ensure children and young people are seen at the right time for occupational therapy and speech and language therapy.

The trust should consider providing out of hours support for the children's community nursing, and children's complex care team, from managers known to the team, children, young people and families.

Community inpatients:

The trust should ensure that all care plans are individualised and recovery and goal oriented. Records should be easily available to all staff providing care as some information was available in electronic format whilst other information was kept in paper format at the bed side of patients.

The trust should ensure that they complete regular temperature checks for fridges and the clinic room.

The trust should ensure that all clinical equipment is regularly serviced and in date.

The trust should ensure staff utilise a recognised tool to assess and monitor patients regularly to see if they are in pain.

Community end of life care:

The trust should ensure that all community nursing teams providing end of life care ensure audits take place and share the results with teams.

The trust should consider making end of life training mandatory for those staff who deliver this care. The trust should review how they record ad hoc end of life training and competency checks that staff take part in.

The trust should ensure that all staff receive ergonomic workplace risk assessments.

The trust should ensure that staff record when they have checked the contents of a treatment bag.

The trust should ensure that all supervision and appraisal records are uploaded onto the trust's shared electronic database.

Our findings

The trust should ensure staff record and action all complaints.

The trust should ensure that policies and procedures for caring for children at the end of their life are included in trust policies.

The trust should ensure that IT systems are aligned and easily accessible for all staff.

Sexual health services:

The trust should ensure service plans to re-implement community hubs and embed new innovations within the service go ahead.

Is this organisation well-led?

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

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

Leadership

The trust board had the appropriate range of skills, knowledge and experience to perform its role.

Board members had a broad range of experience, skills and knowledge, with a diverse range of backgrounds both within the NHS and across the private sector. The trust provided board members with a comprehensive induction and held seminars within their board development programme to ensure all members were able to fulfil their roles effectively as part of an effective and experienced board.

The trust had a senior leadership team in place with the appropriate range of skills, knowledge and experience.

The trust had a strong and effective senior leadership team, who were providing high quality, compassionate leadership.

The trust had a lead for child and adolescent mental health, learning disability and autism, as well as a physical health lead.

The trust board and senior leadership team displayed integrity on an ongoing basis. We saw examples of appropriate and respectful challenges during board meetings and within committee meeting discussions. The team worked well together to achieve the best outcomes for staff and patients throughout the service.

Fit and Proper Person checks were in place. There were a small number of delayed disclosure and barring service (DBS) certificates within these checks. However, the trust had identified this as an issue, and had subscribed to the annual update renewal service to ensure these were all up to date on an ongoing basis.

Our findings

When senior leadership vacancies arose the recruitment team reviewed capacity and capability needs. The trust reviewed leadership capacity and capability on an ongoing basis.

The trust had commissioned a developmental well led review scheduled to begin in April 2022 to assess the leadership and governance of the trust, and to identify any actions in response to this. This included a review of capacity and capability needs.

The trust had a three year leadership development strategy in place, with full support of the board. Funding was in place for additional training and operational development posts to support this strategy. The strategy was kept under review in recognition that some people would inevitably move on to different opportunities and leave their posts, to ensure that succession planning was in place. The need to build future leaders was recognised within the strategy and was part of ongoing work in the trust.

The trust also completed an annual skills audit of all non executive directors (NEDs) to identify skills currently on the board, as well as highlighting any potential skills gaps that exist, or would be created when any NEDs left their post in future.

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

The board and senior leaders had a good understanding of their priorities and challenges, as well as what action was being taken to address these. This was evidenced within their board and sub committee meeting minutes, board reports, and during our conversations with them during the inspection.

Throughout the pandemic the trust held regular Covid-19 briefing calls for all senior and on call managers to ensure people were kept up to date.

The trust had also established a Senior Leadership Network that met on a regular basis to update members on trust and national developments to ensure they were sighted on the current priorities.

There was a programme of board visits to services and staff fed back that leaders were approachable.

Non executive director quality visits to services had necessarily paused during the pandemic, but had recently restarted. Leaders fed back to board following the visits. Our findings from the core service inspections showed largely positive feedback from staff.

In recognition of the challenges with meeting staff and visiting services during the pandemic, and to give staff the opportunity to speak with leaders, the trust senior leaders had increased their communication to staff. This included the Chief Executive of the trust starting “Paul’s open door”, a forum that enabled staff to openly contact him to raise any issues or comments.

Leadership development opportunities were available, including opportunities for staff below team manager level.

Our findings

The trust had accessed funding from NHS England, Health Education England and the South West Leadership Academy to enable them to deliver a number of cohorts of the Integrated Care System "Five Elements of Successful Leadership" development programme for staff. Staff also had access to the FLOURISH leadership programme, a positive action development programme provided within the One Gloucestershire Integrated Care System.

Succession planning was in place throughout the trust.

Succession planning was identified as a priority within the Trust's People Strategy.

Vision and strategy

The trust had a clear vision and set of values with quality and sustainability as the top priorities.

The trust mission of "enabling people to live the best life they can", was supported by their vision of "working together to provide outstanding care". This was underpinned by the trust values of

- working together
- always improving
- respectful and kind
- making a difference.

These values were integral to the trust strategy, and ran through all of the trust's work with patients and staff. Leaders spoke about living the values through their behaviours.

There was a robust and realistic strategy for achieving trust priorities and developing good quality, sustainable care across all sectors.

The 2021-2026 trust strategy "Better Care Together, With You, For You" identified four strategic aims for the trust

- providing high quality care
- promoting better health
- sustainability
- creating and maintaining a great place to work.

The overarching strategy was underpinned by six integrated strategies (including digital, quality, estates and people strategies) and an annual business plan that was regularly reviewed by the trust.

The strategy had been developed following the merging of the two trusts and during the pandemic but had not yet been fully put into practice effectively.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The vision, values and strategy were developed with the support of colleagues within the trust, patients and carers, governors and system partners. Before the pandemic, while developing the strategy, the trust brought people together to discuss what was important to them. This was to ensure that the values were developed from this input, and was meaningful for people who would be working to these values.

Our findings

Local providers and people who use services had been involved in developing the strategy. The strategy was developed with the additional input of service users, governors and system partners.

Staff knew and understood the trust's vision, values and strategy and how achievement of these applied to the work of their team. The trust embedded its vision, values and strategy in corporate information received by staff.

Our findings from the core service inspections showed that staff knew and understood the vision and values and how they applied to the work of their team.

The trust aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. This included active involvement in sustainability and transformation plans.

An Integrated care system (ICS) is a partnership bringing together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to ensure health and care services are collectively planned to meet the needs of the local population. The trust strategies were aligned with the wider "One Gloucestershire" Integrated Care System and referred to themselves as such throughout the strategy and associated documents.

Partnership and collaborative working across the ICS were key priorities to the trust. The trust was clearly an influential partner in the system, and understood the importance of addressing health inequalities throughout the system.

Senior leaders were actively involved in developments across the wider integrated care system to ensure they were working strategically to deliver high quality, sustainable care. However, it must be noted that the trust was in the early stages of aligning their strategy with the ICS and wider system priorities as the system was still in the development stage.

The trust replaced their Sustainable Development Management Plan with the new (NHS) Green Plan from 2021, in line with the 'Greener NHS' programme. This was a mandatory requirement for all NHS organisations. The aim of the plan is to develop system wide strategies and enable the NHS on its journey towards net-zero carbon emissions. In response, the trust has both an executive and non-executive lead for sustainability and appointed a head of sustainability.

The trust had planned services to take into account the needs of the local population.

The trust merger in 2019 took place with a clear objective of improving the health care provision to the local population by providing a comprehensive community and mental health offer.

The trust strategy recognised areas of deprivation within the local population and the potential impact of this on both physical and mental health. The trust plans included playing an active part in developing and delivering priorities within the local health and social care system, addressing health inequalities, and improving the health of the wider local population.

The leadership team regularly monitored and reviewed progress on delivering the strategy and local plans.

The trust board regularly reviewed and monitored progress against their strategy They were mindful of the challenges post merger in integrating as one trust through a global pandemic. Within the core services inspections it was clear that some staff did not feel the trust had fully integrated as yet and there was work still to be done to progress this.

Our findings

Culture

Staff felt respected, supported and valued across all sectors.

Our findings from the core services inspections confirmed that staff working in the trust generally felt respected, supported and valued. Staff health and wellbeing were a significant focus for the trust, particularly throughout the pandemic.

During the pandemic, the trust offered priority access for staff to the Improving Access to Psychological Therapies (IAPT) service, launched a Mental Health Wellbeing line for staff across the Integrated Care System, and gave everyone two additional days leave to thank them for their work.

The People Strategy set out to ensure a "healthy and happy high-quality workforce, performing well in all local and national performance standards". The strategy was overseen by the Resources Committee, and provided regular assurance to the board.

The most recent NHS staff survey results for 2021 identified no changes in staff engagement and a 0.1% reduction in morale from the previous survey, completed pre pandemic. Both responses were above the trust's benchmarking average. The staff response rate improved by 7% from the previous survey.

Around 60% of survey responses showed either no change or improvements.

Results indicated that over 78% of staff would recommend the trust as a place to provide care, while 68% would recommend the trust as a place to work.

Staff rated the trust above average in the areas of being compassionate and inclusive, staff being recognised and rewarded, staff having a voice that counts, being safe and healthy, always learning and staff engagement and morale. The trust was rated as below average in working flexibly and working as a team.

The trust was disappointed with the feedback in relation to working flexibly and as a team, having worked hard to provide a flexible environment through the pandemic. However, having reflected on the results, they were in the process of confirming recommendations for action to address this.

The trust's strategy, vision and values underpinned a culture which was patient centred.

Throughout the core service and well led inspections it was clear that the trust culture placed patients at the centre of everything they did.

Staff felt positive and proud about working for the trust and their team. This was evident through the core service inspections. Managers were particularly proud of the work and dedication of their teams throughout the pandemic.

The trust recognised staff success by staff awards and through feedback. A staff award ceremony had been planned for Autumn 2020, but had to be put on hold due to the pandemic. The trust held a virtual appreciation evening instead, with a view to recommencing the awards post pandemic.

The trust also held other award events, including the Apprenticeship Awards, and the Better Care Together Awards, which celebrated staff commitment, dedication, compassion and expertise through the trust's core values.

Our findings

The trust nominated colleagues for national and regional awards. Coln Ward in Cirencester was successful in winning the NHS Parliamentary Awards in the Care and Compassion category in the South West following one of these nominations.

The trust worked appropriately with trade unions and valued their input, particularly through the pandemic. However, there was some room for improvement in both the relationship and communication with staff side representatives. Representatives did not all have allocated time for the role, which made it difficult to balance this with their other commitments. There was some work to be done in terms of succession planning as staff side representatives left their positions. While it was felt that the trust was travelling in the right direction, there were some concerns around the amount of time it took to make progress.

Managers addressed poor staff performance where needed. Examples of this were apparent during the core service inspections.

The trust had appointed a Freedom To Speak Up Guardian and provided them with sufficient resources and support to help staff to speak up.

The Freedom to Speak Up Guardian presented their report to the public trust board on a six monthly basis. The Freedom to Speak Up work in the trust was not just focused on raising concerns, but was also focused on cultural changes within the trust.

The Freedom to Speak Up Guardian had the support of approximately 40 champions within the trust. All concerns raised through the champions went through to the Freedom to Speak Up Guardian to address. Champions did not have protected time for the role, and there were some challenges with releasing staff to fulfil the role in light of staffing and workload pressures.

The Freedom to Speak Up Guardian and champions had increased the awareness of their role and available support through having an increased on site presence in areas not only where concerns were raised but also through proactive cultural work. Once the champions network had been fully developed, the trust was planning to develop a Freedom to Speak Up strategy.

Staff felt able to raise concerns without fear of retribution. Work had taken place within the trust to address concerns raised, to ensure that staff felt comfortable to speak up. We saw evidence of how the trust had responded to concerns in one of the hospitals and had put an action plan in place to address these. The learning from this was disseminated to ensure this was embedded across the trust and address any potential cultural issues within the trust.

Staff had access to an Ambassador for Cultural Change (Freedom to Speak Up Guardian) and Champions who also provide support to people who may have experienced harassment or bullying. Staff also had access to Work in Confidence, a confidential and anonymous portal on the speaking up page of the internal internet pages to enable staff to obtain further advice and support.

Staff knew how to use the Freedom to Speak Up process and about the role of the Freedom to Speak Up Guardian.

All staff received an introduction to the Freedom to Speak Up role and process during their induction, and had access to e-learning. The Freedom to Speak Up Guardian and champions had also visited sites to ensure staff were aware of the processes and how to use them.

Our findings

The Freedom to Speak Up Guardian was also leading the "Civility Saves Lives" project, which had recently been launched, looking at the impact on patient safety. This was part of a wider piece of work on culture within the trust following learning from previous incidents.

The trust applied Duty of Candour appropriately.

The trust launched a "Saying sorry" campaign at the end of 2021 to promote a proactive approach to duty of candour. An email was sent to all staff advising that in the event of a clinical incident, an apology should always be made to those affected.

The trust took appropriate learning and action as a result of concerns raised.

The trust undertook investigations following serious incidents, including safeguarding concerns, and complaints. Investigations included recognition of positive practice, areas for improvement, actions to be taken as a result and how this learning would be shared across the trust.

While the trust had a backlog of complaints built up through the pandemic, they had been able to address all of these.

We were given examples during the inspections of how investigations have led to changes and improvement in care provision. The trust had also worked with people who had raised concerns and embedded them into the trust as experts by experience, to support improvements to services.

Pharmacy staff were encouraged to report medicines incidents and we saw evidence of discussion at the medication safety group and some examples of learning and change of practice from incidents. However, a review of rapid tranquilisation, which was suggested in October 2021, had not been acted upon. We raised concerns with the trust about rapid tranquilisation following the core service inspection.

Each inpatient service had a medicines link worker who could attend the medication safety group to raise concerns and passed back medicines safety information to the wards. Services were kept up to date with a medicines newsletter that also highlighted learning from medicines incidents.

All staff had the opportunity to discuss their learning and career development needs at appraisal. While we saw during the core service inspections that some staff were not up to date with their appraisals during the pandemic, the trust were addressing this. Compliance was improving and was around 76% completion rate.

Staff had access to support for their own physical and emotional health needs through occupational health. Alongside the occupational health service, during the pandemic, the trust introduced an additional 24/7 telephone counselling service for staff.

As part of their commitment to staff wellbeing, the trust established a Health and Wellbeing team, alongside monthly health and wellbeing newsletters, access to psychological support, and investment in staff rest areas to offer space away from the work environment. Staff wellbeing was a priority for the trust.

Sickness and absence figures were not outliers.

Our findings

Sickness had undoubtedly been an additional challenge to the trust as they experienced additional sickness absence directly related to Covid-19 throughout the pandemic. This clearly contributed to workforce pressures throughout the trust.

Staff turnover for the previous 12 months was approximately 12%, and the trust had 6% vacancies as of February this year.

While mandatory training (particularly face to face training) had been difficult through the pandemic, the trust was reporting 94% staff compliance in March this year, exceeding their 90% target.

Staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression.

We heard how the trust was committed to promoting equality and diversity at all levels. The People Strategy made a specific commitment to promoting equality, diversity and inclusion.

While the trust employed staff from a range of ethnic backgrounds, the overwhelming majority of the workforce (89%) declared their ethnic background to be white. The March 2022 equality report indicated that 84.5% of staff were women, and 15.5% were men. The trust employed people between the ages of 18 to 80 years.

Workforce Race Equality Standard.

In 2015 the Workforce Race Equality Standard (WRES) was introduced across the NHS in England. Following analysis of the experience of colleagues from a non-white ethnic background that indicated this group of staff had experienced discrimination whilst working in the NHS, this was introduced to enable organisations to analyse and close any gaps between the work experiences of non-white ethnic staff compared with white staff. The WRES constitutes part of the Standard NHS Contract and the results from each trust must be published annually on their website.

The report for the trust identified that only a small number of non-white staff were in senior posts. The data also showed that non-white staff were more likely to enter the formal disciplinary processes at some point in their employment. The trust had developed an action plan to address these key themes.

This action plan included the Positive Action Development Programme, “Flourish”, a leadership development programme aimed at staff from a minority ethnic background, with a disability or long term health condition, or from the LGBTQI+ community. Staff also had access to the “Ready Now” and “Stepping Up” training programmes through the NHS Leadership Academy.

Workforce Disability Equality Standard.

The Workforce Disability Equality Scheme (WDES) also forms part of the Standard NHS Contract. The WDES is a set of measures which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The results must be published annually on the trust’s website. Data collected by the trust indicated that 3% of staff had declared a disability or long term health condition. The trust had developed an action plan to support staff with a disability or long term health condition. Actions had included forming a disability/long term conditions staff network.

Staff networks were in place promoting the diversity of staff.

Our findings

The trust had established a diversity network with a range of sub group networks including ethnic minority, LGBTQI+, and disability networks. The trust had also established a dedicated women's leadership forum. The networks held a summer diversity conference last year.

The overarching diversity network met every two months and was chaired by a non-executive director who was also the who was also the non-executive lead for Equality Diversity and Inclusion within the trust.

Teams had positive relationships, worked well together and addressed any conflict appropriately. We saw examples of this within the core service inspections.

Governance

Financial governance.

NHS England/Improvement raised no concerns in relation to the financial governance of the trust.

The trust delivered a £3.6m financial surplus in line with the 2019/2020 plan. The 2020/21 financial regime was impacted by the Covid-19 pandemic. Organisations were expected to breakeven as a minimum, the trust reported a £47k surplus in 2020/21. The draft accounts for 2021/22 indicate a £0.5m surplus against a breakeven plan.

NHS England/ Improvement have allocated trusts and Integrated Care Systems to one of four 'segments'. A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). For 2021/22 the trust is in System Oversight Framework (SOF) segment 2. The Gloucester system is also in SOF segment 2.

Audit work did not identify any significant issues arising from the trust's Covid-19 arrangements. No incidences of serious fraud were flagged.

The trust finance team (revenue, capital, reporting, management) had good engagement with NHS England/ Improvement and open conversations were held to cover financial risks and potential mitigations.

The trust's Director of Finance and Deputy Director of Finance both attended the monthly Gloucester Resource Steering Group (RSG) where both the revenue and capital forecasts were discussed along with risks and mitigations. The trust provide a copy of their monthly finance report and are consistent with the discussions with the regional team.

The Gloucestershire Integrated Care System has been given funding to be shared between all the partners in the system. The trust has been negotiating to ensure it receives an appropriate level of funding to deliver services but also to support the system to achieve financial balance.

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

The trust had robust and effective governance structures in place. These were reviewed on a regular basis to ensure they continued to be effective. There continued to be some work to be done to ensure the effective delivery of the trust strategy, following the disruption of the trust through the pandemic. The trust acknowledged that some work was needed to improve ward to board assurance, but that systems were in place to enable these improvements.

Our findings

The non-executive directors chaired all governance committees. These included the Audit and Assurance, Quality, Resources, Charitable Funds, Great Place to Work and Forest of Dean (hospital) assurance committees. All committees self assessed their effectiveness annually.

An established medicines governance system was in place with a clear reporting structure. The head of medicines management submitted quarterly reports to the Quality Assurance Group and an annual medicines optimisation report to the Quality Committee. The Board was very supportive and delivered constructive challenge from the medicine and operations directors and the non-executive directors.

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

Non-executive and executive directors were clear about their areas of responsibility. All responsibilities were clearly outlined to non-executive and executive directors. Each non-executive director had assigned areas of focus and quality visits as part of their portfolio.

Appropriate governance arrangements were in place in relation to Mental Health Act administration and compliance. The trust had quarterly Mental Health Act legislation scrutiny committee meetings, where any issues were discussed and escalated to the board as needed. Lessons learnt was a standing item at these meetings. The trust had effective systems in place to scrutinise Mental Health Act paperwork, and to flag up any actions required to ensure the trust were compliant under the Act.

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

Service specific improvement plans were developed as needed when issues were identified.

Staff at all levels of the organisation understood their roles and responsibilities and what to escalate to a more senior person. This was evident during the core service inspections.

The trust was working with third party providers effectively to promote good patient care. We were given an example of effective work with third party providers to support people referred to the trust needing treatment for eating disorders. Due to a considerable increase in referrals and waiting list times increasing, the trust had worked with third party providers to ensure that people on the waiting list had support in the short term while waiting for allocation.

Management of risk, issues and performance

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

All incident activity and trends were monitored by the quality assurance group. The quality committee received assurances in relation to serious incidents from the quality assurance group. The most frequently reported incidents included those involving skin integrity, restrictive interventions, self harm and falls.

All incidents were reported through the national Patient Safety Reporting Mechanism. This was received by NHS England, Gloucestershire Clinical Commissioning Group and the Care Quality Commission.

Our findings

The trust had robust review and reporting systems in place, and were able to demonstrate their learning and improvements following incidents, complaints and safeguarding concerns.

A patient safety report summary of patient safety incidents, never events, serious incidents and other reportable incidents was presented to the board. The trust commissioned clinical incident investigations as needed.

The patient safety and business intelligence teams met on a fortnightly basis to validate the data from the datix incident reporting system, and to develop reports as part of the governance processes. There were plans to further refine these reports to provide additional narrative on incidents to enable opportunities for development and to embed learning. Any identified themes from the datix incident system fed into the improving care group

The learning from deaths report was presented to the board. Learning from completed mortality reviews was presented as learning on a page, with the information disseminated through the Pan Operational Governance Group. This information was also shared with the quality assurance group and quality committee.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

The trust performance dashboard included a post pandemic recovery overview. Monthly reporting and assurance through the operational governance and quality assurance groups also formed part of the post pandemic recovery plans.

The trust had identified a range of quality priorities as part of the quality dashboard performance reporting. The identified priorities for 2021/22 had largely been achieved, with the only outstanding actions being in progress towards achieving these.

The board were confident in their processes for managing and monitoring risks, issues and performance. We saw evidence in the committee minutes of appropriate challenge and escalating concerns as needed, as well as ongoing risk oversight.

Leaders were satisfied that clinical and internal audits were sufficient to provide assurance. Teams acted on results where needed.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register.

The trust had well established and defined systems for escalating risk, issues and performance through the organisation.

Many of the items on the corporate risk register closely aligned with those highlighted within the core service inspections of front line services. Workforce pressures and increased demand and complexity were key issues highlighted throughout the inspection.

Robust arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Recorded risks were aligned with what staff said were on their 'worry list'.

Our findings

The risk management group met quarterly to review all significant operational and all strategic risks to ensure the trust had a consistent approach to risk ratings, that these were being effectively managed in a timely way and escalated as appropriate. Any risks that were not agreed to have been appropriately rated were fed back to the local risk managers.

The trust board had sight of the most significant risks and mitigating actions were clear.

The trust had a strategic board assurance framework (BAF) in place which was reviewed regularly by the individual risk owners, the audit and assurance committee and the collective executive team. The BAF was aligned to the trust risk register and reported to the board. The board assurance framework adopts the NHS standard format. It is used to identify risks to the delivery of the trust's strategic objectives, and to capture the controls and assurance in relation to strategic risks.

Each item on the board assurance framework was linked to strategic aims. All items were scored, with a rationale and any mitigation clearly identified. All risks were allocated to an executive lead, and a lead committee to oversee.

The key risks on the board assurance framework related to resources not meeting demand, including staffing recruitment and retention, and recovery from the pandemic.

The trust was confident in ward to board assurance but felt that there was some room for improvement. The trust had a management action plan, including the need to align the board assurance framework with corporate risks. The trust were confident that the board had a good understanding of the key risks and how these were being managed.

There were comprehensive plans in place for emergencies and other unexpected or expected events. For example adverse weather, a flu outbreak or a disruption to business continuity.

The trust had demonstrated a dynamic and proactive response to the recent pandemic.

The trust had a comprehensive Operational Resilience and Capacity Plan and Pandemic Flu Action Plan in place as part of their assurance process for emergency preparedness. The trust also planned to update their adverse weather plan as part of their business plan for 2022/23 to incorporate the learning from recent storms.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. Where cost improvements were taking place, they did not compromise patient care.

The director of nursing, therapies and quality and the medical director had to approve any cost improvement plans at the planning and delivery stages, to ensure an appropriate clinical risk assessment informed any decision making.

Information management

The board received holistic information on service quality and sustainability. The board and senior staff expressed confidence in the quality of the data and welcomed challenge. Board members were generally confident in the data provided. Board and committee meetings scrutinised and challenged the data at an appropriate level.

The trust was aware of its performance through the use of KPIs and other metrics. This data fed into the board assurance framework.

Our findings

The Board and its subcommittees developed a set of key performance indicators (KPIs) which allowed for robust analysis of operational data and were regularly scrutinised.

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

This information was used to review priorities and to target support to different teams and localities as needed.

The trust had developed a new digital strategy to enhance monitoring and reporting across the organisation, and were in the process of developing integrated reporting measures.

Information was in an accessible format, timely, accurate and identified areas for improvement, however, there were some issues with the IT systems.

The trust worked with different IT systems for physical health and mental health services. While the trust were hoping for a single integrated IT system, this work was ongoing. The trust were working on an improvement project to look at getting better connections between the systems to ensure they were able to share information more effectively. The trust were carrying out a project to resolve data quality issues within the physical health clinical system and ensure that data collected was accurate and reliable.

Systems were in place to collect data from wards/service teams and this was not over burdensome for front line staff. However, we saw from some of the core service inspections that data collection was not always straightforward for teams who were working with different IT systems.

IT systems were not always used effectively to monitor and improve the quality of care. There were a number of issues with the systems. The separate mental health and physical health systems did not communicate well with each other. The trust were aware of this issue and the potential impact on the information available to them, and were working to address this.

Staff generally had access to the IT equipment and systems needed to do their work.

Some community staff had issues with accessing the IT systems when working in remote areas, with poor reception and files that did not communicate with each other.

The trust were working on simplifying the current IT systems. This was an ongoing piece of work in terms of ensuring that all IT systems were able to communicate with one another and share information.

It was evident through the core service inspections that a number of teams were having issues with accessing the right systems and data to support them in their roles.

Leaders submitted notifications to external bodies as required.

Information governance systems were in place including confidentiality of patient records.

The trust had appointed a Caldicott Guardian and Senior Information Risk Officer.

Our findings

The trust learned from data security breaches.

The Data Security and Protection Toolkit (DSP) is the set of NHS standards for information governance and cyber security. It draws together the legal requirements, central guidance set out by NHS policy and best practice, presenting them in a single standards process to improve the handling and protection of IT systems and information held by NHS providers. The trust's data security and protection toolkit score for the 2019/20 submission was graded as green. The submission date for the 2020/21 toolkit was extended in recognition of the ongoing impact of the pandemic.

The data security and protection toolkit internal audit had rated the trust as low risk. The audit had found one medium risk related to data incident response plan. The trust had taken action to resolve this and to ensure the data incident security plan in place was robust.

The trust's business plan for 2022/23 included the updating and monitoring of the data security and protection toolkit to ensure continued compliance.

The trust board submitted an annual data security standards declaration to NHS Digital.

The trust audit and assurance committee had received a presentation on cyber security and potential vulnerabilities. There had not been any reported vulnerabilities to date.

Engagement

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

The trust's commitment to engagement with patients and carers was evident throughout their strategy, vision and values.

The trust had established an engagement committee sub group of governors. The sub group were attending a range of events to enable them to speak with the public to increase the visibility of the trust, and listen to what people had to say. This had included attending a recent farmer's market in Stroud with local voluntary sector representatives.

The trust had also engaged extensively with the general public as part of the Forest of Dean hospital proposals to replace the estate at Lydney and Dilke Community Hospitals with a new Community Hospital in Cinderford.

All public board meetings began with a patient or carer feedback story to ensure service user voices were heard.

The ward/service team and division had access to feedback from patients, carers and staff and were using this to make improvements. We saw positive examples on inspection of how feedback, including complaints and serious incidents, had been acted upon to improve care.

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

Staff, patients and carers could access information on the trust website. Staff could also access additional information on the trust intranet.

Our findings

The trust held monthly team talk sessions as digital events, led by executives or deputies. These were open to all trust employees to attend, and gave them an opportunity to find out the latest trust news from the executive team. These also gave staff an opportunity to share their thoughts, feelings and concerns. Executives also published a regular blog to keep staff informed.

Patients, carers and staff had opportunities to give feedback on the service they received in a manner that reflected their individual needs. The trust encouraged people to complete the friends and family test to enable feedback about people's experiences. They used this information to identify what was working well and what could be improved.

The trust sought to actively engage with people and staff in a range of equality groups. The trust diversity network met every two months. The network was chaired by the lead non-executive director for equality, diversity and inclusion for the trust. The trust programme of service user engagement included a focus on building relationships with people from excluded or hard to reach communities.

The trust offered public Governors, training on appointment. They were actively involved in the operation of the trust.

The trust had invested in training for the Governors, who felt that they were increasingly familiar with and understanding of their role. Public and staff Governors felt that the board and senior leaders communicated with them effectively, and that there was a good honest working relationship in place. They consistently received feedback from the trust and were involved in and understood the decision making processes within the trust. The Governors were confident that the non-executive directors provided an appropriate level of challenge.

The trust had a structured and systematic approach to staff engagement.

The Chief Executive of the trust offered a regular open engagement opportunity for all staff.

The Joint Negotiation and Consultative Forum met at least bi-monthly, and enabled senior leaders to work in partnership with staff side colleagues. Staff side representatives also met regularly with managers to discuss, monitor and share information on a number of staff related issues.

The trust was in the process of establishing a Healthcare Support Worker Council, to ensure that healthcare support workers were enabled to have a voice within the trust.

Patients, staff and carers were able to meet with members of the trust's leadership team and Governors to give feedback.

The trust had been working closely with the community to encourage feedback, including carrying out webinars and attending community events.

The Chair of the trust attended annual meetings with local MPs, and chaired the quarterly meetings of the countywide League of Friends Chairs.

Middle managers, on behalf of front line staff, engaged with external stakeholders such as commissioners and Healthwatch.

Our findings

Healthwatch is an independent statutory body, who work with NHS leaders and other decision makers to ensure patient feedback is heard and to improve standards of care. Representatives from Healthwatch Gloucestershire had an open invitation to attend the trust board meetings.

The trust had recently established a board level stakeholder advisory group, the Working Together committee, to support and progress effective engagement.

The Chief Executive of the trust had also recently met with local voluntary sector representatives to facilitate a meeting between the community mental health team leads and the voluntary and community sector to explore effective ways of working together moving forwards.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans.

The trust was engaging well with the Integrated Care System.

The trust Chief Executive Officer played an active role within the Integrated Care System meetings, boards and strategic workshops, including chairing the Community Mental Health Transformation Board.

The trust Health and Wellbeing Hub gave a presentation at a care homes providers network meeting to proactively engage in outreach work within that area. To further develop networks, the trust had also attended meetings with a range of primary care network groups.

The Chief Executive of the trust was actively involved in mental health initiatives across the South West region and was also the lead Chief Executive Officer for tackling inequality for the Gloucestershire Integrated Care System. They were also a member of the South West Equality, Diversity and Inclusion Board, and the South West Inequalities Leadership Forum.

The head of medicines management engaged with other pharmacy leaders in the system and led various workstreams to improve the safety and quality of medicines optimisation in Gloucestershire.

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

Learning, continuous improvement and innovation

The trust had a planned approach to participating in improvement and innovation projects, national audits and accreditation schemes and shared learning.

The trust board demonstrated a strong commitment to learning and development across the organisation. The trust was fully committed to its quality improvement transformation and innovation programme, and identified learning and improvement as a key strategic objective. The trust were actively engaged in regional and national networks for shared learning. They had received a University of Gloucestershire academic accreditation for preceptorship for 2021/22.

During 2020/21, the trust took part in all six of the national clinical audits related to mental health and community health services provided by the trust.

The trust was actively participating in clinical research studies.

Our findings

During 2020/21, the trust registered and approved a total of 23 studies in a range of different areas. The pandemic directly impacted on a reduction in the number of studies for 2021/22.

There were organisational systems to support improvement and innovation work.

The trust was developing a research and innovation strategy focused on creating a research and innovation hub to provide training, education and support to staff wanting to be involved in any research or innovation.

Staff had access to training in improvement methodologies and used standard tools and methods. Staff could access bronze, silver and gold quality improvement training to develop the quality improvement capacity and capability within the trust. Experts by experience had also been given the opportunity to access this training with a view to developing them as quality improvement experts.

Effective systems were in place to identify and learn from unanticipated deaths. A learning from deaths report was presented to the quality assurance group as part of the mortality review processes. Following mortality reviews, the trust produced learning on a page documents to identify learning points, areas of good practice, and action to be taken. The document also identified how learning would be shared throughout the trust.

External organisations had recognised the trust's improvement work. Individual staff and teams received awards for improvements made and shared learning.

The trust were awarded a green rating from NHS England/ Improvement in recognition of their merger plan for the trust.

Staff used data to drive improvement.

While there were issues with the IT systems, the trust were still able to obtain information to support and drive improvements, and to demonstrate where resources should be best targeted.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Good	Good	Good	Good	Good
Community	Good	Good	Good	Good	Good	Good
Overall trust	Requires Improvement ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022	Good ➔➔ Aug 2022

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

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement ↓↓ Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Good ↓ Aug 2022	Good ↓ Aug 2022
Community-based mental health services for older people	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Wards for people with a learning disability or autism	Good ↑ Aug 2022	Good ↑ Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Good ↑ Aug 2022	Good ↑ Aug 2022
Community mental health services for people with a learning disability or autism	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Requires improvement Jan 2016	Good Jan 2016
Wards for older people with mental health problems	Requires improvement Jun 2022	Requires improvement Jun 2022	Good Jun 2022	Good Jun 2022	Requires improvement Jun 2022	Requires improvement Jun 2022
Mental health crisis services and health-based places of safety	Good Jan 2016	Good Jan 2016	Outstanding Jan 2016	Outstanding Jan 2016	Good Jan 2016	Outstanding Jan 2016
Long stay or rehabilitation mental health wards for working age adults	Requires improvement Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Forensic inpatient or secure wards	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Specialist community mental health services for children and young people	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018	Good Jun 2018
Community-based mental health services of adults of working age	Requires improvement Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016	Good Jan 2016
Overall	Requires Improvement	Good	Good	Good	Good	Good

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

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community urgent care service	Good Mar 2022	Good Mar 2022	Good Mar 2022	Good Mar 2022	Good Mar 2022	Good Mar 2022
Community health sexual health services	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022
Community health inpatient services	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022
Community end of life care	Good Aug 2022	Good Aug 2022	Outstanding Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022
Community health services for adults	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022
Community health services for children and young people	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022	Good Aug 2022
Overall	Good	Good	Good	Good	Good	Good

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

Community health services for children and young people

Good

Is the service safe?

Good

We rated it as good.

Mandatory training

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

Nursing staff received and kept up-to-date with their mandatory training. Managers monitored this and alerted staff when training needed updating. All teams were meeting the trust targets for mandatory training compliance.

The mandatory training was comprehensive and met the needs of children, young people and staff.

Training was provided through an online system, completion of service specific competencies, and face to face sessions. Managers monitored and supported staff with completion of competency workbooks during regular supervision and annual appraisals.

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 attended three group safeguarding supervision sessions per year. Managers had ensured future availability of these sessions following a decrease in availability during the pandemic. 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. Staff received training and access to tools to consider and respond to child sexual exploitation, and female genital mutilation.

Staff knew how to identify children and young people at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff attended safeguarding meetings and submitted relevant reports prior to these.

Staff highlighted safeguarding risks and children or young people subject to a child protection plan in their care records.

The health visiting team held a monthly risk meeting for specific localities' safeguarding risks which highlighted any children or young people who had not been seen for eight weeks.

However, in the health visiting team the lead professional for safeguarding was not identified within the care records. There was an alert on the care records for any children or young person under a child protection plan, but the identified practitioner was recorded on a separate system. This made it difficult to identify the lead professional, as staff needed to log in to a separate system to access this information. Other teams, such as school nurses, used a function within the care records systems that enabled this information to be held on a list and easily viewed. This supported practitioners in maintaining an awareness of the children and families on their waitlist and managing their workload.

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 clean and well-maintained.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

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.

During the COVID19 pandemic the resuscitation council guidelines changed in relation to rescue breaths (a type of first aid given to provide breath to a person who has stopped breathing). Managers had recognised the implication of this with delivering basic life support to children and young people and organised training on the use of bag valve masks. Staff ensured that bag valve masks were provided to staff and stored in each child and young person's home.

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.

Staff carried out safety checks of specialist equipment.

Staff told us that there had been ongoing issues in accessing necessary equipment to provide treatment. This was partly due to supplier issues but also due to a lack of space to store larger equipment. Staff had escalated these concerns and managers fed back on progress with resolutions during team meetings. However, this remain an ongoing concern for staff.

Staff completed home environment risk assessments during initial assessments, where care was provided in children and younger people's homes.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Community health services for children and young people

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.

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 in the children's community nursing and complex care team recorded baseline physical observations as necessary and developed risk management plans to ensure they identified and acted quickly on any new risks or physical deterioration. Where appropriate staff completed paediatric early warning scores and followed National Institute for Health and Care Excellence (NICE) traffic light systems to support identification of risk of serious illness in children.

The service had access to mental health liaison and specialist mental health support if staff were concerned about a child or young person's mental health. Staff routinely met with the children and adolescents' community mental health teams to discuss children and young people under both services, or 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

Managers used workload and capacity tools to ensure there was enough staff with the right qualifications, skills, training and experience to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.

The occupational therapy team had a contracted whole-time equivalent establishment of 19.64. There were 2.9 whole time equivalent vacancies in the team. The school aged immunisations team had a contracted whole-time equivalent establishment of 18.43. There were 6.13 vacancies in this team.

The speech and language therapy team and occupational therapy team head of service posts were vacant. All teams told us they had experienced a decrease in capacity and an increase in demand for services. The physiotherapy team establishment had been reduced and staff told us there were not enough team members to manage the caseload and current demand for the service. The head of service had escalated staff concerns about staffing levels, workload and waiting lists to managers.

Staff from the health visiting team told us that they were not always able to complete their work within their contracted hours and therefore worked overtime. Health visitors covered duty on specific days, but this was not protected time. There was no receptionist or admin support at Quedgeley health clinic. Health visitors told us it was difficult to carry out all the necessary tasks as the duty worker at this site such as, facilitating clinics, duty role of responding to calls, and answering the door to the building. Health visitors felt this put them at risk of an error on these days. Staff had discussed their concerns with managers but did not feel any action had been taken.

Community health services for children and young people

Managers used workload and capacity tools to plan and allocate staff levels and mix. Managers limited their use of bank and agency staff and requested staff familiar with the service. 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 up-to-date, and stored securely. However staff did not always use the electronic care records system efficiently and to its full capability.

Overall, children and young people's progress notes were comprehensive and all staff could access them easily. However, in the children's community nursing team, most electronic notes were written and stored within the ongoing progress notes. This made it difficult to quickly access historical reports and records, and staff needed to scroll back within the record, rather than accessing specific reports within separate related tabs.

Staff did not use the electronic records system consistently as some teams utilised functions such as alerts, waiting lists, and templates, whereas others recorded all information within progress notes or on separate spreadsheets. A quality improvement project was progressing to improve the quality and consistency of record keeping, and to use the electronic systems more efficiently. Staff were engaged in the project and provided examples of improvements that had already been embedded within teams. The project was expected to result in the service having better quality data about the service and service users, and enable use of the system as both a clinical and performance reporting tool.

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

Managers completed audits of the quality of care records and acted on results to make improvements where needed.

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

Medicines

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

The service had a medicines management policy and staff followed this. Staff completed, stored and managed all medicines and prescribing documents safely and accurately.

Medicines management arrangements were adapted where care was provided in children and young people's homes. Staff in the children's complex care team administered medicines in line with community pharmacy prescription labels. Band 4 support workers in the children's complex care team completed medicines management training competencies and followed a service specific standard operating procedure.

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.

Community health services for children and young people

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust 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 shared learning through team meetings, daily handovers and team emails.

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. This included the children's community nursing team meeting regularly with a local acute trust to monitor discharges. This was implemented following incidents related to poor discharge of children from hospital to community services.

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

Managers debriefed and supported staff after any serious incident.

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

Is the service effective?

Good

We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidenced-based practice. Managers checked to make sure staff followed guidance. However staff did not always develop personalised care plans that set out clear goals.

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

The school nurses and health visiting teams worked together to deliver the healthy child programme. Staff used a range of reviews, assessments and tools to monitor the health and wellbeing of children and families. Staff used age appropriate assessments and identified any concerns or support required early.

Staff completed height and weight measurements of children during most reviews. Staff told us they followed national guidance on delivering the healthy child programme and that measurements were completed if staff or families had

concerns about the child's growth. However, we found a discrepancy in one of the height and weight records that could have indicated a concern with the child's growth. Although this appeared to be a recording error, staff had not followed up on this to ensure the records were accurate. We also observed that there was no height measure available at one site where health reviews were taking place. Staff told us they could access this if necessary.

All teams used a wide range of evidence-based assessment tools, therapies and interventions.

We saw evidence of comprehensive and personalised care plans, and evidence based care and treatment within the care records of children, young people and families accessing health visitors, school nurses, physiotherapy, speech and language therapy, children in care teams and the children's complex care team. However some teams did not always develop personalised care plans that set out clear goals. Nurses in the children's community nursing team included care plans and actions within progress notes but these did not always set out clear goals. Managers had noted this issue during a care records audit and an improvement plan was in place for completion in June 2022. We also noted within occupational therapy care records that goals were not always linked with personalised assessment of the child or young person's needs.

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 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 was 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 had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. Managers monitored performance in relation to local and national targets. Following the pandemic, managers had developed coronavirus recovery action plans and monitored progress with this. The school age immunisations team, school nursing, and health visiting teams were on target to meet annual targets for immunisations, the national child measurement programme and new birth visits.

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.

Managers and staff used the results to improve children and young people's outcomes. Managers discussed outcome measures and audit results during monthly governance forums 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.

The breastfeeding lead for the service was accredited for UNICEF baby friendly initiative stage 3. The lead was part of the infant feeding network and had completed the baby friendly initiative toolkit with families.

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. Staff told us their inductions were comprehensive and that they were supported through shadowing of staff, mentorship, training and the completion of competency assessments.

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. However, health visitors and children's nursery nurses told us that it was difficult for them to access clinical supervision due to their workload. The trust provided supervision rates for all teams, which showed that rates were low for this team.

The supervision rates for other teams were also low. However, this was not in line with what most staff in these teams reported, and managers told us that they did not always utilise the trust online system to document supervision sessions. All managers reviewed staff caseloads during regular supervision sessions.

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

Most staff told us that managers ensured they received any specialist training for their role. Bespoke training and workshops were delivered during team meetings. Staff gave examples of specialised courses on topics including sensory needs, autism spectrum disorder, and incontinence. However, staff in the children's community nursing team told us that they did not always have an opportunity to access specialised training for new interventions and medications that they were providing. This included a recent introduction of administering endocrine injections. Staff told us they had utilised previous skills and information leaflets to ensure this was administered safely but felt they would have benefitted from some specialised training. Specialised training had previously been provided by a nurse from local acute trusts when the service started providing new interventions. Staff had raised their concerns with managers and received feedback that training would be provided prior to any future introduction of interventions.

Staff who attended national conferences of external training courses provided feedback and training to other team members.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism.

Managers identified poor staff performance promptly and supported staff to improve.

Community health services for children and young people

Multidisciplinary working

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.

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 regular 'team around the child' meetings, which ensured a multidisciplinary approach. The service had a 'well child' nurse whose role was to provide care coordination to children and young people with complex needs. The nurse engaged with children and young people, their families, schools, other health care teams and external agencies to coordinate care and improve communication between everyone involved in the care provided. Children, young people and families provided positive feedback on the support and improvements in the multidisciplinary approach they had experienced through the well child nurse's role.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. All teams engaged in regular meetings with community children and adolescent mental health (CAMHS) teams to support multidisciplinary working. The children in care team had effective joint working relationships with CAMHS and attended consultations for children and young people.

In collaboration with another trust, the service had set up a two-year pilot of a persistent physical symptoms team. The team consisted of a paediatric consultant, clinical psychologist, and occupational therapist. Children and young people were offered a fortnightly psychoeducational therapy programme across four sessions, delivered by different disciplines within the team. The multidisciplinary team met monthly to discuss referrals and invited the referring team to these meetings.

A senior nurse from the children in care team also attended care panels to ensure the team had an awareness of any children or young people who may come under their care.

School nurses and health visitors worked well together and with schools as a team to benefit children, young people and their families. Staff provided training sessions and medical awareness sessions to school staff on subjects such as asthma, anaphylaxis, and continence.

Staff attended national conferences and were part of relevant networks for specialised care, such as bowel and bladder UK, the south west children in care network and the infant feeding network.

We observed a speech and language therapy triage assessment which included multidisciplinary involvement from education, CAMHS, school nurses, health visitors and the looked after children team.

All services worked well with acute paediatricians and other secondary care specialist teams.

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.

Community health services for children and young people

Staff assessed each child and young person's health and provided support for any individual needs to live a healthier lifestyle.

The school nurses had received funding through the contain management outbreak fund (COMF) and had developed a 'school readiness' project aimed at children due to start school in 2022 and their families, who may have been impacted by the coronavirus pandemic. The project included delivery of workshops for parents and reception school teams which included advice on areas including continence, sleep and healthy eating.

Consent, Mental Capacity Act

Some 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.

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

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

Most staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. However, some staff within the children's community nursing team were unclear on their understanding and application of Gillick competence, which applies when working with individuals under 16 years. Although staff gained consent prior to carrying out any interventions or care, this was usually sought from parents or carers. We noted that documentation of the competency of a child to give their own consent was raised as an area requiring improvement in the annual care record audit for this team. An action plan had been developed and was due for completion in June 2022.

Staff recorded consent in the children and young people's records and involved children and young people in discussions around consent. However, it was not always clearly recorded whether the consent had been provided by the child, young person, or their parent. Staff did not routinely use the Gillick competence template within the electronic care records to evidence this. Not all staff in the children's community nursing teams were able to articulate their understanding of Gillick competence. However, we were confident that staff were able to apply the principles effectively.

Clinical staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards.

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

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Community health services for children and young people

Is the service caring?

Good

We rated it as 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.

Children, young people and their families said staff treated them well and with kindness. Families provided overwhelmingly positive feedback during inspection and through the friends and family feedback test. The positive feedback often related to families feeling listened to, supported, understood and the whole family receiving compassionate care.

All teams were engaged in a 'language that cares' project. Staff talked about the project and how they had implemented the ethos and principles of language that cares by having thoughtful conversations and debate to change the way professionals and other adults talked and thought about children and young people. We saw staff considering and using 'language that cares' in care records, during interactions, and when discussing how they might appropriately challenge other adults, such as foster carers, where this wasn't used. The service had considered children and young people's views on the benefits of the project, and had included oversight of project developments within routine quality checks to ensure it became embedded into routine practice.

The children in care team ensured all reports used 'language that cares' to ensure these had the voice of the child and were person centred.

Staff followed policy to keep care and treatment confidential. The school nurses also provided a confidential health texting service, which children and young people could contact anonymously through. We saw of evidence of staff supporting children and young people using this service, and building a professional relationship that lead to the child or young person attending a drop in or face to face appointment.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs.

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. A member of the health visiting team had attended an external infant sleep course and presented feedback to the team on ways to talk positively about safer sleep and the wording of these messages to ensure they were culturally inclusive.

Emotional support

Community health services for children and young people

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.

The school nurses and health visiting teams provided parent workshops and baby hubs where they could receive information on a range of relevant subjects.

A pilot respiratory physiotherapy team was in place and provided training to support families in managing the care of children and young people at home. Prior to this, families had reported a gap in service, having a lack of information and feeling unsupported with the child or young person's needs. Feedback from the pilot and the benefits of the service had been presented to the trust board. Families told of learning skills and receiving support that was 'invaluable', helped them to feel more confident, benefitted the whole family, and led to reduced hospital admissions.

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 family's wellbeing. Families and young people told us that they felt listened to and understood by staff. Families from the children's community nursing team and complex care team told us that staff regularly contacted to check in and monitor their wellbeing.

We observed clinics provided by occupational therapy, physiotherapy, and children's nursery nurses. Children, young people and their families were provided evidence-based information and advice, shown techniques and skills to meet their needs, and provided positive feedback following these sessions.

Managers had recognised the importance of face to face care and treatment in supporting the wellbeing of children, young people and families, such as new and first time parents. Most teams had only suspended face to face care for a few months during the coronavirus pandemic. Managers had sought out larger venues and developed new processes to support continued face to face contact in safe environments, where social distancing and infection prevention and control could still be implemented.

Families told us that where care and treatment had been provided over a long period of time, they were allocated a lead practitioner or nurse, and this ensured continuity and consistency of care. Staff knew children and young people well and understood their personal, cultural and religious needs. Families told us that children and young people experienced less distress and allowed staff to carry out specific interventions as they knew staff well and had developed trusting relationships with them.

We received positive feedback from school staff regarding school nurses going 'above and beyond' to provide emotional support and guidance to children and young people. This included providing extra sessions to children and young people during the pandemic, and ensuring they received holistic support and care, when other services were not providing face to face services and some organisations were closed. They told us that the routine drop-in sessions had provided an opportunity for children and young people to raise concerns and to feel listened to and receive advice, which they could not access from mental health services due to long waiting lists.

Understanding and involvement of patients and those close to them

Community health services for children and young people

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 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. Families told us that staff knew children and young people well and changed their methods of communication to ensure the child or young person's views were sought, and information communicated to them.

We observed clinics and care provided in a range of settings and teams. We observed staff to communicate with children, young people and families in a way that ensured they could understand the information, received emotional support, and were fully involved in the care or assessment. This was further evidenced by the response, and feedback from the children, young people and families, and the outcomes of the sessions.

The 'well-child' nurse supported children, young people and families during transitions, such as between schools and to adult services. Children, young people and families told us they felt involved in planning and decision making related to their transition between services.

Managers ensured relevant leaflets, information and clinic letters were provided to children, young people and families, and age appropriate.

The trust had worked with children and young people ambassadors from Gloucestershire council to implement the 'language that cares' improvement project and develop health passports within the children in care team.

Families, children and young people told us that staff advocated for them during multidisciplinary meetings and with other organisations, such as schools. The well-child nurse attended medical appointments and meetings with children, young people and families to support with communication, and explained any outcomes or information that they had not understood or had difficulty retaining.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. All teams received regular feedback through the family and friends test. Managers sought feedback from children, young people and families when developing and reviewing pilot projects and new interventions.

Staff supported children, young people and their families to make advanced decisions about their care.

Children, young people and families gave positive feedback about the service. Negative feedback from friend and family tests was very low for all teams. Negative feedback generally related to difficulties with the environment and appropriateness of video sessions during the coronavirus pandemic, rather than the care provided by the staff.

Is the service responsive?

Good

We rated it as good.

Community health services for children and young people

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. Heads of the service attended monthly operational delivery and development forums as part of an integrated directorate. During these meetings managers shared service developments and local intelligence to support the planning and organisation of services.

The teams worked well with commissioners and other health care providers to plan care and meet the needs of children and young people in the area. Where gaps in service provision across the county had been identified, the service worked well with other organisations to develop and pilot new services. This included a persistent physical symptoms team, community respiratory physiotherapy team, and a preschool social communication diagnostic pathway.

The school nursing teams had completed a community assessment through a windshield survey, which is a tool to complete an environmental observation of the community. The team used the results of this to plan the provision of services, including drop in clinics.

The public health nurses had been successful in obtaining a 'contain outbreak management fund'. The objectives of the proposal focused on providing integrated targeted intervention, in high index of multiple deprivation (IMD) areas, to reduce the impact of Covid-19 on families, and ensure equity of access to services.

School nurses provided community clinics for vision screening that home educated children and young people could access. The service was also linked in with the local home education social media accounts. Staff were able to send information about drop in clinics and other local services though this forum and via an inclusion officer.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services.

Managers monitored and took action to minimise missed appointments. The trust had a 'was not brought' policy for missed appointments, which staff adhered to. Managers ensured that children, young people and their families who did not attend appointments were contacted.

Facilities and premises were not always appropriate for the services being delivered. Occupational therapists and physiotherapists told us that there was not always a large enough space to provide therapies and complete observations. Staff from allied health professional roles also told us that they could not access some larger equipment as they did not have large enough facilities to store this. Managers were in the process of identifying further facilities, following the loss of access to a large space within a separate acute hospital. Staff were managing this by providing 'attend anywhere' appointments where children and young people used space within their home. However, staff told us this was not always appropriate for the level of observation or support that was required.

We noted some themes within negative feedback from family and friend's tests. People had stated that some environments were not child friendly and did not have toys for children, which made waiting and keeping their child's

attention difficult during longer appointments. There was also feedback that video appointments were not always useful, that connection often failed, people could not connect, or spent time waiting with no professional joining the call. Staff told us that some toys had been removed from clinics, and appointments changed to video in response to the coronavirus pandemic to reduce risk of infections.

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.

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.

The Children In Care (CIC) team coordinated care well with other services. Staff kept the child or young person at the centre of any decision making and organised care to ensure support was offered by the best placed team to support a particular need. The CIC team used health passports to chart the young person's journey whilst in the care of social services. The health passports had been developed by children and young people who were ambassadors for Gloucester council.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. The health visiting team had recently ensured they had access to tools and assessments in 13 different languages.

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

Staff took account of children, young people and their families' cultural, religious and personal needs and preferences. School nurses had increased uptake of influenza vaccinations by offering school based injections that did not contain pork gelatine, as an alternative to nasal vaccines.

Staff had access to communication aids to help children, young people and their families become partners in their care and treatment.

The service employed a 'well child' nurse who provided care coordination to children with complex needs. The nurse worked with schools, the teacher advisory service, and occupational therapists to ensure children had equal opportunities within schools. This included accessing equipment to support children and young people to attend their preferred schools or providing advice to schools on how to meet children and young people's needs and provide equal opportunities for events such as class residential trips.

Access and flow

Community health services for children and young people

Children and young people could not always access occupational and speech and language therapies when they needed them.

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

The trust had a ratings system to monitor recovery of services. School age immunisations, speech and language therapy and occupational therapy were rated red and referral to treatment and national targets had not been met for these services in 2021 to 2022. Speech and language therapy and occupational therapy referral to treatment rates within eight weeks were below 50%. Both services also had large waiting lists, which were 767 for occupational therapy and 685 for the speech and language therapy team. In April 2022 the average wait in days from referral to first clinical contact was 81 for occupational therapy and 52 for speech and language therapy. The average wait in days from referral to the second clinical contact was 119 days for occupational therapy and 145 days for speech and language therapy. Managers had highlighted an increase in demand and decrease in capacity for both services. Managers ensured there were action plans in place to manage and monitor waiting lists. There was a recovery action plan, supported by an information management improvement project, in place for allied health professional's teams.

Occupational therapy teams had reviewed their pathways and recording to ensure the electronic records system reflected the demand, referral routes and pathways to support the team in screening, monitoring and managing referrals and the waiting list. Managers had ensured a focus on screening all referrals to assess risk and allocate children and young people to the most appropriate waiting list, such as face to face or telephone appointments.

Managers were also reviewing the model and process for referrals to improve system flow. This project included updating the video and digital offer available online. The speech and language therapy team had implemented an early intervention digital tool kit available on the trust site for children, young people, and families to access.

The national child measurement programme and school aged immunisations programmes had been delayed due to school closures during the coronavirus pandemic, reduced face to face working, and the introduction of coronavirus vaccinations. However, managers had implemented a recovery action plan and these services were on track to meet national targets.

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

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

Managers from the children's community nursing team attended a monthly meeting with one local acute hospital to discuss recent discharges and any concerns, or issues with the process. This was started following incidents where discharge from the acute hospital and referral to the team had been poorly managed. Staff had seen an improvement in discharges since the implementation of the meetings.

The well child nurse supported children, young people, and families during transitions, such as between primary and secondary school, and children and adult services. The nurse supported transitions through developing discharge or transition care plans, communicating with all teams involved and ensuring children, young people and families' needs were identified early and met.

Learning from complaints and concerns

Community health services for children and young people

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.

There had been 22 complaints across the service in the previous six months. All complaints had been investigated and resolved. We did not identify any themes or ongoing issues within the complaints.

Children, young people and their families knew how to complain or raise concerns. 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.

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

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good

We rated it as good.

Leadership

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

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care and undertake their roles effectively

Most staff felt supported by their managers and able to raise any issues or concerns. However, some health visitors told us they did not always feel that managers responded to their concerns or acted on ideas to improve the service.

Managers had the opportunity to undertake leadership training. Staff and managers were aware of who board, and senior members of the trust were. Staff told us that board members and directors were visible and accessible. Staff received weekly bulletins from the trust which they felt contained useful information. Managers and team members provided support to their peers within remote teams and based at different sites.

Staff within the complex care team told us that a change in leadership had led to significant improvements. Staff felt more supported, able to raise concerns with managers, and understood their roles and expectations more clearly.

Community health services for children and young people

Staff from the children's community nursing team and complex care team felt that improvements could be made to the out of hours managers support. Staff told us that the out of hours manager was not known to the team. Staff felt they were unable to access the level of support needed from managers who did not have a good knowledge of the team's role and the individual children, young people and families involved. We were provided examples of where staff could not access guidance or reassurance from a manager that they knew for four days, due to bank holiday out of hours cover.

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 had a vision for what it wanted to achieve and workable plans to turn it into action, developed with involvement from staff, children, young people and families, and key groups representing the local community. The vision and strategy had been developed in consultation with staff, children, young people and families and other stakeholder groups.

Staff understood the vision and strategy for their teams and their role in achieving this.

Managers worked with other health services and organisations and planned services to meet the needs of the population.

Culture

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

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. There was an emphasis on improving child health outcomes embedded within the culture of the service.

Despite an increase in demand for services, the morale in 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. The trust provided a wellbeing hub but not all staff felt they were able to access this due to other priorities within their role.

The trust had processes and procedures in place to ensure staff met the duty of candour (the duty of services to be open and transparent with people receiving care from them). Training was included in the corporate induction and further training was available for senior staff. Incident forms prompted staff to ensure they had met the duty of candour with incidents.

Staff knew how to use the speak up process and where to access the Freedom to Speak Up policy. Staff knew who the Freedom to Speak Up Guardian for the trust was and how to contact them.

The trust had an up to date lone-working policy that staff understood and adhered to. Staff utilised a buddy system, and telephone contact to reduce lone-worker risks.

There was an emphasis on development and staff were encouraged to engage in training and personal development opportunities. Staff provided examples of their development within the trust and opportunities for further development. Managers encouraged staff to access further training and development opportunities.

Staff in the children's complex care team told us that there had been a recent positive change within the culture of the team. Staff felt more supported through regular supervision and group supervision with peers. Managers had increased the opportunities for development and band 4s were more empowered within the team. The new manager had completed a staff survey six months into the role to measure staff satisfaction. Staff felt if they raised concerns, there would be an opportunity to learn and felt managers would investigate these appropriately and fairly.

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 trust used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish.

The trust provided a governance framework through meetings at team and management level. There were systems in place to ensure monitoring of services and appropriate action taken to make improvements. Managers attended monthly meetings and forums where key performance indicators, performance dashboards, and quality improvement projects were discussed to ensure performance was monitored and action taken to improve this where necessary.

Team leaders attended monthly and quarterly governance and development meetings where they shared information on projects and learning and provided narratives on performance dashboard outcomes.

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. Staff did not always feel involved in decision-making to help avoid financial pressures compromising the quality of care.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The children, young people and families team had a risk register. Each service also held risk registers and issue logs which could be escalated through governance meetings as necessary.

Open and current risks matched the concerns and risk areas identified by staff.

Community health services for children and young people

Managers reported on current open risks, and provided updates on actions, during the monthly children and young people's directorate governance forum. New and emerging issues were also reported on through this forum. This included discussion of the impact of the risk and any support required to reduce or manage these.

The teams had contingency plans for when the service could be disrupted, such as through adverse weather.

Staff from the physiotherapy team did not feel they were involved in decisions to reduce the staffing numbers for the team. Staff felt the reduction, at a time where demand and caseloads had increased was an example of financial decision impacting on quality of care and increase staff stress. This concern had been escalated to management who had raised this with the trust. Managers were awaiting feedback on this.

Information Management

There was an improvement project in progress to ensure the service collected reliable data and analysed it. Although not complete, this had improved how 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.

Staff had access to enough computers to undertake their roles. Computer systems were secure, and staff had individual passwords to access the systems.

Managers and staff could access quality and risk information about the services for children, young people and families. The service reported on key performance indicators and national targets at divisional and board level. However, there was an information management quality improvement project in progress and not all teams had easy access to reliable data. The aim of the improvement project was to improve the reliability of data to enable managers to understand performance, and track patient pathways to support them in making decisions and improvements. Managers reported on progress with the project during monthly directorate governance meetings and this was part of the directorates risk register.

There were processes and systems in place to monitor reliability of data and access further data through other systems, while the project was still being implemented.

Engagement

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

Staff felt involved and engaged in the development of services. Team leaders and managers were actively encouraged to engage in the development of their service and implement quality improvement projects. Staff were involved in the development of pilot projects and teams, recruitment, writing job descriptions, and identifying gaps within service provision.

Managers sought feedback from children, young people and their families through surveys, and friends and family tests. Children, young people and families were involved in the reviews of pilot projects and teams, including the community respiratory physiotherapy, and persistent physical symptoms teams. The children in care team engaged and co-produced resources with the child ambassadors from Gloucester County Council.

Community health services for children and young people

The trust had a positive and collaborative relationship with external partners to build a shared understanding of challenges within the system and the needs of the local population. Managers worked with other health care teams and organisations to deliver services to meet those needs.

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 driven to continually learn and improve services.

Staff accessed specialist training and engaged with external networks to improve services.

The trust supported managers to identify gaps in service provision and develop innovative ways of working and teams to meet those needs. This included the implementation of specific roles, such as community nurse trainers and a 'well child' nurse, and pilot teams including the persistent physical symptoms team and community respiratory physiotherapy team.

The trust had successfully bid and accessed the 'contain outbreak management fund' to provide a school readiness service, with an aim to reduce the impact of the coronavirus pandemic on pre-school age children due to start school in 2022.

In collaboration with the local council and acute health service, the health visiting and school nursing teams had implemented a preschool social communication diagnostic pathway. The pathway had a multi-agency approach, which included clinics with speech and language therapists, clinical psychologists and paediatricians. The aim of the pathway was to provide early intervention and support to children and their families. Following attendance at the clinic, children and families on this pathway were provided a multiagency support plan.

Managers took action to improve services in response to audits, patient outcomes, complaints and incidents.

Community health sexual health services

Good

Is the service safe?

Good

We rated it as good.

Mandatory Training

The service provided mandatory training in key skills.

Staff kept up-to-date with their mandatory training.

The mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with mental health needs. All staff were required to complete The Oliver McGowan Mandatory Training in Learning Disability and Autism.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

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

All staff received adults and children safeguarding training specific to their role. This included staff working in non-clinical role such as team administrators. Nursing staff received regular safeguarding supervision.

Staff believed that safeguarding was everyone's responsibility. They could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

A designated team within the service provided tailored support to patients who were at higher risk of abuse, such as sex workers and those with a learning disability.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff worked closely with the trust's safeguarding team and the local authority to ensure safeguarding concerns were acted on. All staff knew who the safeguarding lead for the service was.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. An alert could be placed on individual patient records to ensure safeguarding was followed up in a timely manner. The service completed regular safeguarding audits to ensure policies and procedures were followed.

Cleanliness, infection control and hygiene

Community health sexual health services

The service had safe infection, prevention and control methods in place. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.

All areas of the service were clean and had suitable furnishings which were well-maintained. Staff completed infection control audits and regular spot checks on the cleanliness of the service.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Cleaning records were up-to-date.

Staff followed safe infection control principles including the use of personal protective equipment (PPE) and handwashing. In response to the COVID-19 pandemic, additional control measures such as social distancing had been implemented wherever possible. The service had also moved to an appointment only basis so that staff could manage the number of people in waiting rooms and ensure adequate time for cleaning treatment rooms in-between appointments.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. When providing care in the community staff took precautions and actions to protect themselves and patients.

Staff could call for assistance quickly if needed. There were wall mounted call bells in treatment rooms. Staff could also press a green button on their computer screen to call for help, this meant staff could access support quickly and discretely if they felt unsafe during an appointment.

Staff who were required to undertake lone working were supported to do this safely.

The service had equipment to help staff care for patients safely and effectively. Staff had access to laboratory facilities at Hope House and Milsom Street Centre to carry out some diagnostic work. If test results required analysis at external laboratories; clear processes to support the safe transportation of specimens to laboratories and retrieve patients test results were in place.

Staff managed and disposed of clinical waste safely.

Assessing and responding to patient risk

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

Staff identified key risks for individual patients on referral to the service. A well-established triage system was in place to ensure patients who required swift access to the service, for example for emergency contraception, were prioritised. Staff also received risk alerts for patients that accessed the online testing service and took action to mitigate potential risks.

Community health sexual health services

Staff completed risk assessments for each patient using a suite of tools they had developed in-line with clinical best practice. For example, for all patients under the age of 18, staff carried out a Child Sexual Exploitation (CSE) risk assessment to ensure any young people at risk of abuse were identified quickly. Staff reviewed risk for individual patients on a regular basis, including after any incident.

Staff were holistic in their assessment of risk for each patient. They routinely checked each patients' sexual history, current relationships and lifestyle factors such as alcohol and drug use.

Staff had training and resources available to ensure they could respond quickly to emergencies. Emergency drugs, resuscitation equipment and oxygen were available in areas where patients where seen. Staff had access to ligature cutters and had completed an environmental ligature risk assessment at Hope House. All staff knew to call for an ambulance if there was an emergency and had received basic life support training. Posters of best practice guidance published by the UK's Resuscitation Council were displayed in treatment rooms.

The service had access to specialist support if staff were concerned about a patient's mental health.

Staffing

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

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, and locum staff a full induction.

The service had enough nursing, support and medical staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of staff needed for each shift in accordance with national guidance.

The number of nurses and healthcare assistants matched the planned numbers.

Overall, the service had a relatively low vacancy, turnover rates and sickness rates. During the COVID-19 pandemic there had been some increase in short term sickness, but this had not caused serious disruption to the service.

At the time of our inspection there were two vacancies. Managers had support from central recruitment services to drive recruitment of new staff.

Due to the specialist nature of the service, agency staff were not used. Staff within the service worked additional shifts and there was an internal pool of bank staff to fill any gaps on shift.

Managers made sure bank and locum staff had a full induction to the service before they started work.

The service always had a consultant on call during evenings and weekends.

Community health sexual health services

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.

Records were stored securely. All patient care and treatment records were kept on a secure electronic database. Each member of staff had their own personal log in and followed processes to protect patient confidentiality.

Patient notes were comprehensive, and all staff could access them easily. Staff did note that there were occasional issues connecting to the electronic record keeping system. These incidents were escalated to managers when necessary and the trust's IT team were able to provide support. We found no examples where these issues had caused significant disruptions to patient care.

Managers completed audits on the quality of records kept and acted if areas for improvement were identified.

Medicines

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

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

Patient group directives (PGDs) were in place. PGDs provide a legal framework to allow some registered health professionals to administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor). This meant patients who may require routine treatment for chlamydia or required emergency contraception could access treatment quickly.

When needed, nurses could contact allocated doctors for advice and to authorise prescriptions outside the PGDs. PGDs were regularly reviewed and staff could access them easily.

Staff reviewed each patients' medicines. The service had a dedicated pharmacist who was supported by a technician. They provided specialist advice on the use of medicines throughout the service and completed regular checks to ensure medicines were safely managed and prescribed.

Patients were given advice about their medicines and options on how to collect their prescription.

Staff completed medicines records accurately and kept them up-to-date. Patient records highlighted if patients had any allergies. The date and the name of the prescriber was also recorded clearly.

Staff stored and managed all medicines and prescribing documents safely. The majority of prescriptions were issued through the trust's electronic prescribing system.

Safety alerts and incidents related to medicines were shared with staff and used to improve practice.

Incidents

Community health sexual health services

The service had a good track record on safety and there had been very few serious incidents within the 12 months prior to our inspection.

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

Managers investigated incidents and shared lessons learnt with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

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

Staff understood the duty of candour. Duty of candour is a professional responsibility of every health and care professional to be open and honest with patients when something goes wrong. We found clear processes in place to ensure staff were open and transparent and gave patients and families a full explanation if things went wrong.

Staff reported serious incidents clearly and in line with trust policy. Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Following their investigation, managers shared learning about incidents with their staff. Staff received regular feedback from investigation of incidents, both internal and external to the service at clinical supervision and regular team meetings.

There was evidence that changes had been made as a result of investigations where needed.

Is the service effective?

Good

We rated it as 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. The service adhered to the national standards outlined by The British Association for Sexual Health and HIV (BASHH) and other relevant bodies.

Teams worked together to deliver a comprehensive service for the local population. This included contraception and family planning options, genitourinary medicine and testing and treatment for sexually transmitted infections provided by the integrated sexual health team. A specialist team was in place for patients that required assessment and treatment

for HIV, including pre and post exposure prophylaxis medicines (these are medicines that intend to prevent HIV). A psychosexual therapist was available to offer specialist psychological interventions when needed. Although not included within this inspection the service also offered a pregnancy advice service and sexual assault referral centre (SARC).

Leaders ensured any changes to national guidance were implemented at service level. For example, during the COVID-19 pandemic the use of digital images to diagnose patients remotely had increased. The service had reviewed its policy on the use of digital images to diagnose patients to ensure staff were doing this effectively, safely and in line with the most up to date national guidance.

Patient outcomes

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

Managers and staff carried out a programme of clinical audits to check improvement over time. During the pandemic the service had reviewed and refreshed its audit schedule to ensure it delivered relevant, timely information on the quality of service being provided. This included participation in relevant national clinical audits for specific service areas. For example, the HIV treatment team participated in national clinical audits set by the British HIV association (BHIVA).

Outcomes for patients were positive, consistent and met expectations of the national standards. We reviewed the care and treatment records relating to 15 patients and found there were clear plans of care in place.

The service reported to national data sets and local commissioners about the health outcomes for patients. This included, the number of patients seen, statistics on diagnosis and where people were referred from. Managers also used public health 'score cards' to monitor and evaluate how well the service delivered outcomes for the local population.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff received specialist training to deliver specific treatments. This included training programmes delivered by the Sexually Transmitted Infections Foundation (STIF).

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, the completion of appraisals had been affected by the COVID-19 pandemic and long-term staff sickness. The appraisal rate for the service was 62 percent at the time of our visit. Managers were aware of this and had plans in place to improve.

Managers supported staff to develop through regular, constructive clinical supervision of their work. This included regular safeguarding supervisions for all nursing staff. Group supervision sessions were also available to staff to reflect on their practice at work. The psychosexual therapist received external supervision in line with national best practice.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Where possible team meetings were held virtually which meant that staff could access them from a satellite base or when working from home.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role, such as fitting and removing coils and implants and using Cryotherapy to remove abnormal tissue. The operational lead for the service had worked with all clinical teams to refresh the staff competency framework to ensure all staff had the skills and knowledges needed to carry out their roles effectively.

Managers identified poor staff performance promptly and supported staff to improve.

Prior to the COVID-19 pandemic, volunteers had been recruited to support patients in the service. The service had plans to reinstate these volunteer roles.

Multidisciplinary working

Doctors, 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.

Staff held regular and effective multidisciplinary team meetings to discuss patients and improve their care. These meetings happened within each specialist team and at a service level. For example, we observed one meeting between the clinicians based in the specialist HIV treatment service. During this meeting all members of the team reviewed and updated patients' care and treatment to ensure the service was meeting their needs.

Staff worked across health care disciplines and with other agencies to care for patients. The team had good working relationships with local social services, the police and other health care specialists based at nearby hospitals and in the community. This included paediatrics, gynaecology and local GP surgeries.

Although not included within this inspection, the service also provided a Pregnancy Advice Service and Sexual Assault Referral Centre (SARC). A 'SARC coordinator' was in place to work across the teams to manage the cross referral of patients to the SARC when needed.

Health promotion

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

Patients could access information promoting healthy lifestyles and support through the service.

Community health sexual health services

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. This included signposting to community support groups for addictions and substance misuse. The service had also worked with other health care professionals to provide targeted support for homeless people.

Consent and the Mental Capacity Act

Staff supported patients to make informed decisions about their care and treatment. They knew how to appropriately support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

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. When patients could not give consent, staff worked with other professionals to input into best interest decisions, that followed national legislation and best practice.

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

Staff understood and received training in the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act and Mental Capacity Act 2005. Staff knew who they knew who to contact for advice when needed.

Is the service caring?

Good

We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness. Patients said all staff were helpful and friendly. Over the last year 95 percent of all patients felt they had been treated with dignity and respect and had been involved in decisions about their care and treatment. This was based on feedback collected by staff through the family and friends test.

In the 12 months prior to our inspection, staff had recorded feedback from over 1700 patients using the service's electronic reporting system. We sampled 100 patients' feedback and found most patients were very positive about the service.

Patient privacy and dignity was promoted throughout the service. For example, Health Advisors protected patients' identities when contacting their partners to discuss if they may have been exposed to a sexual transmitted infection

(STI). There were clear guidelines on when to break confidentiality if needed, these were proportionate and protected patients' privacy. All treatment rooms were fitted with privacy curtains and a clear system was in place to ensure patients and staff were not disturbed during appointments. Staff played radios in waiting rooms to create a more welcoming space. Reception staff also took steps to ensure that they maintained patient confidentiality when answering telephone calls in open office areas.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may impact their care and treatment.

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 emotional support and advice when they needed it. At Hope House there was a separate waiting area that patients could use if they required further support or did not feel comfortable. This space was positioned close to reception staff who could reassure patients if needed. There was a separate waiting area at Hope House for patients accessing psychosexual therapy or Pregnancy Advice Service.

Staff demonstrated compassion when having difficult conversations with patients. Patients we spoke to felt the service was non-judgmental and staff treated them as an individual.

A chaperone service was available for patients to use.

Information for patients on how to access additional support in the community, including domestic violence helplines and substance misuse support groups, was clearly displayed in waiting areas. This information was also displayed in discrete areas such as patient bathrooms. At Hope House a code word system was in place; if a patient felt unsafe they could ask for 'Hope' at reception to alert staff they required assistance.

Understanding and involvement of patients and those close to them

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

Staff made sure patients and those close to them understood their care and treatment. Staff told us how they ensured patients understood their care and treatment and tailored the support they provided wherever possible.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

Community health sexual health services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff understood the various cultural, social and economic factors of the local population and how these might affect patients' attitudes towards sexual health.

Is the service responsive?

Good

We rated it as good.

Access and flow

Teams had worked together throughout the pandemic to ensure people had been able to access the right care in a timely way with minimal disruption.

Staff had adapted the service delivery model successfully during the COVID-19 pandemic to ensure they were still able to meet the needs of the local population. For example, the service had moved to a pre-booked appointment system. The service had already implemented a well-established telephone triage system prior to the pandemic. Staff commented this had made the transition to new ways of working during the pandemic much more effective and had minimised disruption for patients.

Patients could access some services virtually. The service had implemented a successful home testing service for people who may have contracted chlamydia, gonorrhoea, HIV or syphilis. Teams had also contributed to the redesign of the services' website to ensure that patients were signposted and able to self-refer to the most appropriate service based on their needs.

Managers monitored waiting times and made sure patients could access services when needed. Teams delivered services within national targets, this included those requiring access to emergency contraception or treatment. At Hope House and Milsom Street centre staff had access to laboratories to carry out some diagnostic work. In some cases, this allowed staff to diagnose and treat patients on the same day.

Staff noted overall there had been an increase in demand for the service and were able to describe how they had managed to increase capacity within the service wherever possible. This included extending the telephone triage opening hours and implementing process to support the diagnosis of patients using virtual technology.

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 communities. Teams worked collaboratively with other local organisations to deliver care.

Managers planned and organised services in a pro-active and forward-thinking way to ensure the service met the changing needs of the local population. Staff across the service were passionate about making sure the service could support as many people in the local area as possible.

For example, staff noticed an increase in the number of unplanned pregnancies in specific areas where women were not able to access routine contraception with ease. In response the service delivered a series of 'LARCATHONs', drop-in clinics that women could attend to access long-acting reversible contraception (LARC), in the community over a number of weekends.

The service was also recruiting a new 'PrEP Engagement officer'. Their role was to promote the use of 'pre-exposure prophylaxis' (PrEP) medicine in specific groups where people were at higher risk of contracting HIV through unprotected sex or drug use.

Staff had access to appropriate facilities and premises. At Hope House and Milsom Street Centre facilities had been adapted to ensure they could be accessed by people with additional mobility and sensory needs.

Prior to the pandemic the service had been delivered at a wide range of community hubs to target specific social groups at higher risk of sexual health issues. For example, staff had attended local student fairs. Although this had been scaled back in response to COVID the service had a clear plan to re-establish this in reach work and staff were excited about these plans.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, at Hope House staff had installed a dedicated phone line for reception staff to inform health advisors if a person under the age of 16 arrived looking for support. Staff said this had been implemented to ensure that younger people were seen by the service without delay.

Managers monitored and took action to minimise missed appointments. Staff ensured that patients who did not attend appointments were contacted where appropriate. If patients were known to be at risk of harm or potential abuse staff ensured they contacted them and escalated their concerns to local authorities when needed.

The service relieved pressure on other departments. Anecdotally staff felt that pressures within primary medical services, such as GP surgeries, had led to an increase in the number of patients accessing the service for routine interventions. Staff felt they had worked together to manage this increased demand.

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 the service.

Staff provided individualised support to patients living with additional needs. For example, staff had linked in with other professionals to provide holistic support for patients who were homeless and those who had learning disabilities.

We found examples where the service had gone above and beyond to coordinate care with other services and providers to ensure patients were able to access the care they needed. The Vulnerable Adult Nursing (VAN) team were proactive when working with external agencies to ensure that any patients with specific vulnerabilities had access to care and treatment to meet their wider needs and were safeguarded from abuse.

Staff met the information and communication needs of patients with a disability or sensory loss. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure interpreters or signers were available when needed. The VAN team had started work on refreshing all easy read information given to patients to ensure it was as accessible to patients with additional learning needs as possible.

Staff took the different cultural and religious backgrounds of patients into account and adapted their approach when needed.

Staff within the service worked together to manage patient's pathways who required input from multiple teams. For example, the service had created a coordinator post dedicated to supporting patients who were 'cross-referred' from other teams within the service to the Sexual Assault Referral Centre to (SARC) centre when needed.

Learning from complaints and concerns

Feedback and concerns from people using the service were valued by all staff and were viewed as a learning tool to improve the service.

It was easy for people to give feedback and raise concerns about care they received. Patients knew how to complain or raise concerns. Staff encouraged patients to share their feedback via the friends and family test. The service displayed information about how to raise a concern in patient areas and on their website. Patients could also contact the Patient and Carer Experience team.

All concerns and compliments raised were logged on the incident reporting system, this included informal feedback patient shared during appointment. In the 12 months prior to our inspection the service had logged verbal feedback from 1764 patients though the services' incident reporting system. Managers and leaders reviewed and reflected on this feedback with teams at meetings.

Staff could give examples of how they used patient feedback to improve daily practice.

The service treated complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

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

There had been one formal complaint that the service had investigated in corroboration with the patient. The response had been shared with staff and used as a reflective opportunity.

Is the service well-led?

Good

We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. Each team within the service was led by a specialist consultant and nurse team lead. A senior pharmacist worked across all teams, supported by a technician. A Business Manager was in place to oversee the operational delivery of the overall service.

Community health sexual health services

Leaders had a good understanding of the services they managed. They understood and managed the priorities and issues the service faced. They could explain clearly how their teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff.

Staff were supported to develop their skills and take on more senior roles. Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Staff knew and understood the purpose and future direction of the service.

Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.

The vision and strategy were focused on the sustainability of services and aligned to local plans within the wider health economy. The service worked closely with local GP practices, commissioners and social services to respond to changes in the local population's needs.

Staff had contributed to a business plan which set out clear goals for the service.

Culture

Staff felt respected, supported and valued and were focused on the needs of their patients.

Staff felt able to raise concerns without fear of retribution.

Managers and leaders within the service had embedded an open learning culture. Staff felt confident to raise concerns and share ideas. Staff knew how to use the role of the trust's Speak Up Guardian if needed.

There was a strong learning culture within the service. As a teaching service teams regularly hosted placements for trainee medical and nursing staff. Staff we spoke to said they enjoyed sharing their specialist skills with students and trainees and felt the open culture of the service supported this.

Teams within the service were well connected and worked cohesively to benefit the patient journey. We found many examples of cross team working to benefit individual patients. This included work between the integrated sexual health team and the sexual assault referral centre (SARC).

Staff appraisals included conversations about career development and how it could be supported. The service manager had developed a clear staff competency and staff were encouraged to take advantage of career development opportunities.

The service promoted equality and diversity in daily work.

Staff had access to support for their own physical and emotional health needs through an occupational health service. The psychosexual therapist also worked across the different teams to provide emotional support and aid staff debriefs when needed.

The provider conducted staff surveys to explore staff satisfaction at work and identify areas for improvement if needed. The last staff survey had been completed in 2021. Managers had reviewed results with their team.

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 completed audits on key areas to ensure patients received a safe service. This included safeguarding and infection prevention and control audits. If managers identified areas for improvement, they put plans in place to rectify them in a timely way.

The service sat within the Urgent Care and Speciality Services Directorate within the wider trust. Staff within the sexual health service were able to attend cross working groups and were involved in the wider trust.

There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. Staff could dial into team meetings virtually. Updates and key messages were circulated to staff who could not attend.

Staff had implemented recommendations from reviews of incidents, complaints and safeguarding alerts at the service level. For example, staff across all teams were able to describe what learning and action they had taken following an incident within the Sexual Assault Referral Centre (SARC).

Staff undertook or participated in clinical audits. The audits provided assurance about the key areas of quality and staff acted if areas of improvement were identified. During our inspection we found there was no audit process to monitor the communication of test results to patient's partners. Although we found no examples where patients had not been contacted to discuss their test results, the lack of audit created a potential risk that any deviation away from the policy would not be identified in a timely way. We discussed this with staff at the time of our inspection who agreed an audit would be a useful oversight mechanism.

Staff understood arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. We found many examples where teams had worked together across the service, wider trust and local health and social care system to provide better outcomes for patients.

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.

Staff maintained and had access to the risk register either at a team or directorate level and could escalate concerns when required from a team level. Staff concerns matched those on the risk register.

The service had contingency plans in place for emergencies including adverse weather or a flu outbreak. All teams highlighted they were proud at how well the service had responded during the COVID-19 pandemic. In particular, how they had continued to deliver a good service to their patients and provide support to one another.

Where cost improvements were taking place, they did not compromise patient care. For example the service was in the process of reviewing some medicine prescribing regimes in a way that avoided unnecessary costs but provided the same outcomes for patients.

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 was consistently submitted to external organisations as required.

The service used systems to collect data from teams that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone and virtual meeting system, worked well and helped to improve the quality of care.

Information governance systems included confidentiality of patient records.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. This included information collected through clinical audits, public health score cards and key performance indicator (KPI) dashboards. Managers also used other self-assessment tools to analysis service performance.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed.

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, patients and carers had access to up-to-date information about the work of the provider and the services they used, for example, through bulletins and newsletters. A virtual ‘open door’ email service was available if staff wanted to raise anything directly to the trust’s Chief Executive Officer.

Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. As well as access to feedback services on the service's website, patients could also leave feedback on the service using the friends and family test. A successful patient steering group was in place at the Sexual Assault Referral Centre (SARC). Although we did not inspect this team, leaders had plans to implement a similar concept for the wider service.

Managers and staff had access to the feedback from patients and staff and used it to make improvements. For example, staff had used feedback from patients to improve the waiting room experience. Staff had also involved patients in the redesign of the service's website to make it easy for patients to navigate and find information on how to access the support they needed.

Patients and their carers, if appropriate, were involved in decision-making about changes to the service.

Staff used their specialist knowledge of sexual health to support other areas of the trust. For example, staff from the service had worked with colleagues providing mental health services to develop policies on sexual safety on inpatient wards.

Learning and continuous improvement

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 were given the time and support to consider opportunities for improvements and innovation and this led to changes.

Staff used quality improvement methods and knew how to apply them. Staff had access to training on quality improvement techniques and were encouraged by managers to share their ideas.

For example, staff were starting a quality improvement project to allow patients to access information online by scanning QR codes instead of being given paper handouts.

The business manager for the service had formed good working relationships with other sexual health services provided across the South West. This had allowed the service to benchmark their performance and share good practice with others.

Staff had opportunities to participate in research. For example, one team were hoping to conduct future trials to explore the use of glucose during coil fits to reduce patient discomfort and pain.

Staff participated in national audits and improvement initiatives where possible. Members of the senior leadership team participated in working groups within the British Association for Sexual Health and HIV (BASHH) offering provider perspective in relation to changes in national guidance.

Community health services for adults

Good

Is the service safe?

Good

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

Mandatory Training

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

At the previous inspection, the trust was told they must ensure all staff are up to date with mandatory training, including all safeguarding modules. The compliance rate of completed mandatory training for clinical staff was consistently above 90% across the service. Managers across teams had access to a training matrix and could monitor compliance and identify when training was due.

Managers made good use of the trust's practice facilitators, a county wide group led by the education team, who worked with new staff and staff returning from extended leave to review their competencies and identify any gaps in their learning.

Safeguarding

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

Staff received training in safeguarding level 2 and band 6 level staff received safeguarding level 3 training. The service had a safeguarding team based at the trust headquarters and liaised with local authorities and relevant teams when safeguarding concerns were reported. However, staff did not have access to patients' safeguarding records who had open safeguarding concerns with the local authority because this information was held on a separate system. Staff relied on information coming in to them from the local authority regarding these patients during multidisciplinary team (MDT) meetings.

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

Community health services for adults

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff contacted patients and carers prior to visiting patients in their home to ascertain whether additional risks were present such as covid 19 symptoms. Staff followed protocols to safely dispose of clinical waste following visits to patients' homes.

Environment and equipment

Staff did not always record that they carried out daily safety checks of specialist equipment. We observed that staff checked the contents of the grab bags before they went out on their visits but did not record that they had done so.

We visited four locations and saw clinic rooms where specialist teams providing treatment had enough suitable equipment to help them to safely care for patients. The environment was clean and tidy. There were designated staff across the locations responsible for ensuring calibration and repairs were carried out periodically for equipment used.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff triaged patients upon receiving referrals, prioritising patients according to level of need. Risk assessments were completed upon initial appointments. Care records were individual and outlined specific risk issues for each patient. For example, staff recorded how to enter the patient's home when they were unable to answer the door and considerations when dealing with challenging behaviours.

Staff identified and quickly acted upon patients at risk of deterioration. Care records showed staff escalated concerns, took action and made appropriate referrals made to other specialist services and emergency services when required. Patients' pressure ulcers were documented and had plans to address ongoing treatment needs. They were escalated through a flowchart process and incident reporting system, which resulted in a plan for ongoing treatment and investigation into the cause if a failure in care had been identified.

Staff were taking part in a project called 'NEWS2' with therapy. This meant that therapists could use the escalation tool to get support when they identified the need for it. If staff needed to talk to the rapid response team, they used the 'situation, background, assessment, recommendation' (SBAR) tool to escalate issues in a consistent way.

Staff shared key information to keep patients safe when handing over their care to others. The service used a digital system which staff could access and update all information relating to patients, ensuring relevant 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 other team members, who could contact the service or emergency help, if necessary.

Staffing

The service had 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.

Qualified bank staff were used to fill gaps where vacancies existed to ensure patients' needs were being met. We saw weekly planners used by managers to ensure shifts were covered.

Staff told us they had attended local educational establishments to assist with recruitment for the trust to help reduce vacant posts.

In the integrated community teams (ICT), we saw staff qualified with the specialist practitioner qualification (SPQ). This qualification was designed for district nurses to develop professional growth and enhanced clinical skills.

Within the specialist community based teams, the trust supported staff to gain masters degree level qualifications for the specialism they were practicing in.

The managers could adjust staffing levels daily according to the needs of patients. Managers used a staffing budget tool and completed a trajectory across all staff bands in the services which showed all the vacancies across the teams.

Records

Staff kept detailed records of patients' care and treatment. Services used a secure electronic case management system and all staff had access to this. Staff carried password protected laptops with them and could access relevant documents from a patient's home. Staff completed electronic visit records following every home visit, these included aspects of care given, updating of risks and a colour coded acknowledgement of whether the visit had started or been completed.

Records were clear, up-to-date, stored securely and available to all staff and specialist services providing care.

We reviewed 13 care and treatment records. Staff recorded information in a clear and accurate way which included patient consent to treatment.

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. There were some nurse prescribers within the integrated community teams and across the specialist services who were able to prescribe, administer and give directions within their clinical competence.

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

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents. **Nominated managers within each locality investigated incidents and shared lessons learned within monthly governance meetings then cascaded to the whole team and the wider service.**

Community health services for adults

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

Incidents showed clear detail and reporting flowcharts which explained how the process of escalation and investigation of incidents will happen. Staff followed a pressure ulcer questionnaire (PUQ) to aid decision making about whether to undertake a root cause analysis (RCA) or a serious incidents requiring investigation (SIRI).

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff were aware of this duty and the need to be open and honest with patients where incidents occurred.

Staff met to discuss the feedback and look at improvements to patient care. Staff from different teams attended meetings to discuss incidents raised and any learning. A pressure ulcer overview document displayed an audit of pressure ulcers throughout the previous 12 months which showed themes, trends, reporting and outcomes as a result of the pressure ulcer questionnaire.

Is the service effective?

Good

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

Evidence-based care and treatment

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

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

The diabetes team had recently received accreditation from the Quality Institute for Self-Management Education and Training (QISMET). This accreditation recognised the trust as having met the 'gold standard' of best practice quality standards.

Care records showed the integrated care teams were using the national early warning score (NEWS). This recognised tool improved the detection and response to clinical deterioration. Other national recognised tools used included the Braden scale and Waterlow score which were used for pressure ulcer risk assessment.

Nutrition and hydration

Staff were aware of patients' specific nutrition and hydration needs. Care records included documented checks of any food and fluid charts that were being used within patients' homes. Staff updated and recommended changes as and when required.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. Patients received pain relief soon after requesting it.

Staff explained why patients would receive pain relief and when specific symptoms meant that administering pain relief became a priority. Staff administered and recorded pain relief accurately.

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 appropriate treatment by other specialist teams or no longer required aspects of district nursing care.

Managers and staff carried out audits to check improvement over time. The integrated community teams (ICTs) and specialist teams undertook regular audits on various aspects of the services provided. For example, ICT care records were regularly checked by managers, podiatry records were routinely audited to ensure accuracy and nail surgery regrowth audits were carried out.

Managers used information from the audits to improve care and treatment. We saw a pressure ulcer action plan from the tissue viability team based on findings from the trend analysis and skin integrity reports. Actions taken, showed implementation of additional resources where they were required and reviews to processes where needed for improved outcomes.

The trust used an online digital performance programme that showed various aspects of performance data within team caseloads. We observed downward trends in treatment waiting times and more efficient timescales of patients accessing different services. This evidenced improvements in efficiency and effectiveness across the ICTs. Staff told us this was relatively new and further data had yet to be analysed and interpreted.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. All staff undertook a corporate induction upon employment prior to local inductions to the workplace and job role.

Managers supported nursing staff to develop through regular, constructive supervision of their work. All staff told us they received regular supervision. This was evidenced on digital dashboards staff had access to. Some staff told us in specialist teams that clinical supervision had been irregular but was improving.

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

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, all staff within the complex leg wound service studied a leg wound masters degree course and time was allocated for this.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff told us they were supported to undertake training in specialist areas of interest. Staff in the ICTs were supported to progress through training and the special professional qualification (SPQ) for district nurses. Leaders told us they were proud of the 'grow your own' approach to developing staff. Across the ICTs and specialist services, staff were undertaking degree level qualifications that were specific to their roles.

Managers identified poor staff performance promptly and supported staff to improve. Staff described a situation they were working through to improve practice. Trust practice facilitators were utilised to help implement content relevant to staff training needs.

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 effective multidisciplinary meetings to discuss patients and improve their care. We saw examples where local authority adult social care teams were involved in meetings with integrated community team leaders to improve options for patients requiring certain care packages. Other examples included involvement of specialist teams to ensure district nurse teams were treating patients according to recommendations of the specialist team's advice and guidance.

Staff worked with the rapid response team to request support. The rapid response team were an admission avoidance service. They provided ward based treatment within people's own homes, practitioners were made up of paramedics, nurses, physiotherapists and occupational therapists.

The falls and rapid response team had effective links with the fire service. This ensured the correct support was available when attending to patients needing urgent alterations to their environment to meet their immediate needs.

Care pathways were reviewed by service leads across the ICT teams and speciality teams.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support. Leaflets were available for patients specific to their health concerns, such as smoking cessation and healthy eating.

Community health services for adults

Staff across the ICTs and speciality services worked with patients to maximise their independence in managing their own treatment. For example, the integrated community teams assisted patients in their own homes to administer insulin only when they were unable to do this themselves.

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 within the trust's corporate induction. It was not part of the mandatory training programme, but was considered part of the essential to role training, which included refresher training.

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 could describe and knew how to access policy and get accurate advice on the Mental Capacity Act.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes. Care records showed consent had been sought from patients and when there was fluctuating capacity. There were clear protocols, contacts and arrangements documented to ensure best interest decisions were being undertaken appropriately.

Is the service caring?

Good

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

Compassionate care

We observed staff treat patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff showed compassion and kindness when discussing patient needs and care with others, and in their documentation of patient visits.

Patient feedback was overwhelmingly positive. Thank you cards from patients and relatives were put up around offices for staff to view and included references to kindness, compassion and professionalism shown.

Emotional support

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

Community health services for adults

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

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.

They gave them emotional support and advice when they needed it. One patient said they were "very kind, not rushed, reassuring and very efficient too".

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 across the services routinely rang patients to book their appointment and asked whether they required family or carers present for support.

Staff made sure patients and those close to them understood their care and treatment and supported them to understand how to self administer medication where possible and appropriate.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff involved the community learning disability team to assist nurses and therapists when treating patients who had learning difficulties and learning disabilities.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Staff provided patients and their families with information on how to complete the Friends and Family Test (FFT) to feedback their experience of care and treatment provided. Patients gave positive feedback about the service.

Staff supported patients to make advanced and informed decisions about their care. Care records documented preferences of patients for when they lacked capacity to make a decision for themselves. Care records showed that recommended summary plan for emergency care and treatment (ReSPECT) forms were present in patient care records.

Is the service responsive?

Good

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

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 the themes and trends of care requirements of the local communities.

Community health services for adults

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

The service had systems to help care for patients in need of additional support or specialist intervention. The integrated community teams referred patients to specialist services when further intervention was required. For example, patients were referred to the tissue viability team for pressure ulcers that required specific methods of treatment.

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

The service relieved pressure on other departments. A response team had recently been set up to specifically provide assistance within two hours for people who had a fall within the community. This service was available for patients who had two or more falls within six months. This resulted in people being assisted sooner and relieved pressure on emergency services.

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.

Locality managers met regularly with staff from the local authority adult social care teams to discuss availability and requirement of care packages for people who needed them.

Patients were seen in their own homes and staff were flexible with appointment times to meet patient preferences where possible. The trust operated an evening district nursing service based at Edward Jenner Court and visited patients between 19:00-08:00am who required urgent appointments and delivery of care needs during this time.

The service had information leaflets available for patients and the local community. Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff across the integrated community teams and speciality services had completed the Oliver Mcgowan training which assisted staff to better understand and work with people who have learning disabilities and/or Autism.

The two hour response team had close links with the fire service. This assisted the process of making an environment safe for people who required assistance following a fall.

Access and flow

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

The integrated patient flow team acted as a point of access for teams, supporting them with referral and transfer to other services. They held daily situation report (SITREP) meetings to review demand and capacity issues in the various services within the trust. Information from the SITREP was passed to partners such as, acute wards and local authority adult social care who were impacted by pathways of care within the trust.

Community health services for adults

Staff told us that wait times had increased for speciality services as a result of the challenges faced from the Covid-19 pandemic. However, waiting times were reducing and target times for treatment were being met across most of the specialist teams. An online statistical tool used by the trust also showed the trend of waiting times reducing month on month.

A podiatry appointment we attended was a self referral, the application date to appointment visit date was less than 10 days. The patient stated their satisfaction with how easy the service was to access.

Integrated community teams did not have waiting times and were able to show effective response times to triage and visiting patients.

Managers and staff started planning each patient's discharge as part of the initial assessment process. Managers told us that although patients had discharge dates documented, they were flexible if further care and treatment was required. Patients were not kept on staff caseloads longer than required.

Staff supported patients when they were referred or transferred between services. Care records showed referrals to specialist teams and collaborative working between teams.

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 and 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. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Each team had their own scheduled timetable for meetings which included an agenda, incidents and complaints for managers and staff to discuss feedback and any learning.

Staff could give examples of how they used patient feedback to improve daily practice. Learning from one complaint led to the service proposing a peer to peer assessment and triage course for all nurses across all localities. This aimed to prevent a further occurrence of an issue raised during the complaint.

Is the service well-led?

Good

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

Leadership

Community health services for adults

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. Staff described accessible, visible and approachable leaders. Managers told us they were able to access training to complement their roles. Staff told us managers supported them to develop their skills and take on more senior roles.

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.

Posters showing the trust strategy were displayed within all locations we visited and staff were able to explain to us what each of the trust strategic aims meant.

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.

Staff told us they could be open and honest with their managers. Reasonable adjustments were made for staff. For example, there were office workstations that had been adapted to enable staff to undertake their roles. Other staff explained situations where managers had been supportive and considerate of personal circumstances and challenges they were facing. Some adjustments in working arrangements were made to support staff when this was the case.

Staff told us they felt proud of their roles and were encouraged to undertake further training to enhance skillset and career progression.

Staff had access to a Freedom to Speak Up Guardian, a 24 hour staff help line and other wellbeing information such as 'it's ok to talk'.

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.

Community health services for adults

The integrated community teams and specialist services had individual arrangements for governance processes within their service. However, arrangements for each service did involve senior staff and managers taking part in meetings with agenda items covering governance and quality. For example, there were band six governance monthly meetings within the integrated community teams. Governance meetings for podiatry were chaired by the head of profession bi-monthly and included agenda items such as complaints, concerns, reported incidents, policy updates and risk assessments.

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.

The digital data display tool used by the trust helped managers to identify areas that highlighted positive and negative trends. Managers were able to view statistics across community services and could identify themes and trends which impacted on patients.

Managers joined an online 'issues' chat where they logged concerns that did not constitute an incident. Managers shared an example of how useful this chat was during recent storms when teams could check in with each other across the region to make sure they were ok.

Managers told us there were specific situations that required additional resources to cope with unexpected events. For example, managers of integrated community teams told us they would adjust staffing levels where the local communities were more vulnerable during winter months of the year.

Managers and staff regularly met with other services such as South Western Ambulance Service Trust (SWAST), local authority adult social care and the acute services to identify issues within the trust regarding capacity and flow of patients.

The trust had a risk register which outlined specific risks relevant to each service

Information Management

The service collected data and analysed it. Staff could find the data they needed, to understand performance, make decisions and improvements. The information systems were secure but not all integrated. Data or notifications were consistently submitted to external organisations as required.

Managers ensured staff had access to NHS work mobile phones so contact details and personal information was not taken home with them. Staff had access to portable IT devices with personal login details so they could update patient information whilst visiting patients in the community.

All staff within the integrated community teams and specialist teams had access to systems that made sharing patient information possible. However, we saw that there was more than one system that did not automatically synchronise with others. This meant relevant information could be held in separate systems and difficult to find. Staff told us the trust were aware of this and IT system integration across the trust was expected to happen in the future.

Staff told us that wifi access in rural areas hindered their ability to update and upload patient records during these community visits.

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.

The services held team meetings regularly and staff confirmed that there was good engagement. We reviewed team meeting minutes for an integrated community team, which demonstrated that line managers updated staff with information such as but not limited to, deployed staff returning to original roles, available training sessions, incident reports and a round robin check in with staff to monitor wellbeing.

Managers cascaded information from managers meeting to team meetings. Band 6 governance meeting minutes showed correlation between what was discussed in those separate meetings.

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.

Staff told us about quality improvement (QI) projects and workstreams they were involved in. For example, staff explained about working with acute trusts and pharmacists developing work around catheter care and communication. Other recent and current QI projects being undertaken by either integrated community team or speciality teams include but not limited to, deteriorating patient QI project and the pressure ulcer questionnaire.

Wards for people with a learning disability or autism

Good

Is the service safe?

Good

Our rating of this service improved. We rated it as good because:

Safe and clean care environments

People were accommodated in single ensuite flats with access to their own communal and outdoor space.

Flats were clean, individually furnished and fit for purpose, although some areas were in need of repair and redecoration. At the time of the inspection two flats were being refurbished. The estates manager told us the measures in place to maintain and protect the surroundings, such as the use of specialist paint.

People were protected from the spread of infection. Staff followed infection control procedures and we saw appropriate use of personal protective equipment (PPE). There were adequate supplies of hand sanitising gels.

The number of staff assigned to work in a flat depended on the individual's needs. CCTV cameras were used to observe individual people when staff had to withdraw from situations where there was a potential risk of harm to the person or others. CCTV was used where it was deemed appropriate for staff not to be close by the person while continuing with one to one observations. People's capacity to make specific decisions about the use of monitors was assessed and best interest decisions reached where they lacked capacity to consent to this.

Although the CCTV policy stated that to protect people's privacy and dignity external visitors were not permitted to enter areas when observations were taking place, there was no reference to internal staff having access during observations. This meant other staff with access to the clinic area could view the CCTV monitor.

Individual risks to the person were assessed and action plans were developed and reviewed to reduce or remove any environmental risks identified.

People were protected from potential ligature risks or anchor points in the service. An anti-ligature product reduces the risk of self-harm through strangulation, by making it as difficult as possible to secure a cord or other material in place. Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The ward manager told us that ligature audits and risk assessments were completed before commissioning a flat and when staff were observing people through CCTV.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff checked, maintained, and cleaned equipment.

Staff had easy access to alarms in the event staff assistance was needed

Safe staffing

Wards for people with a learning disability or autism

People's care and treatment was delivered by sufficient numbers of staff on duty. Staff understood the person's needs and received training to keep them safe from avoidable harm.

When we sought feedback from one person about staffing, the smiley card was used to indicate their awareness and approval of the staff. Relatives said there were sufficient numbers of staff assigned to work with their family member. They said the staffing numbers increased depending on the anxiety levels of their family member or organised activity. They also told us there was a high turnover of staff.

Staffing levels had increased, and managers confirmed there were staff vacancies. They told us that every effort was made to cover vacant hours including deploying staff to support individuals where there was a need for higher staffing levels. Bank and permanent staff were used to maintain staffing levels. Minimum numbers of agency staff were used.

Berkeley House had 21% staff vacancy and 8.8% sickness. Staff described measures to reduce turnover and sickness rates. They told us sickness rates were due to COVID symptoms and exposure. Back to work interviews were held with staff returning from absences. Staff emphasised that sickness rates were not due to poor morale as managers were always approachable.

Escorted leave or activities were rarely cancelled even when the service was short staffed**.** Relatives and staff told us there were occasions when escorted leave was delayed allowing for people to become calm and reduce the potential risk to the person or others.

The service had enough daytime and night-time medical cover and a doctor was available to go to the ward quickly in an emergency. Relatives said their family members had access to medical staff as needed.

People were cared for by skilled staff who were up to date with their mandatory training. Staff told us about their induction which included specific training for people with learning disabilities and autistic people. While an internal induction was also completed the induction, pack was basic and not specific for people with learning disabilities and autistic people.

Staff told us training was mainly online. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Risk assessments were individual, person centred and reviewed regularly. Staff knew the risks to people and the actions needed to reduce or remove the risk. Staff also completed risk assessments for activities such as swimming, eating and drinking and physical health.

Staff completed health action plans, and people were invited to an annual health check. Epilepsy management plans demonstrated a protocol for management for people with a diagnosis of epilepsy together with an emergency rescue remedy protocol and a contingency plan if required.

Staff used NEWS2, a recognised escalation tool, to assess physical health. Escalation for review by medical staff were part of the risk management action plans. Individual hospital and communication passports were developed to help medical staff understand the person in the event of a hospital admission

Relatives said the staff organised medical care and accompanied their family member on appointments.

Wards for people with a learning disability or autism

The service supported people whose behaviours at times placed them and others at risk of harm. Positive Behaviour Support (PBS) plans were developed with the person and followed best practice in anticipating, de-escalating and managing challenging behaviour. Also included in the PBS plan was “My best day,” “Things I need to learn,” “Important things YOU need to know about supporting me”.

Relatives told us the staff recognised their family member’s triggers of behaviours and used the appropriate strategies to reduce the level of distress, anxiety and frustration. Reactive strategies detailed the triggers to people’s behaviours. Each behaviour had a supportive intervention based on gentle teaching, an approach based on building safe, loving and engaged relationships. For example, strategies varied depending on the level of behaviours, such as having their own space to ‘self-smooth’ rather than intervene. The plans for de-escalation strategies were all built around people’s preferred activities. As a result, restraint and seclusion was rarely used.

Safeguarding

Staff understood how to protect people 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.

One person said “safe” when holding the bedroom card. Relatives told us their family member was safe at the service.

Staff understood how to protect people from abuse and the service worked well with other agencies to do so. Staff attended safeguarding training for adults and children on how to recognise and report abuse. They were aware of their responsibilities towards ensuring people were safeguarded from abuse including how to recognise the signs of abuse, raising safeguarding referrals and who to inform if they had concerns.

Speaking up from staff was taken seriously. The ward manager gave us an example of a recent safeguarding referral following concerns raised by staff of poor practice they had witnessed.

Medicines management

The service used systems and processes to prescribe, administer, record and store medicines. They knew about and worked towards achieving the aims of STOMP (stopping over-medication of people with a learning disability, autism or both).

Medicine records were not always completed accurately. Medicine administration records were not always signed to demonstrate administration or used codes to indicate the reason for non-administration. There were omissions for three of the four records reviewed for a month which included 12 topical cream omissions for one person, three oral medicines for another and two for a third person.

The service ensured people’s behaviour was not controlled by excessive and inappropriate use of medicines. When required medicines or rapid tranquilisation medicines were not used to manage behaviours as other less restrictive techniques were used to reduce people’s distress.

Track record on safety

The service managed safety incidents well. Staff recognised incidents and reported them appropriately. Staff received feedback from investigation of incidents, both internal and external to the service.

Wards for people with a learning disability or autism

Staff understood the duty to be transparent and open with relatives about events. Relatives said they were informed about important events such as incidents, accidents and visits to the Emergency Department.

Managers debriefed and supported staff and people after any serious incident. Electronic reporting systems were audited to ensure debriefs with the person and staff involved took place. Easy read and social stories were used as part of debriefs.

Is the service effective?

Good  

Our rating of effective improved. We rated it as good.

Assessment of needs and planning of care

Care plans reflected the person's assessed needs. They were personalised, holistic and strengths based. Individual care plans based on people's physical, social and emotional needs were developed where appropriate. Care plans were recovery focussed and respected people's rights.

People were involved in the care planning process; they were provided with Easy Read copies and their relatives told us they were invited to reviews. People were involved in the reviewing of their care plans which happened during multi-disciplinary team meetings

A named child and adolescent mental health (CAMHS) nurse developed care plans for a young person in the service. These plans were then reviewed with the community CAMHS nurse. Outcomes for the young person were measured through an electronic system.

The Health of the Nation Outcome Scale (HoNOS) was used at the service to measure progress including the pathway for people with learning disabilities. This included behaviour, symptoms, impairment, and social functioning.

Positive Behaviour Support (PBS) plans were linked to care plans which gave staff guidance on how to manage people's needs. The roles of the behaviour support workers included developing PBS plans as well as working alongside support workers to seek their views and ensure plans were followed.

Best practice in treatment and care

People benefitted from a range of treatment and care delivered by staff based on national guidance and best practice. This included access to psychological therapies, support for self-care and the development of everyday living skills. People were supported with their physical health and were encouraged to live healthier lives.

Staff used recognised rating scales such as NEWS2 to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. Staff identified patients' physical health needs and recorded them in their care plans.

Wards for people with a learning disability or autism

The service had introduced good practice guidance such as on reduction of restrictive practice and STOMP (stopping over-medication of people with a learning disability, autism or both). This meant that staff understood patients' positive behavioural support plans and provided the identified care and support. The ward manager had an awareness of the right support, right care, right culture document and told us the service had an open-door policy to challenge practice.

Skilled staff to deliver care

People's needs were met by skilled staff and they had access to the full range of specialists required to meet their needs. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff which included shadowing more experienced staff.

Relatives said the staff were skilled and understood the needs of their family members and how to manage situations. Managers ensured staff, including banks staff, had the right skills, qualifications and experience to meet the needs of the people in their care.

Staff we spoke with were long-standing and said their mandatory training was up to date, although some face to face training was delayed due to COVID restrictions. Nurses said their registration was maintained through continuous professional development (CPD) which meant they were able to practice safely and effectively. Staff attended conferences and workshops specific to supporting people with a learning disability and autistic people. For example, communication, restraint and distraction techniques. During handovers staff practiced BSL (British Sign Language) signs.

Managers supported staff through appraisals, individual supervision, team meetings and with opportunities to update and further develop their skills. Supervision timetables were on display in the office. Staff said their individual supervision with their line manager was six weekly. Areas discussed during supervision included performance, concerns, and professional development including training needs.

The ward manager told us of support given to staff with managing situations which placed them at risk of harm. Speech and language therapists delivered training around communication for people who expressed their anxiety and frustrations towards staff. We were told managers acted on staff suggestions for having a presence from deputy managers in flats at points during the day.

Multi-disciplinary and interagency teamwork

MDT meetings were held weekly, and discussions alternated between positive behaviour support (PBS) plans and profiles of mood state (POMS). MDT meetings were attended by psychiatrists, therapists, nurse prescribers, lead nurses and, where possible, health care assistants. Relatives were involved with plans of discharge and invited to MDT meetings.

Independent Care, Education and Treatment Reviews (ICETRs) were undertaken to identify identified recommendations to improve the quality of care and treatment and to identify any barriers to discharge. The ICETR had concluded that people accommodated in single flats and not free to mix with others were in long term segregation. The care of people in long term segregation (LTS) was reviewed to ensure restrictions were minimal.

Changes to people's outcome and actions arising from MDT meetings were shared with staff during handover meetings and daily progress notes together with weekly emails from the ward manager.

Wards for people with a learning disability or autism

The service had effective internal and external working relationships with teams and organisations. For example, external safeguarding teams and independent support workers employed by the Local Authority to deliver activities attended MDT meetings and took the role of advocate to the person.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

People's mental health status was documented in their care files and relatives we spoke with knew the conditions of their family member's Section under the Mental Health Act 1983.

People were reminded of their Section 132 rights and recorded clearly in their care notes each time. Staff used the person's preferred method of communication which ensured they understood their legal position and rights under the Mental Health Act. For example, staff used social stories and easy read formats.

Relatives told us staff ensured their family member had their Section 17 leave (permission to leave the hospital) as agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff told us Section 17 leave was rarely cancelled but was, at times, delayed when the person's behaviours may impact their ability to have successful and meaningful leave.

People and their relatives had easy access to information about independent mental health advocacy. There were easy read notices on display for information which referred to leave and for people with an informal status.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. There were monthly mentor sessions with managers to ensure they were knowledgeable of people's rights under the MHA.

Good practice in applying the Mental Capacity Act

Staff supported people to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005. Staff assessed and recorded capacity clearly for people who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. They knew the types of day to day decisions people made. For example, activities and clothing choices, and meals. Relatives said the staff were knowledgeable on the most appropriate periods when to assess their family member's capacity to gain consent.

People were supported to make specific decisions for themselves before best interest decisions were made. Capacity assessments were completed and recorded for specific decisions such as care and treatment, covert medicines and CCTV. Best interest decisions were made in consultation with the appropriate decision maker where the mental capacity assessment had identified the person lacked capacity to make specific decisions. Staff understood how to support children under 16 to make their own decisions without the need for parental permission or knowledge under Gillick competency. Staff knew how to apply the Mental Capacity Act to patients aged 16 and over and where to get information and support on this. They worked closely with services for support and to ensure people were kept safe.

Wards for people with a learning disability or autism

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

We sought feedback from people with complex communication needs. We used the person's preferred means of communication. For example, one person showed a positive reaction when we asked about the kindness of staff. Relatives praised the staff for the kindness, compassion and respect shown to their family member. They said the staff were knowledgeable about the person and the manner they used to approach the person. For example, humour, accepting refusal and patience.

Staff showed compassion and support when they were managing situations that placed them at risk from behaviours people used to express frustrations. Staff knew people well and took least restrictive action which ensured situations were not escalated. Staff explained the reasons for their action and described their approach once the person was more receptive to their engagement.

We saw people respond to staff when they engaged with them. We saw one person engaging with staff. The staff on duty facilitated our conversation during play which included naming staff and preferences of activities. Staff engaged well with the person, giving them time to respond before asking further questions. The staff we spoke with gave us examples of people's responses to their kind and compassionate approach. They said some people made eye contact, others used touch and some smiled when they delivered care and treatment or as they approached them. Relatives we spoke with confirmed their family member used the behaviours described when they wanted to engage or when they "liked" specific staff.

The staff expressed pride in their role within Berkeley House and spoke about people with warmth and enthusiasm. They showed detailed understanding of the person and how to support them in the best way.

Involvement in care

Relatives said they were involved in their family member's care planning. People were encouraged where possible to be part of their care planning and risk assessment. People were provided with easy read versions of their Care and Treatment Review (CTR).

Staff involved people in care planning and risk assessments and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

People's individual feedback about their experiences of their care was gathered in a way the person was able to understand it. For example, an easy read debrief was developed to support a person to give feedback about incidents. Relatives told us their feedback was sought and taken seriously and, if necessary, acted upon.

Wards for people with a learning disability or autism

Is the service responsive?

Good ➔➔

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

Access and discharge

The service was taking steps to support people with discharges. They worked well with services providing aftercare and managed patients' move out of hospital.

Bed management

There were five people living at the service with two vacancies at the service. Meetings with Commissioners and the hospital's transformation operation lead were held to discuss potential admissions and the most appropriate pathway for the person. Pathways were separated into community placement or for hospital admission at Berkeley House. Decisions about admissions to the hospital were decided at MDT meetings.

People's discharges were planned and phased discharges were taking place to ensure the placements were successful. Staff were supporting people in their adult social care placement by maintaining contact and by ensuring the staff were working within person's preferences, likes and dislikes. The ward manager considered the potential for decline as the support from the hospital was withdrawn.

Relatives told us they were involved in their family member's plans for discharge.

Discharge and transfers of care

Managers acknowledged people had been living at the service for significant periods due to the lack of appropriate placements in the community.

A policy on admissions of young people into adult wards was not in place for the service, despite having admitted a young person. The service predominantly accommodated adults. Care plans that focused on educational need were in place but no discharge plans, although discharge was being considered for this young person in September to a life home. The service had developed strong links with the child services to support any young people in the service.

Monthly discharge meetings took place. However, discharge plans were not in place for all the people in the service. While we recognise the difficulties of discharging people from assessment and treatment units, the model of care needs to align with positive outcomes which respect the individual's rights, and include discharge planning in their person centred care plans.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings supported people's treatment, privacy and dignity. Each person had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.

Wards for people with a learning disability or autism

Accommodation was arranged into single flats with en-suite bedrooms, their own lounges and outside space. Flats were spacious, personalised with photos and in some gardens, there were bird boxes, flower boxes and chimes. The environment was supportive of neurodevelopment for people with autism. For example, no echo (reflection of sound) or glaring bright lights. The environment was 'low arousal, uncluttered and people had access to a cool down sensory room, which provided a quiet space. There was minimal furnishing which helped provide a low arousal environment.

Meeting the needs of all people who use the service

Relatives told us they were able to maintain relationships with their family members. Staff accompanied their family member on visits to their homes and there were no restrictions on visits to the hospital.

Staff developed individual therapeutic activity timetables, and Easy Read copies of the timetable were on display in the people's flats. Staff were knowledgeable about people's preferred activities. For example, if the person preferred having meals out, swimming, watching films or outings.

There were weekly visits from an independent support worker employed by the Local Authority. Their role included accompanying the person on activities, such as outings and liaising with relatives.

The service met the needs of people including those with a protected characteristic. People had access to spiritual, religious and cultural support and staff helped people with communication, advocacy and cultural and spiritual support.

People had support from speech and language therapists. Communication passports on people's preferred method of communication were in place. Mood boards to help people express their emotions were used for some individuals. Easy read posters about activities, advocates and symbols were on display in flats. At handovers staff were able to practice and increase their skills with Makaton and sign language.

Listening to and learning from concerns and complaints

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

People, their relatives and carers knew how to complain or raise concerns. Relatives told us they felt confident to approach managers with complaints. Easy read complaint posters were displayed in flats and a "You Said, We did" approach was taken by the staff towards resolving complaints.

The ward manager gave us an example of a recent complaint regarding equipment. The complaint was taken seriously, the procedure was followed, which included an investigation by The Patient Advice and Liaison Service (PALS), and an apology was offered. Relatives said they felt confident to approach managers with concerns and that a satisfactory outcome would be reached.

Is the service well-led?

Good ↑

Wards for people with a learning disability or autism

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable to people and staff. The ward manager told us senior leaders were visible and their visits to the service were regular. They were kept informed on progress of the service and their successes.

Local leadership was provided by a ward and deputy managers. They were aware of the challenges facing the service. Staff told us that their managers were supportive and provided direct care as appropriate. They said the ward manager visited every flat to greet people and staff which developed a rapport and was improving morale.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The future vision for the service was based on developing an onsite Outreach service. The aim was to prevent unnecessary admissions by stabilising community placements, giving staff an opportunity to develop relationships with the person, carry out assessments and support the provider. The outreach staff would support community providers to strengthen the community team.

Culture

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

The team worked well together and were confident that managers would take their suggestions and concerns seriously.

Relatives told us the staff sought their feedback about the service and felt confident to raise concerns without fear of reprisals to their family members at the service.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

A range of audits were used to assess and monitor standards of care and safety. The ward manager sought guidance and advice at the Quality Assurance meetings where shortfalls from the audits were identified. Individual assessments, risk assessments and care plans were reviewed during multidisciplinary meetings.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Wards for people with a learning disability or autism

Identified risks were escalated through the hospital governance structure and recorded on the trust risk register. All risks were managed in line with the Risk Management Policy and Pathway with oversight at hospital and senior operational governance forums.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in quality improvement activities.

An audit system to assess and monitor the standards of care was in place and action was taken where shortfalls were identified.

Engagement

Managers engaged actively with other local health professionals to ensure that an integrated health and care system was commissioned.

Staff were kept informed about current changes and lessons learnt during handovers and staff meetings. A "Sunday read" was sent to all staff by email which included the news from the week, goals of the week, training and changes to people's care.

Learning, continuous improvement and innovation

A project designed by the organisation on developing partnerships with Commissioners to enable people to live successfully in the community with support and prevent admission to hospital. The aim of the project was to discuss with Commissioners referral and to reach decisions on the best pathway for the person. The project lead was supporting staff on managing admissions as not many discharges had taken place.

Acute wards for adults of working age and psychiatric intensive care units

Good ↓

Is the service safe?

Requires Improvement ↓↓

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. However, staff did not always undertake all the relevant equipment checks to maintain clinical safety.

Safety of the ward layout

Staff completed and regularly updated risk assessments of all wards areas and removed or reduced any risks they identified.

Staff could observe patients in all parts of the wards. The wards had mitigated blind spots by installing convex mirrors at key areas across the service.

The wards complied with guidance regarding mixed sex accommodation. The sleeping accommodations were single rooms with en-suite toilet and washing facilities. There were separate male and female corridors. Female patients had key fob access to their allocated areas.

All wards had a designated female lounge. However, we saw the female lounges on all wards were being used by male patients which did not meet the requirements of the Department of Health guidelines. The service had not taken any action to address this.

There were identified potential ligature anchor points and the service had mitigated the risks to keep patients safe. A ligature point is anything that could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. The wards had recently installed new alarmed bedroom and bathroom doors to mitigate the ligature risks. These were checked daily to ensure they were fit for purpose.

To review staff's awareness of ligatures, staff on Abbey ward had undertaken ligature scenario training which staff said was very useful.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. Due to Covid-19 the wards completed monthly audits which reviewed for example, standard infection prevention and control practices and the environment. We found no issues or concerns with the documents seen.

Staff followed infection control policy, including handwashing. All wards achieved 100% compliance with their hand hygiene audits for March and April 2022.

Cleaning records were up to date and demonstrated regular cleaning. Housekeeping staff were aware that cleaning strategies had been enhanced due to the Covid-19 pandemic and had changed their practice accordingly.

We saw housekeeping staff followed good hygiene standards when cleaning the wards.

Clinic room and equipment

While the clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs, staff did not ensure these were checked regularly.

The wards had a dedicated room for administering medicines, which were locked, secure and only accessible to authorised staff. Across all wards staff did not consistently check the medicine fridges and clinical rooms temperature daily. We found numerous gaps in recording between October 2021 and April 2022.

Emergency equipment and medicines were stored in the wards' clinic rooms. Staff did not always undertake the required checks. There were frequent gaps between January and March 2022. Across the service, most of the sharps bins for the disposal of used needles had the date of opening although one bin on Greyfriars ward was overfull. The manager confirmed they would arrange for this to be removed and replaced.

Safe staffing

The service generally had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

While the service did not always have enough substantive staff to keep patients safe, they alleviated the risk by employing bank and agency staff. Staff told us that while they accepted they needed "ad hoc" agency staff this often led to extra pressure due to having to provide additional mentoring and/or support. All staff said this was impacting on providing timely support to patients. However, the incident reports seen did not identify any patient harm or risk.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The rotas showed the service had the number of staff required to meet the needs of patient. This was often done by reducing the number of nurses required and increasing the level of health care assistant cover.

The ward manager could adjust staffing levels according to the needs of the patients. The service had enough staff on each shift to carry out any physical interventions safely. Managers used a staff escalation tool to review the staffing requirements for the wards. There was a weekly touch point meeting which reviewed the staffing requirements. Ward managers often had to be part of the numbers due to staffing shortages which meant they could not always oversee the day to day running of the wards**.**

The trust had offered a financial bonus to staff to work additional shifts and staff confirmed they often picked up extra shifts. The managers told us they did not monitor staff working hours to ensure this did not exceed the working time regulations.

Acute wards for adults of working age and psychiatric intensive care units

The service had high vacancy rates at 32%. Managers told us they were actively recruiting and were waiting for some overseas staff to begin their roles.

The service had high rates of bank and agency nurses but requested staff familiar with the service. Managers ensured all bank and agency staff had a full induction and understood the service. This was confirmed by agency staff we spoke with. They also said they had been mentored for their first week to familiarise themselves with the running of the wards.

Levels of sickness were above the trust target of 4% at just below 10%. The matron told us there were no identified themes regarding the level of sickness and that managers supported staff who needed time off for ill health. The managers confirmed they continually monitored the level of sickness within the service.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. This was confirmed by patients we spoke with.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

While there was no weekend consultant cover there was always a consultant on call 24 hours a day seven days a week especially at weekends and out of hours to cover the inpatient units. Staff said the on-call doctors always responded quickly in an emergency.

Managers could call locums when they needed additional medical cover. Medical staff we spoke with said they ensured all locum staff had a full induction and understood the service before starting their shift.

The medical staff confirmed they received regular appraisal.

Consultants, doctors and the pharmacist attended regular ward rounds alongside the patients.

Mandatory training

Most staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff.

Agency and bank staff confirmed they had also attended the trust's mandatory training requirements.

Managers monitored mandatory training and alerted staff when they needed to update their training. We saw details of forthcoming training on display in the staff rooms.

Assessing and managing risk to patients and staff

Acute wards for adults of working age and psychiatric intensive care units

Staff did not follow national guidelines when using rapid tranquilisation. The service did not always comply with the provider's least restrictive interventions programme. However, staff used restraint only after attempts at de-escalation had failed. The service did not have personalised emergency evacuation plans (PEEPs) in place for patients with mobility concerns.

Assessment of patient risk

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool.

Risk assessments were reviewed regularly and updated following any incidents and fed into the patients' care plans.

Staff completed risk assessments for patients thought to be at risk of self-harm or suicide.

Management of patient risk

The service did not have personalised emergency evacuation plans (PEEPs) in place for some patients with mobility concerns. A PEEP is a plan for a person who may need assistance, for instance, a person with impaired mobility, to evacuate a building or reach a place of safety in the event of an emergency. While there were clearly identified locations where patients would be moved to during an emergency there was no plan on how staff would support patients with reduced mobility.

The wards located on the first floor had evacuation chairs. Evacuation chairs are specially designed seats into which mobility-impaired people are secured and transported from a building, usually via stairways. However, none of the staff were trained in their use. This was discussed with the matron who confirmed they were in conversation with the trust's leadership team regarding this.

Staff were aware of individual patient risk. The Greyfriars ward had access to an infrared technology system allowing for quick and easy monitoring at night. Staff said they asked patients' consent before using the system. However, this was not reflected in the patient records seen.

Staff told us there were occasions where a patient had left the ward by climbing over the garden wall. To manage the risk, the service had created up to date risk assessments and staff were also supporting patients when in the garden. The matron told us staff were undertaking relational security training. Relational security is the knowledge and understanding staff have of a patient and of the environment, and how this information is linked into appropriate responses and care.

Staff identified and responded to any changes in risks to, or posed by, patients. The Greyfriars ward had an "extra care area" away from the main clinical area which provided a therapeutic and/or low stimulus environment for staff to engage patients in managing for example; their disruptive behaviour and/or levels of aggression.

The trust had a policy for searching patients. Details were included in the patients' welcome pack. Staff gave patients and carers information about restricted items. Staff checked patients' belongings on admission to the wards or on return from leave.

Use of restrictive interventions

Acute wards for adults of working age and psychiatric intensive care units

Staff did not follow the National Institute of Health and Care Excellence (NICE) guidelines when using rapid tranquilisation. We reviewed the quality of physical health monitoring following rapid tranquilisation. We found that only one of the eight records seen had been fully completed, one was partially completed and the remaining six had no monitoring information documented. This meant there could be a risk of staff not identifying and responding to patients who may have an adverse effect from rapid tranquilisation.

While staff said they participated in the provider's restrictive interventions reduction programme, which met best practice standards, they did not always ensure that patient's behaviour was not controlled by excessive or inappropriate use of medicines. The service did not always follow the least restrictive option when prescribing medicines. This was reflected in three of the patient records seen. A proposed review of the use of rapid tranquilisation was also identified in the medication safety group's October 2021 minutes. However, there was no proposed action plan as to when this would be completed.

Following the inspection, the trust informed us their rapid tranquilisation guidance policy was under review to update the flow chart and re-emphasise the post observation monitoring. The trust's incident report was also being adjusted to confirm evidence of the post observation monitoring. Specific training was being developed for staff.

Staff said they made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff had received training in Prevention Management of Violence and Aggression (PMVA).

The de-escalation suite/extra care area policy clearly outlined the procedures and recordings staff should follow. However, risk assessments did not clearly identify how staff should manage, prevent or respond to the risk re-occurring. Care plans were not detailed to show how the levels of risk identified were to be reduced.

Greyfriars ward used safety pods to facilitate safe restraint and administration of intramuscular medicines. A safety pod is a specially designed bean bag that allows physical restraint to be carried out in a safer way during challenging situations.

As required (PRN) medicines used to restrain could only be given a set number of times before being re-authorised. PRN medicines were reviewed at weekly multidisciplinary team and patient reviews.

Safeguarding

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

Staff received training on how to recognise and report abuse, appropriate for their role. Staff were aware of the safeguarding team and who to contact for support.

Staff knew how to recognise adults at risk of or suffering harm and made safeguarding referrals if they had any concerns. Staff worked with other agencies to protect patients.

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

Staff followed clear procedures to keep children visiting the wards safe.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Staff had easy access to clinical information to ensure they maintained clinical records.

Most staff had access to essential information. The provider used an electronic system for the recording of essential information on a patient's care and treatment. Due to staff shortages, staff told us there were often delays in the input of information onto the electronic recording system. However, staff were provided with updates on patients' care, health and routines during handovers.

Records were stored securely.

Medicines management

The service did not always use systems and processes to safely prescribe, administer and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff did not always manage medicines safely.

Medicines were ordered, stored and disposed of safely. However, we found out of date medicines across the service. These were brought to the attention of ward managers for destruction and replacement. Prescription stationery was stored securely and tracked to avoid misuse. Controlled drugs (medicines requiring more control due to their potential of misuse) were stored and recorded appropriately. However, Greyfriars ward were not consistently recording controlled drugs stock checks, according to trust policy.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The trust had an electronic prescribing and medicine administration (EPMA) system. Pharmacy staff used the EPMA system to identify and prioritise new patients which enabled them to reconcile their medicines (the process of accurately listing the medicines patients were taking before admission). Patients received information about their medicines from the pharmacist.

On Greyfriars ward nurses prepared, administered and recorded medicines given to patients. On other wards medicines were administered by healthcare assistants, but EPMA was signed by nurses. Registered staff told us they were assured that the allocated healthcare support workers were competent to administer medicines. However, there was no process for feedback from healthcare support workers to ensure recordings of medicine administration was accurate. If medicines were not given the reason for this was not recorded consistently. Staff recorded the information in more than one place which made it difficult to identify why patients were not taking their prescribed medicines.

Staff had received training in the management of antipsychotic medicines. However, on review of 16 medicine records we found that two patients had been prescribed a high dose antipsychotic medicine which exceeded the upper limit stated in the British National Formulary (BNF) guidelines. There was no assessment of the risk of using an antipsychotic medicine above the recommended dose and physical health monitoring, required to make sure a patient is not developing adverse effects, had not been recorded.

Acute wards for adults of working age and psychiatric intensive care units

The storage of emergency medicines had been recently risk assessed. Where a risk of a potential emergency could be anticipated, would be prescribed and supplied for individual patients. Wards kept emergency medicines to treat anaphylaxis (a severe and potentially life-threatening reaction to a trigger such as an allergy). Other emergency situations would be escalated to emergency services, via 999.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

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

Staff raised concerns and reported serious incidents and near misses in line with the trust's policy.

Staff understood the duty of candour and gave patients and families a full explanation when things went wrong. Patients and their families were involved in these investigations.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service.

Managers debriefed and supported staff after any serious incident.

Staff told us they were aware of feedback from investigation of incidents.

Is the service effective?

Good ➔➔

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

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed care plans which were reviewed regularly through multidisciplinary discussion and updated as needed.

Staff completed a mental health assessment of each patient either on admission or soon after. Staff told us that emergency admissions during the evening were often difficult to be assessed and would usually occur the following day or the next working day following a weekend.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The Greyfriars ward had a health and exercise practitioner who provided physical health screening. They worked closely with the therapy team and were able to refer patients at risk for example of falls or malnutrition. They also supported patients with visits to the dentist or the optician when required.

All patients had a care plan which met their mental and physical health needs. However, the level of patient involvement was low with only two of the eight patients spoken with saying they had been involved in the creation of their care plans. The records seen did not identify attempts to involve patients with their care planning.

Staff regularly reviewed and updated care plans when patients' needs changed.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. However, staff we spoke with were not able to describe how this treatment would be used to support the patients with their recovery.

Staff delivered care in line with best practice and national guidance. The service provided electroconvulsive therapy (ECT). The aim of the treatment is to relieve the symptoms of some mental health problems. We followed the treatment pathway of patients and saw the service had complied with national guidelines which included obtaining consent prior to each session.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients’ dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The engagement and physical health team (EPT) had created a timetable which was varied and focussed on the patient’s physical health. There was a range of gym equipment which patients could use. The health and exercise team completed pre-gym assessments to check patient’s suitability to use the equipment.

Staff used technology to support patients. Patients had access to electronic tablets to make video calls with friends and families.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The trust’s audit programme covered areas such as; inpatient falls, diabetes management and physical health examinations. We saw action plans attached to audit reports. However, the managers were not able to demonstrate how they would use this information or manage the actions.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care.

The service had access to a full range of specialists to meet the needs of the patients on the ward. Ward staff included registered nurses, healthcare workers, medical staff, occupational therapists, physiotherapists, psychologists, dieticians and speech and language therapists and pharmacy professionals.

Acute wards for adults of working age and psychiatric intensive care units

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. The therapy suite was able to provide support for bariatric patients. All staff had been trained in the use of the equipment.

Managers gave each new member of staff a full induction to the service before they started work. All bank and agency staff were provided with an overview of the ward and what to do in the event of an emergency.

Managers supported staff through regular, constructive appraisals and supervision of their work. Although supervision records were not always recorded both the managers and staff confirmed they received regular supervision every four to six weeks. Following the inspection, the trust informed us they were working with managers by expanding their Care to Learn process to provide an accurate picture of supervision.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. For example, staff had recognised that they needed training for supporting patients with a personality disorder. This was an area the managers had recognised and were looking at what may be available to provide additional support to staff.

Managers made sure staff received any specialist training for their role. For example, Resuscitation Level 3 training was part of the trust's mandatory training.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency teamwork

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 held weekly multidisciplinary team (MDT) meetings to discuss patients and improve their care. Staff told us that patients were not included but were represented by a member of staff. Six of the nine family members/carers told us that they had not been involved in decisions about the care and treatment their relative received.

Medical staff told us that advocates were not formally invited to the MDT meetings but could attend on the patients' request. This meant it was unclear if the patient's voice was clearly reflected at the MDT meeting.

At handover meetings, staff shared clear information and referred to the psychological and emotional needs of patients as well as any changes in their care.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff could explain patients' rights to them.

Acute wards for adults of working age and psychiatric intensive care units

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

We spoke with staff who confirmed that Independent Mental Health Advocates (IMHA) attended the wards regularly. While staff informed us the IMHAs attended the wards regularly to see patients so that they could explain what they could offer, this was not documented within the care records.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Section 132 of the Mental Health Act requires the manager of a hospital to inform a detained patient of their legal position and rights. Staff explained to each patient their rights in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. The Section 132 rights Audit for February 2022 showed the wards achieving between 73% and 92%.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. Staff told us that this could on occasions be a challenge, but all patients spoken with confirmed they had received their leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to. We observed this was discussed where appropriate during the ward rounds.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. Staff said they informed those patients who were informal of their rights to leave the ward freely. We observed that the service did not have posters on display informing them of this right. This was brought to the attention of the managers who said that they would attend to the shortfall. Following the inspection, the trust informed us that all relevant posters were now on display.

Care plans included information about after-care services available for those patients who qualified for it under section 117 of the Mental Health Act.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They did not always understand the trust policy on the Mental Capacity Act 2005.

The Mental Capacity Act (MCA) training did not form part of the trust's mandatory training programme. It was however considered part of the essential to role training, which included refresher training. Most staff said they had a good understanding of the MCA principles, and we found no issues or concerns in the records seen.

Acute wards for adults of working age and psychiatric intensive care units

Staff made applications for a Deprivation of Liberty Safeguards (DoLS) authorisation only when necessary and monitored the progress of these applications.

There was a clear policy on MCA and DoLS and staff knew how to get advice where necessary. Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. Staff made applications for a Deprivation of Liberty Safeguards authorisation only when necessary and monitored the progress of these applications. We noted that mental capacity assessments and best interest decisions where applicable had been completed and recorded appropriately.

Is the service caring?

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. They understood and respected the individual needs of each patient.

Staff gave patients help, emotional support and advice when they needed it.

They supported patients to understand and manage their own care treatment or condition and directed to other services if they needed help.

Staff followed policy to keep patient information confidential.

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

Involvement in care

Staff did not always involve patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff ensured patients understood the arrangements for their care and treatment and communicated this with them in a way they could understand, especially where patients had communication needs.

Patients were given the opportunity to provide feedback on the service at their weekly community meeting.

Most patients said staff listened and treated them well. They said nurses looked after them and there were enough staff to help if they needed anything. However, some said they found it difficult to interact with staff due to the high turnover.

Patients were supported to make decisions on their care which was reflected in the records seen. However, six of the eight patients we spoke with told us they did not feel involved in their care and care planning.

Involvement of families and carers

Staff did not always inform and involve families and carer appropriately.

Staff said they supported, informed and involved families or carers which was recorded in patient records. However, six of the nine carers/relatives we spoke with said they had not been given information or been involved in decisions about their relative.

Staff said they helped families to give feedback on the service. However, all nine relatives/carers we spoke with said they had not been given the opportunity of providing feedback on the service.

Staff told us they supported, informed and involved families or carers. Carers and family members said staff were “really helpful” and provided a level of care which was “thoughtful and considerate.” Six of the nine carers we spoke with said that communication to families could be improved. However, all said that they felt their relatives were safe on the wards.

Most carers and families said staff were considerate of their specific needs when organising family visits.

The trust had arrangements for carers and families visiting the wards during the Covid pandemic as well as ensuring carers and families could contact patients virtually and on the telephone. However, five of the nine relatives/carers said that updates regarding visiting was “not good” and “could be improved.”

Is the service responsive?

Good

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

Access and discharge

Bed management

Acute wards for adults of working age and psychiatric intensive care units

Although staff managed beds well there was not always a bed when a patient needed one due to the considerable demand. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave.

Senior leadership and management staff alongside the crisis team monitored patient waiting time. We attended a bed management meeting which reviewed the number of patients waiting for admission. All patients were RAG (red, amber, green) rated to ensure they were prioritised appropriately. The overseeing team said they aimed to admit patients as soon a reasonably possible to avoid delay in the management of their wellbeing.

Patients were moved between wards during their stay only when there were clear clinical reasons, or it was in the best interest of the patient. The trust did not have a process of recording whether patients were moved at night but staff we spoke with said they did not move or discharge patients at night or early in the morning.

The matron attended a daily bed management meeting to review their bed stock. The data seen showed that the bed occupancy for the service averaged 96%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Length of stay refers to the average number of days those patients spend in hospital. The managers told us the main reason for any extended length of stay was due to the complex needs of the patients and the unavailability of beds or suitable placements in the community.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Staff on Greyfriars ward said they always had a bed available if a patient needed more intensive care. They said they tried to ensure this was not far away from the patient's family and friends although on occasions this proved difficult.

Discharge and transfers of care

The service had arrangements to meet patients' urgent or emergency mental health care needs including outside office hours and in an emergency.

The service had low numbers of patients who had experienced a delay to their discharge in the last year. Staff told us that the main reason for delays in a patient's discharge was the unavailability of beds and the lack of suitable accommodation in the community.

Although staff started to complete discharge paperwork on admission, discharge planning was not clearly documented in patients records and staff did not always document when discussions about discharge had taken place with patients. This was identified as an issue in the clinical audit report regarding personalised discharge care planning for October to December 2021. This was also reflected in the feedback from carers we spoke with who said communication between staff and families "could be better."

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

Acute wards for adults of working age and psychiatric intensive care units

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom, which they could personalise.

Patients could make phone calls in private. However, the patients we spoke with were unhappy with the length of time it took for their equipment to be electrically tested which averaged nine days.

Patients were able to see their families in a dedicated family friendly suite which represented the patient's home environment. Amenities included refreshments and toys for visiting families and children.

The service had an outside space that patients could access.

The service offered a variety of good quality food which included a vegetarian option. Staff told us they could cater for each patient's individual needs which included vegan and gluten free diets. Patients told us it "was nice" to have fruit bowls available.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff helped patients to stay in contact with families and carers. Families and carers told us they could visit the wards to see their relatives.

The wards displayed information to patients which included a list of useful contacts in the local community that patients could approach for support. For example, MIND who provide mental health advice, support and services to empower anyone experiencing a mental health problem.

Therapists worked closely with communities to provide work and education opportunities for patients.

Meeting the needs of all people who use the service

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

The service could support and adjust for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Managers made sure staff and patients could get help from interpreters or signers when needed.

Patients had access to spiritual, religious and cultural support. Patients had access to a spiritual calendar as well as chaplaincy services. Staff said they were able to support patients who adhered to the Muslim faith.

The therapy centre provided activities for all patients which included a gymnasium, music room, activity room and library. Patients told us they enjoyed listening to music and watching sport in the television room.

The physical centre had a dedicated physical health room where patients could be seen by the nurse to receive treatments such as massages. Staff told us this was very popular with patients.

Listening to and learning from concerns and complaints

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

It was not clear how patients were given information on how to complain or raise concerns. We did not see complaint posters on display. However, patients, relatives and carers said they knew how to complain or raise concerns. Following the inspection, the trust informed us that all relevant posters were now on display.

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

Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

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

Is the service well-led?

Good  

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

Leadership

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

Ward managers were visible on the wards and sometimes made-up staffing numbers when there was a low fill rate. Staff we spoke with felt well supported by their ward managers and matron. They reported that the matron was visible and keen to support the service. Staff reported that morale was improving but was still deemed to be low.

The matron confirmed they received support from the deputy director for mental health and learning disabilities when required. All ward managers confirmed they received continuous support from the matron to enable them to do their role.

Acute wards for adults of working age and psychiatric intensive care units

The wards' matron and deputy director for mental health and learning disabilities had regular contact with staff and patients. Staff said they felt comfortable and confident in approaching them if they had any concerns.

Staff were aware of the trust's executive team and confirmed they often visited the wards.

Vision and strategy

Staff knew and understood the provider's vision and values and how they (were) applied to the work of their team.

The trust's vision, values and strategies for the service were evident and on display on information boards throughout the wards. Staff we spoke with understood the mission and vision of the organisation.

Most staff were able to relay that the trust's core vision was to enable people to live the best life they can while working together to provide outstanding care. The staff appraisal process incorporated the trust values and behaviours to ensure staff worked in accordance with them.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff said that morale across the service was low with their workload being the common factor.

Staff understood the speaking up process for raising concerns. While staff were informed about the role of the Freedom to Speak up Guardian and speak up champions, they did not feel they were particularly visible. Most staff said they felt more confident in raising concerns with their manager or matron.

Staff told us they felt very tired and were not achieving everything they wanted. They said they wished they could re-organise their workload so they could provide extra support to patients. All said they attempted to spend as much quality time with patients as possible.

Most staff said they found working on the wards over the last few months very challenging due to the mentoring of ad hoc agency staff.

Staff said the trust responded efficiently during the coronavirus pandemic and had taken steps to demonstrate their support for the team and understanding of their experience. Most staff told us they felt respected, supported and valued in their work. Staff said they enjoyed supporting patients to get better.

Staff reported that the trust promoted equality and diversity in its day-to-day work and provided opportunities for career progression. For example, staff described being able to have flexible working practices which enabled them to maintain a good work life balance.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level.

The matron and managers could access information from a variety of sources that allowed them to understand their team's performance against identified key performance indicators. However, they were unable to tell us what they did with this information or how they managed any actions to measure improvement across the service.

The Working Aged Adult Inpatient and Crisis resolution and home treatment team (CRHTT) meetings looked at key areas such as learning events, patient safety and risk management and staff management and leadership. Although the minutes seen had an action plan which provided updates on the ongoing actions, we saw no evidence as to how this was cascaded to staff for their information.

The ward managers, senior managers and senior clinicians attended meetings where they looked at the management of the service. While there were processes in place for the matron/managers to receive information this was not always effective. This included for example, the observation of patients' physical health after rapid tranquilisation.

Ward staff completed clinical quality audits and data on incidents and complaints. Clinical governance meetings reviewed incidents and the care provided and ensured any learning was shared both within the wards and outside the service. Staff we spoke with were able to describe incidents which had occurred across the service.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Identified risks were escalated through the hospital governance structure and opened centrally on the trust risk register. All risks were managed in line with the Risk Management Policy and Pathway with oversight at hospital and senior operational governance forums. The risks identified to the service were; safe staffing levels, high number of vacancies and high sickness levels.

Due to Covid pressures with staffing there had been no team meetings. Staff told us they had not attended a team meeting for a while.

The services had business continuity plans in place in the event of an emergency that threatened service delivery.

Information management

While staff collected data, they did not always analyse the outcomes and performance indicators.

Information management

Staff engaged actively in local and national quality improvement activities. Managers received feedback on their key performance indicators from the matron. However, the ward managers were not able to provide any narratives or action plans in response to how they managed the dashboard data received.

The trust used several tools and audits to collect data on the service. The performance reports provided information on areas such as mandatory training, appraisal rates, occupied bed rates, length of stay and discharges.

Staff had access to electronic and paper documents they needed.

The electronic system supported staff to report incidents and manage their own performance.

The managers had oversight of the information they needed to support their roles. While the audit data gave the ward managers a breakdown of their current position and an overview of areas such as staffing, we did not see evidence of how this was cascaded to staff to improve the service.

There was enough equipment and information technology available for staff to do their work.

The service made notifications to external bodies as required.

Engagement

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population.

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

Staff had access to the trust's intranet system which provided them with up-to-date information on items such as policy updates.

Patients and carers could access information about the service through the trust website. The information available gave a brief description of each ward and their contact details.

Patients told us that they were able to provide feedback at either their patient community meetings or directly with staff. Relatives and carers, we spoke with said they had not been given the opportunity to provide feedback on the service.

Learning, continuous improvement and innovation

The matron and managers worked together as a team to make improvements in the running of the service.

Leaders were responsive to concerns raised and performance issues and sought to learn from them to improve services.

Staff said they were given the time and opportunity to learn.

Community end of life care

Good

Is the service safe?

Good

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

Mandatory training

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

Staff received and kept up-to-date with their mandatory training. The compliance rate of completed mandatory training for clinical staff was consistently above 90% across the service.

The mandatory training was comprehensive and met the needs of patients and staff. However, end of life training was not mandatory for nurses delivering this care to patients. This meant that a staff member received the training but it was not refreshed as mandatory training would be. Some nurses had not had their end of life training refreshed since they started in the job but did have access to specialist ad hoc training opportunities in the course of their role.

End of life training was classed as 'essential to role' for nurses delivering this care and was covered during the induction process via webinars on the trust's training site, 'care to learn'. This training included verification of life extinction and syringe pump training. Important conversations training was also available.

The local hospice delivered training such as recognising an end of life patient. Community nurses accessed end of life 'masterclasses' which were live sessions provided at different times of the day or night for those working night shifts.

Managers provided staff with ad hoc 'experiential learning' whilst shadowing shifts, doing joint home visits or when a learning opportunity developed on the ward. They offered staff shadow experience but this was not recorded.

The competencies framework for community nurses included recognition of life extinction, sub cutaneous fluid administration and syringe driver management. There were no dates recorded when sub cutaneous fluid administration and syringe driver management training had been completed or how often the training needed to be refreshed.

The trust did not provide any child end of life training for the children's team. Some staff had completed courses in children dying and verification of life extinction training was in process. The local children's hospice were a charity who provided this training. Staff were checked on their syringe pump competencies and clinical skills and ad hoc training was provided by the children's hospice.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers held dashboards to monitor training compliance. Each staff member had a record of mandatory training which their manager could access. The dashboard included the completion date, expiry date and the window in which the staff member had to retake the training.

Managers made good use of the trust's practice facilitators, a countywide group led by the education team, who worked with new staff and staff returning from extended leave to review their competencies and any gaps in their learning. They met with new starters every month and then with their managers every month. Managers could refer staff into the service when they recognised a learning need with their team member. These training records were attached to staff personnel files.

The staff training matrix in Cheltenham was not up to date as some staff had not signed off the competency form.

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.

Nursing staff received training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff demonstrated robust safeguarding practices where they identified safeguarding situations in the community and arranged appropriate joint visits with social services. Staff completed risk assessments and mental capacity assessments, recorded the outcomes, made appropriate challenges about individual outcomes and arranged further support.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. There was information on the wards about how to raise a safeguarding concern. Patients open to safeguarding concerns had a red flag on the toolbar at the top of their patient record. Safeguarding cases were documented in weekly meetings.

However, staff did not have access to patients' safeguarding records who had open safeguarding concerns with the local authority because this information was held on a separate system. Staff relied on information coming in from the local authority regarding these patients during multidisciplinary team (MDT) meetings. This meant that all of the safeguarding information was not always known by staff who were either responsible for that patient on a ward or visiting them out in the community.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff accessed support from the trust's safeguarding leads. Staff raised incident reports which were sent to the safeguarding team. Staff then referred any concerns to the local authority safeguarding team. They invited the local authority and adult social care to multidisciplinary team meetings as well as specialist consultants where relevant.

Staff followed safe procedures for children visiting the wards. No children under the age of 16 were allowed to visit patients on community wards due to covid restrictions. However, there was no written protocol for this. Risk assessments were in place for patients who posed a risk to children. Staff put in additional security measures and applied duty of candour to all concerned. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

Cleanliness, infection control and hygiene

Community end of life care

The service controlled infection risk well. They used control measures to prevent the spread of infection before and after the patient died.

Wards in community hospitals that delivered end of life care were clean and had suitable furnishings which were clean and well-maintained. The service generally performed well for cleanliness. Action was taken following infection control audits. There was no mortuary on site. Staff used an external funeral service who transferred patients from the hospital or their home.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). All staff wore appropriate PPE and ensured visitors on the wards adhered to the same infection control principles. However, visitors were permitted to embrace their dying relative. Staff took their masks off to show more compassion towards a dying patient. Patients at the end of their life were swabbed for Covid on admission but not again after this so they could be left alone respectfully. Community nurses disposed of any PPE at the patient's home.

Staff completed a handover form for the funeral service to inform them of the patient's cause of death and any pre-existing conditions. One copy went with the patient and one stayed on the patient's records.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes, staff did not always take precautions and actions to protect themselves and patients.

Patients could reach call bells and staff responded quickly when called. On hospital wards, staff turned alarms off when a patient was approaching the end of their life. They 'dehospitalised' the room as much as possible to enable the patient to die in peace.

The design of the environment followed national guidance. Staff placed discreet signs on the room door to alert staff that a patient was nearing the end of their life. Where possible, staff positioned end of life patients at the end of the corridors so they were not disturbed by others. Staff were able to adapt end of life rooms so they had changing colour mood lights, patients were able to watch films and pets were permitted to visit the ward. Some wards had also accommodated wedding ceremonies on the wards for dying patients.

However, at Cheltenham district nursing team, the chairs in the district nurses offices were uncomfortable and staff had not received ergonomic working risk assessments. Rooms were hot and stuffy, and staff had problems with computers that did not connect to the screen. No ergonomic risk assessments about the working environment had been carried out.

Staff did not always record that they carried out daily safety checks of specialist equipment. In the community teams, we observed that staff checked the contents of the grab bags before they went out on their visits but did not record that they had done so.

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

Community end of life care

The service had enough suitable equipment to help them to safely care for patients. The trust had replaced all their old syringe pumps with new models to ensure patients at the end of their life did not have to deal with identified issues such as low battery life. The inpatient wards lent out syringe pumps to community teams if they needed additional pumps.

Community nurses completed requests for equipment through the council's community equipment supplies. Requests for equipment for end of life care patients were always prioritised.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. Risk assessments considered patients who were deteriorating and in the last days or hours of their life.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately.

Staff in the community teams used a 'supportive and palliative care indicators tool' (SPICT) to help identify patients with deteriorating health.

On the wards, staff identified patients who had less than 12 months to live during their multidisciplinary team (MDT) meetings. Staff did not record this discussion on a pro forma and relied on staff competency to make sure certain questions had been asked.

Staff completed a 'shared care record' within an MDT for all end of life patients. As a team with input from the lead clinician, staff identified patients who had stopped responding to treatment. On the wards, the ward doctor completed the shared care record and in the community, the patient's GP was responsible. Staff ensured the patient's anticipatory medication chart was included in this care plan.

Staff completed risk assessments with each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff completed risk assessments with family members to administer subcutaneous medication for common end of life symptoms. This meant that carers did not have to wait for home visits to respond to breakthrough symptoms, which was especially helpful for them during the evening or out of hours. The risk assessment contained appropriate safety considerations and described the prescribing suggestions for each common symptom.

Staff knew about and dealt with any specific risk issues. Staff demonstrated good mitigation of risk such as moving one patient with a family member and the same name and on the same medication to a neighbouring ward to reduce the chance of medication errors.

On the community inpatient wards, staff completed risk assessments for patients at high risk of falls which often meant their door would be left open for additional observations. Staff situated these patients as close to the nurses station as possible.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient’s mental health).

Staff were taking part in a project called 'NEWS2' with therapy. This meant that therapists could use the escalation tool to get support when they identified it. If staff needed to talk to the rapid response team, they used the 'situation, background, assessment, recommendation' (SBAR) tool to escalate issues in a consistent way.

Staff shared key information to keep patients safe when handing over their care to others. Patients at the end of life had a blue star alert on their patient record to indicate this. If a patient was receiving palliative care, this was marked as an alert in red at the top of their record. A purple R indicated that a patient had a 'recommended summary plan for emergency care and treatment' (ReSPECT) form in place. Staff created care plans for patients using a syringe driver and administration of medication.

Nurses recorded a patient's syringe driver battery status after each visit so the nurse doing the next visit was aware of the status.

ReSPECT forms were completed by patients with staff support if they were on the wards. In the community most forms were completed by the patient's GP.

Shift changes and handovers that happened in the patient's home or on the wards included all necessary key information to keep patients safe. ReSPECT forms and shared care plans were kept as a paper record with the patient, so if a patient chose to die at home, this information stayed with them. This paperwork was not scanned onto the patient's electronic record until they passed away, which meant staff could only access this information during a home visit or on the ward, but not whilst working in the office planning a visit or communicating with other professionals. This meant that any do not attempt cardiopulmonary resuscitation (DNACPR) documents were not available for staff to check unless they were with the patient in the home or on the ward.

Patient records had specific sections, such as patient and carer communication. However, staff were not completing these sections and instead just recorded this information in patient visits notes. This meant managers or other staff had to scroll through patient notes to find specific information.

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. End of life care patients were always prioritised so managers made sure they had enough staff to provide the support they needed.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Managers completed a daily situation report to identify any end of life patients. Managers requested extra staff across the team to ensure that end of life patients had sufficient staffing to support them. All palliative patients were prioritised.

The managers could adjust staffing levels daily according to the needs of patients. Managers used a staffing budget tool and completed a trajectory across all staff bands in the services which showed all the vacancies across the teams. Staff working in the children's services worked additional hours to support children dying at home. Managers produced a specific roster which included two additional staff per day to support these children.

The service had reducing sickness rates. Managers met with their financial service directors to discuss their team's performance around workforce, sickness and absence and training and appraisals.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff who had left the team came back to work on the bank to support the teams. However, substantive nurses always took the lead with end of life care patients.

Managers made sure all bank and agency staff had a full induction and understood the service. Before using agency staff, managers gave the agency a list of competencies required to provide end of life care.

Medical staffing

The service had enough 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. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. On the community wards, there was a doctor on duty from 8am to 6pm. From 6.30pm onwards, staff accessed the contracted GP out of hours service or rapid response team. Nurses could use anticipatory medication as they were competent to do so rather than wait for the out of hours GP to respond. All registered nurses had verification of life extinction training.

In the community, staff referred to the patient's GPs. Most GPs shared the same electronic database as the nursing team.

Records

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

Patient notes were comprehensive and all staff could access them easily. Patient records were all held on the trust's shared electronic database. However, when a patient reached their end of life, they held a paper shared care record that stayed with the patient. This was then uploaded onto the electronic database when they died.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines

Community end of life care

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff completed a separate medication prescription chart for anticipatory prescribing for symptom control.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. The pharmacist and pharmacist technician checked medication twice a week. Staff from the children's complex centre completed monthly medication checks for anticipatory medication.

Staff completed medicines records accurately and kept them up-to-date. Two nurses completed weekly controlled drugs checks.

Staff stored and managed all medicines and prescribing documents safely. Staff stored controlled drugs safely and injectable medicines in a specific cupboard. Staff had completed a risk assessment with the local pharmacy to store controlled drugs in the patient's own lockable medication pod box in case of a catastrophic event.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services. Staff were able to order more medicines when required.

Staff learned from safety alerts and incidents to improve practice. Staff reported any medicines errors on the trust's incident reporting system. The team manager, pharmacist, matron and medicines management lead were copied into all medicines errors logged on the incident reporting system. Staff applied duty of candour to patients and next of kin when a medicines error occurred. Staff asked their ward doctor or patient's GP to review the patient if there were any clinical risks as a result. Staff involved in medicines errors received supervision or a debrief with a nurse in the team. Nurses completed a reflective practice session with staff involved. As a result from learning from incidents, staff carrying out medicines administration on the wards wore red aprons so they would not be disturbed during the medicines round.

There was a medicines newsletter, which had sections on learning from errors and updates around controlled drugs. Staff accessed information on end of life symptom control medication on the trust's intranet. This had embedded links to the most updated policies for syringe drivers, how to dispose of controlled drugs and the number of who to contact from the medicines optimisation team.

Staff made sure that any prescription errors by GPs were quickly escalated and followed them up personally.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

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

Staff knew what incidents to report and how to report them. For example, staff followed clear definitions of how to report a patient's pressure ulcer, which were grouped into categories.

Community end of life care

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff recorded and rated the incident, recorded what actions were taken and confirmed the level of harm.

The service had no never events on any wards.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social

care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

Staff received feedback from investigation of incidents, both internal and external to the service. The pressure ulcer lead sent the district nursing teams a monthly summary of incidents reported, themes identified and learning identified, including referrals to other services such as podiatry. This was shared in weekly team meetings. Band six staff attended monthly meetings to discuss information cascaded from the professional lead meetings.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. The trust had made the decision to replace old syringe pumps after issues had been identified with their battery life. This included training for all staff on how to operate the new model. All staff had received additional sepsis training as a result of a serious incident in one locality.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers met with all staff involved in medication errors and recorded their discussions in staff supervision files.

Managers debriefed and supported staff after any serious incident. All staff were involved in the debrief following a patient's death. These were led by the palliative care consultant and included all staff from the call handlers who took the initial referral to the nurse that supported the patient when they died. The team reviewed complex cases, how patients and their families could have been better supported and how staff could have been better supported. Debriefs included a teaching session from the consultant.

Is the service effective?

Good

Our rating of effective improved. We rated it as 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.

Community end of life care

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

Staff followed national guidance, 'one chance to get it right', about treating and caring for patients at the end of their life. Information about this guidance was displayed on the boards around the community hospital wards and was also available on the trust's intranet. There was also information displayed about ambitions for palliative and end of life care, the end of life care framework, advanced care plans and ReSPECT forms. Any updates to national guidance were sent to staff via emails, disseminated during team meetings and minutes recorded.

The trust's end of life policy was linked to national guidance.

One of the community hospital ward managers led on 'dying matters' week every year. Information around this was displayed in the main reception of the hospital.

The practice development team set up end of life training courses and managers reviewed the content with staff. When policies were reviewed, these were sent out to teams to discuss then ratified with a policy group then sent back out to staff. These were all discussed during weekly team time meetings.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Teams had support from registered mental health nurses as part of their multi disciplinary team meetings. When required, mental health nurses met with patients, provided education and were available for support and advice on the phone.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Staff followed communication guidelines following the death of a patient.

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 made sure patients had enough to eat and drink, particularly those with specialist nutrition and hydration needs. Staff discussed food and fluid options with patients at the end of their life. Staff treated patients with dignity and respected their choices around their preferences.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff recorded discussions around food and fluid in patients' shared care record.

Specialist support from staff such as palliative care consultants from the local hospice and other professionals was 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 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. Staff recorded pain relief consistently in patients' care notes.

Community end of life care

Patients received pain relief soon after requesting it. Staff discussed patient's pain relief needs during each home visit or whilst on the ward.

Staff prescribed, administered and recorded pain relief accurately.

Patient outcomes

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

The community hospital teams participated in the annual 'national audit of care at the end of life' (NACEL). Following the inspection, the trust told us they had adapted some of the questions in the NACEL audit to enable them to have their own community survey.

Community hospital teams also completed an audit on the use of 'recommended summary plan for emergency care and treatment' (ReSPECT) forms. The results from 2021 were discussed at clinical matrons' groups and were risk rated in November 2021.

The community nursing teams had created a template to start ReSPECT form audits but they had not yet completed any audits. These were due to begin at the end of May 2022.

Outcomes for patients using inpatient services were positive, consistent and met expectations, such as national standards.

Managers and staff used audit results to improve patients' outcomes. The trust had set up a mortality review group who met monthly. The meetings included feedback from medical examiners and comments about specific patients which were then fed back to the team that cared for them in weekly updates. The mortality group presented case studies based on the learning from supporting a particular end of life patient.

All community hospital wards sent a questionnaire out to relatives about end of life care evaluation. Outcomes were recorded on the ward's database. Feedback was sent to staff on a weekly team brief.

Not all managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time.

Competent staff

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

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Teams comprised managers, nursing leads, matrons, community and district nurses, therapists, occupational therapists and administrative staff.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work, although appraisal rates had dropped over the pandemic.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Staff received named nursing supervision to discuss their caseload then separate personal supervision. However, supervision records were in the process of being transferred over to a shared database and this meant in some bases that managers couldn't access their supervision records. In Tewkesbury community nursing teams, there were gaps in supervision between December 2021 and April 2022.

The clinical educators supported the learning and development needs of staff. Staff had personnel files, that all managers and administrative staff could access. Practice facilitator reports were kept in there. These were continuous discussions with a documented plan at the end of each meeting.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff attended weekly team meetings where feedback from families and feedback from incidents were minuted and shared amongst team members via emails. During the pandemic, these daily meetings happened online.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff booked in admin time and supervision time on the rota when they were supporting a complex end of life care patient.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Nurses were trained in verification of life extinction so carers did not have to wait for a GP to attend.

Managers identified poor staff performance promptly and supported staff to improve. Practice facilitators met with managers to identify any training and development needs of their staff team.

Managers recruited, trained and supported volunteers to support patients in the service. One volunteer working in a community hospital did so to show appreciation for the team who had supported their family member when they died. Volunteers were given induction, training, supervision and development opportunities.

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.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held weekly meetings.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff worked with other teams within the service effectively, such as the children's community service who also provided palliative care to children. They received referrals from their local hospital or from out of area hospitals. Advanced care plans for children

were completed with the consultant paediatrician from the local acute hospital. The palliative care consultant from the acute hospital regularly attended team meetings to provide clinical support for staff providing this service. Staff worked with other palliative care teams to produce shared care plans with their families. Staff completed risk assessments with family members to support them to administer medication to end of life patients.

Staff supported nurses working in children's services to help put up syringe drivers when required.

Staff worked with the rapid response team to request support. The rapid response team were an admission avoidance service.

Staff were supported by night sitters who phoned into the service during the night to update staff on a patient's wellbeing. Staff could also contact a local palliative care charity who provided support and care to palliative care patients at home.

A lack of carers in the Gloucestershire system was a big issue for teams when they needed to fast track a continuing health care assessment. This often meant that patients died without a care package in place.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Health promotion

Staff gave patients practical support to help them live well until they died.

The service had relevant information promoting healthy lifestyles and support on wards. There was information displayed around community hospitals about tissue viability and ulcer prevention.

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.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff completed mental capacity assessments with patients for specific decisions, such as a decision to go into a care home. The first page of a patient's shared care plan was dedicated to mental capacity assessments.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff completed mental capacity assessments on pro formas which included the five core principles of the MCA. Staff repeated information back to patients when they had made a decision to make sure they had understood.

When patients could not give consent, staff made decisions in their best interests, taking into account patients' wishes, culture and traditions. Staff completed mental capacity assessments and a record of actions taken to make a best interests decision, with registered nurses and recorded these in the patient's care records.

Staff made sure patients consented to treatment based on all the information available. Patients were given information about the flu vaccine and this information and their decisions were documented in their care plans.

Community end of life care

Staff clearly recorded consent in the patients' records. Staff recorded consent on a 'non compliance' template if a patient disagreed with a medical decision and staff assessed that they lacked capacity. The form prompted staff to carry out a best interests decision which identified the patient's preferences, to identify goals and to consider all the risks.

All staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. However, Mental Capacity Act training was not classed as mandatory training by the trust. This training was classed as 'essential to role' training and so covered in induction.

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

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. In community hospitals, patients' Deprivation of Liberty Safeguards documents were completed correctly and printed out at the end of their beds.

Staff could describe and knew how to access policies and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Community mental health nurses visited teams to discuss the Mental Capacity Act with teams if they needed any support around assessing patients' capacity.

Managers did not always monitor how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding.

Compassionate care

Patients were truly respected and valued as individuals and were empowered as partners in their care.

Feedback from patients, those who were close to them and stakeholders was continually and overwhelmingly positive about the way staff treated patients. Patients and carers said that staff went the extra mile and the care they received exceeded their expectations. For example, staff sprinkled bird seed on the window ledges at one of the community hospitals so patients could enjoy watching birds feed close to their beds. Staff surrounded a patient with things that were important to them when they died. For example, staff hung an artist's favourite pieces of work around them on the walls of the ward when they were approaching the end of their life.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Relationships between patients, those close to them and staff were strong, caring and

supportive. These relationships were highly valued by staff and promoted by leaders. Patients and carers were overwhelmingly positive about the care offered to the patient and carers. Patients said that staff were very respectful, asked what they wanted and what was important to them. They said they did not interfere and stopped unnecessary treatment such as turning. Patients said they felt safe and well cared for on the wards in the community hospitals.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff held multi disciplinary meetings to discuss the care and support needs for complex patients who required additional professional input. During these meetings, staff spoke with the upmost respect and understanding.

Staff recognised and respected the totality of patients' needs. They always took patients' personal, cultural, social and religious needs into account. During lockdown, when visiting relatives was restricted, staff directed relatives to a window where they could reach through and hold their dying relative's hand as they passed. Staff knitted hand crotched hearts that patients held when they passed away which were then given to their relative if they could not visit them. Staff gave children of dying relatives a 'worry' teddy bear that they could take away with them. Staff gave hand crafted material tote bags to family members to put their personal belongings in when they died, so they had something more dignified than a plastic bag to carry their belongings in when they left the ward.

Emotional support

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

Patients' emotional and social needs were highly valued by staff and were embedded in their care and treatment. In the community hospitals, relatives could stay in an overnight family room when their relative was approaching the end of their life. Staff supported family members discreetly and without question so they could spend the most amount of time with their loved one. For example, staff supported a relative with a leg dressing so they did not have to leave their dying partner to attend an ulcer clinic at another hospital.

Staff supported patients who became distressed in an open environment, and helped them maintain their privacy and dignity. Staff booked double appointments when they needed to have important conversations with family members about their dying relative. Staff made sure there were two staff on a visit when children were involved.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff had access to training on having important questions with patients and carers. Staff made sure there were two staff around to deliver difficult news to the families of a dying relative.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff placed an image of a hummingbird on the door of a patient who had just died so the family were not unnecessarily disturbed. Staff put a symbol of a red teacup on the door of a patient who wanted tea during the tea round but didn't want to be asked each time.

When patients or carers rang in to the community team out of hours, call handlers informed them where they were in the queue to help manage their expectations.

Community end of life care

Understanding and involvement of patients and those close to them

Patients and carers were active partners in their care. Staff were fully committed to working in partnership with patients and making this a reality for each person. Staff always empowered patients to have a voice. They showed determination and creativity to overcome obstacles to delivering care. Patients' individual preferences and needs were always reflected in how care was delivered.

Staff made sure patients and those close to them understood their care and treatment. During lockdown, staff made sure patients had access to digital tablets so they could make and receive video calls from their families. Staff respected patients' choices and preferences. This was documented clearly on patient notes. A patient's preferred place of death was recorded in their notes.

Staff carried out risk assessments for the inclusion of patients and carers in the administration of medication for common end of life symptoms. Staff assessed the patient or carer and reviewed their competencies during follow up checks.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. Staff held discussions with carers about what support they needed. Carers said that staff had good listening and negotiation skills. Staff gave age appropriate leaflets out to families about end of life information.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. In community hospitals, there were patient experience feedback boards displayed in communal areas. Compliments were emailed to the patient experience team so the trust could collate all positive feedback.

Staff supported patients to make advanced decisions about their care. Staff supported patients to complete ReSPECT forms themselves.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service. A post bereavement survey was linked into the end of life care plan. Carers completed an end of life care evaluation form when their relative passed away. Staff attended funerals to talk to and support relatives. The trust had a patient experience team who were able to discuss any concerns with relatives and resolved at a local level. There were leaflets about how to raise a compliment and a complaint on the wards in community hospitals.

Is the service responsive?

Good

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

Service delivery to meet the needs of local people

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

Community end of life care

Managers planned and organised services so they met the needs of the local population. End of life services were available to patients in a community hospital or in their own home. Children's community services were also provided to children who were dying at home by the children's community nursing team. Children from birth to 18 years old were supported. Children were usually supported by nurses in the community following a referral from hospital.

Facilities and premises were appropriate for the services being delivered. There were relatives' rooms between wards in the community hospitals. Staff could also bring in riser recliners and fold away beds for relatives which were risk assessed according to the individual.

However, there were no commissioned end of life rooms in any of the community hospitals.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. Staff had access to the crisis team and mental health team. The mental health team were invited to multi disciplinary team meetings. Teams had access to the complex care at home team which was based in the mental health team. The consultant and registrar in psychiatry met once a month.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff had access to the specialist palliative care team at their local acute hospital. Gloucestershire had a 'Your Circle' website which signposted patients to services they may need.

Managers ensured that patients who did not attend appointments were contacted.

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.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff working in the community hospitals worked with district nurses to support patients to go home to die if that was their choice. Patients' preferred place of death was documented in their care plans.

Wards were designed to meet the needs of patients living with dementia. In the community wards, staff put a purple butterfly above the bed of patients with dementia. There was a red doorframe for the toilet and red plates and cutlery.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff also supported patients with learning disabilities with a hospital passport.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Patients had access to multi lingual staff and an interpretation service from the trust. There were adaptations in place for people with hearing loss.

The service had information leaflets available in languages spoken by the patients and local community.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Community end of life care

The visiting chaplain service had been suspended in hospitals during lockdown. However, patients could request a visit and staff would help arrange a chaplain to come into a hospital or visit someone at home.

Access and flow

Patients could access the specialist palliative care service when they needed it. Waiting times from referral to achievement of preferred place of care and death were in line with good practice.

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets. End of life referrals into a community hospital or district nurse team came through a single point of access. End of life patients were prioritised especially if they were within the local area. The service accommodated out of area patients. Staff were able to transfer some patients to other hospitals to make room for end of life patients. Demand, capacity and patient flow were managed through a bed management team. Patients could be fast tracked into the service. Community nurses sent out 'just in case' boxes to patients if they wanted to die at home.

Patients in the community were triaged and placed on a central ledger by call handlers. Call handlers inputted data onto a monitor board so they could view and review where calls were coming in from. Staff worked out of hours to triage referrals and co-ordinate night visits. Referrals came in from 111, out of hours GPs, patient and carers. There were more 111 calls at the weekend when patients found it hard to get hold of their GP. The district nursing team could see urgent referrals which were colour coded to indicate how urgently they needed to be seen.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Patients who wanted to die at home were fast tracked and staff made sure there was equipment in place so they could be safely discharged home. However, a lack of available carers in the community meant that some patients who had applied for continuing health care funding did not have a care package in place before they died.

Night staff had access to pool vehicles so they could travel longer distances to see patients out of hours.

The service moved patients only when there was a clear medical reason or in their best interest.

Staff did not move patients between wards at night.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

There were no delayed discharges with end of life care patients.

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.

Community end of life care

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Managers held a complaints spreadsheet for their teams. There was evidence of duty of candour being used. Complaints were on the agenda for Primary Care Network meetings and Gold Standard Framework palliative care meetings.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. However, complaints did not have an actioned date or described how the learning was shared.

Managers shared feedback from complaints with staff and learning was used to improve the service. The patient advice and liaison service (PALS) team contacted the end of life lead when there was a complaint for this service, who visited or phoned the person to understand their concerns. The learning from events team worked with the end of life quality group. This included experts by experience who were relatives of patients who had passed away.

Staff could not give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good

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

Leadership

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

Staff described accessible, visible and approachable leaders. Staff on the wards said they knew the senior management team. The Director of Nursing visited end of life patients on Christmas Day last year. The Deputy Director of Nursing visited staff to facilitate debriefs to the teams if there was a complex patient, a complaint or an incident.

Managers on the community wards walked around the wards and said hello to all the patients before they started their shifts. If there was anything missed or needing to feedback to staff, managers were able to spot this quickly.

Specialist leads managed their own teams.

The end of life lead met with team managers monthly.

Managers undertook leadership modules which were a requirement for their role. The trust provided further leadership training for all managers.

Vision and Strategy

Community end of life care

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.

There was an end of life work plan which included education of staff, managing complaints and shared care plans. The trust had an organisational strategy which included end of life care provision. 'One Gloucestershire' embedded this strategy which included dignity, peace, communication and respect for end of life patients. All staff were able to access this strategy on the trust website.

However, working with children at the end of their life was not included in clinical procedure policy and guidelines around end of life were adult focused, including syringe pump training.

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 staff from different cultures working within the community teams. Staff worked hard to build a relationship and rapport with families to understand their needs.

Following a high number of deaths in one area, the Deputy Director of Nursing visited the team and carried out a full debrief with the team. The Deputy Director asked staff about what individual support they needed.

Staff had access to a freedom to speak up guardian, a 24 hour staff help line and other wellbeing information such as 'it's ok to talk'.

Community hospital managers challenged language used on the ward to eliminate any bias and maximise the respect shown to patients. In Cirencester, there was a 'mind your language' board on display.

Staff had access to counselling and clinical psychologists conducted support sessions. The team felt that they were supported throughout the pandemic. Staff said they felt they could express themselves in team briefs.

Managers showed compassion to teams who had lost members of staff over the pandemic. Staff held services for the family members, raised funds for the family to go on holiday, made a plaque for the staff member, attended the funeral and in one case, put solar lights in the hospital garden which matched ones purchased for the family so the deceased staff member could be remembered at work and at home.

Psychologists were brought in to team meetings for staff to explore their health and wellbeing. Staff could request mindfulness sessions. Therapists offered coffee mornings. Nurses had a protected half hour weekly to join online palliative debriefs. The local palliative care support team had a link in each area and worked with specialist GPs and consultants.

Community end of life care

Teams held staff awards and celebrated success. Staff described strong supportive teams with a dedicated and passionate outlook.

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.

Since our last inspection, where we identified that a lack of processes to capture the effectiveness of end of life care meant there was not sufficient information to enable leaders to understand performance in this area, the trust had set up a mortality review group. The mortality review groups reviewed deaths on the trust's incident reporting system and met with multi disciplinary teams to examine post death learning. This led to a ward debrief and discussion around where there was learning and room for improvement. The mortality review group met regularly with matrons, medical examiners and heads of medical and clinical care. These meetings were minuted and action logs were produced.

Issues arising out of ward meetings were escalated to clinical governance meetings, which were then taken to community hospital governance meetings, directorate governance forums then cascaded back to the teams.

Since our last inspection, the recruitment of a medical examiner had enhanced the reporting process and helped look at learning which included feedback from relatives, questionnaires, learning from the respect audit and the national end of life care (NACEL) audit. The end of life lead attended monthly governance meetings. End of life care templates on the trust's shared electronic database had been amended to capture information about patient's preferred place of death and anticipatory medication.

Community hospital teams had contributed to a ReSPECT form audit in November 2021 but had not received the data back from it. Community nursing teams had not heard of the NACEL audit and did not contribute to it.

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.

Managers contributed to a hospital risk register which could be escalated up to the trust risk register. Managers completed a daily situation report for staffing and RAG rated their team. This was a live document which the senior management team could access to look at score of each team. The document identified where the staffing gaps were for that day and how many end of life patients there were which meant additional staffing was required.

Managers joined an online 'issues' chat where they logged concerns that did not constitute an incident. Managers shared an example of how useful this chat was during recent storms when teams could check in with each other across the region to make sure they were ok.

Managers were working with central recruitment to review job roles, work with social media and attend student fayres.

In community hospitals, the ward's quality dashboard was updated and on display for all to view.

Community end of life care

Information Management

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

Not all staff were able to access all clinical systems. Managers were in a working group to decipher the best way forward and the best system to use. Staff on hospital wards did not have digital tablets. They had to work from work stations on wheels (WOWs). Managers had put in funding requests for a digital tablet on every ward.

Wi-Fi was inconsistent on the hospital wards and connectivity was a challenge for community district nurses. Some teams stored an emergency laptop that could print off all the medication prescriptions for each patient should the Wi-Fi go down. Staff also held paper admissions books with each patient's next of kin details so they could contact them in an emergency.

Managers ran an end of life daily report which identified all end of life patients across the county. Over the pandemic, teams set up live channels to save spreadsheets. The SHREWD report risk rated each team's weekly staff capacity. The report looked at how many registered and unregistered staff there were on shift, whether they were working from home or on shift, any urgent nursing requests and how many end of life patients there were per day in each patch. This helped managers understand what the workload would be like each day. Managers met before the weekend to discuss how many syringe drivers were needed over the weekend and how many staff were needed for end of life care. Teams normally had between 40-50 cases each day. So, if managers looked at the report and saw there were over 50 admissions, they knew there would be an impact on demand. The report looked at the skill mix across the county and moved staff around if required.

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.

An end of life quality forum cascaded information to teams working in community hospitals or district nursing teams.

Staff contacted a patient's GP when they died along with their palliative care nurse and any other agencies so they were all aware.

Staff invited the families of patients who had died on a community hospital ward to come back and visit the nurses who cared for their relative.

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.

Community end of life care

The trust had set up access to a culture app for staff which described religions and cultures, food and drink, calendar dates, communication and end of life considerations.

Community teams developed a feedback tool based on weekly gold standard framework meetings. This was developed after nurses gave feedback that they felt unprepared for some visits which ended up in crisis. The tool went through the 'plan, do, study, act' (PDSA) cycle and was risk rated. The aim was to give nurses more information about a palliative patient. As a result there was an end of life holistic communications register which was added to the nurses' online team group.

Community health inpatient services

Good

Is the service safe?

Good

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

Mandatory Training

The service provided mandatory training in key skills to all staff however not all staff were up to date with this training.

The mandatory training was comprehensive and met the needs of patients and staff. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Each ward we visited had a dementia lead nurse and dementia link workers.

The trust target for staff mandatory training was 90%. All training other than Safeguarding Adult and Children Level 2 and Level 3, Resuscitation Level 3 and Moving and Handling training met this target.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers we spoke with told us some training compliance rates were low due to staff being on long term sickness or maternity leave.

Safeguarding

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

Staff received training specific for their role on how to recognise and report abuse. Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff followed safe procedures for children visiting the ward.

Staff knew where to find information on safeguarding and knew how to recognise abuse and to raise concerns. The trust had a head of safeguarding and named nurses for safeguarding on each ward. We observed a good example of a safeguarding response where a patient had a pressure sore. Staff reported this to senior staff and a safeguarding alert was made to the local authority. The team discussed developing a care plan focused on specific issues to manage pressure sores.

Cleanliness, infection control and hygiene

Community health inpatient services

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

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection. Staff regularly washed and dried their hands; hand sanitisers were available in communal areas and by patient bedsides. Staff also ensured regular, thorough surface cleaning took place in all communal areas. Infection prevention and control formed part of the trust mandatory training and staff we spoke with at the time of inspection were compliant with this training.

All clinical areas we visited were visibly clean and tidy and gel dispensers and hand washing facilities were available. Treatment rooms had waste disposal bins for non-clinical and clinical waste and sharps containers were not overfilled. Arrangements were made for hazardous and non-hazardous material to be segregated and disposed of in accordance with the trust's policy for the safe handling and disposal of health care waste.

Each ward had an infection control link nurse who was able to attend training and study sessions to support the ward with infection control issues. The wards also had access to the trust infection prevention and control team for advice and training on all infection prevention and control related matters. Various aspects of infection prevention control techniques, such as hand washing, were audited monthly.

Across all the services we visited, staff washed and sanitised their hands before and after contact with patients. All staff had access to personal protective equipment such as aprons and gloves and used them appropriately. Staff complied with the trust's policy and national guidance about being bare below the elbow when providing care.

The infection prevention and control nurses attended the "Matrons Walkarounds" along with facilities and estates managers whereby they walked around the wards. During this walk around issues were reported and the matrons escalated these to the Matrons Governance Committee.

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.

The trust had processes and systems in place that ensured people received equipment in a timely fashion. Managers told us that if a patient had identified equipment requirement such as bariatric beds and hoists; these were ordered once referral had been accepted prior to admission. Managers also told us they worked closely with the Rehabilitation and Re-enablement team who had an equipment store with a range of essential transfer equipment including basic wheelchairs, commodes, and toilet aides and provided cover seven days week. We found that staff knew how to obtain equipment out of hours and at weekends.

During the inspection we visited four wards and checked a range of equipment items. Not all items that we checked were within date. For example we saw a portable suction machine and thermometer were out of date at Abbeyview ward. These were brought to the attention of the manager and were removed immediately. We also checked resuscitation bags on all the wards we visited. These were all sealed and tagged. Staff carried out a weekly check of the resuscitation bags and oxygen bags.

Patients could reach call bells and staff responded quickly when called.

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

Patients who required mobility equipment, home adaptation equipment and pressure-relieving equipment upon discharge were supplied these through third party suppliers, who were responsible for servicing and delivering equipment to patients at home.

Staff disposed of clinical waste safely.

Assessing and responding to patient risk

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

Comprehensive risk assessments were carried out for people who used the services and risk management plans were developed in line with national guidance. These were assessed, monitored and managed appropriately.

Staff completed a 72 hours post admission checklist. Teams discussed and reviewed patients through a daily ward round meeting. This meeting was a platform whereby members of the multi-disciplinary team met and discussed the care, process and plans for patients. We observed two ward round meetings . The issues discussed included: unusual patient behaviour; blood sugar results; falls risks; patients that required manual handling with a minimum of two staff; equipment issues; medication and prescriptions; care plan reviews including the impact on the family; tissue viability referrals; and a full review of all patients requiring insulin.

Staff used appropriate guidance and tools to assess patients. We saw the use of the Situation, Background, Assessment, Recommendation approach (SBAR approach) which was used for all patient assessments together with a confidential team board detailing patients' national early warning score. (The NEWS2 tool was developed by the Royal College of Physicians to improve the detection and response to clinical deterioration in adult patients and was a key element of patient safety and improving patient outcome.)

In addition, the SBAR considered patient acuity; Malnutrition Universal Screening Tool (MUST) assessment; risk stratification; referrals; psychiatric and mental health assessment; Waterlow chart score for assessing the risk of acquiring a pressure ulcer; bowels; mobility; and resuscitation status.

The trust had a sepsis policy which was in date and based on NICE guidance. Staff we spoke with understood sepsis and how to assess the risk.

Staff were attentive to the risk of pressure ulcers.

Staffing

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

Nurse staffing

While each location had vacancies for health care assistants, we saw the service had a flexible workforce to ensure there were enough nursing and support staff to keep patients safe. Agency and bank staff were used where vacancies existed. Managers told us there was a continued cycle of nursing recruitment for vacancies, including recruitment of international nurses. Rosters were completed at least six to eight weeks in advance. This enabled managers to identify if there were unfilled shifts so this could be escalated, and mitigations put in place. We looked at staff rotas and saw the number of nurses and healthcare assistants matched the planned numbers. Staff told us staffing levels were pressured during the Covid-19 pandemic with staff working extra hours to ensure patient safety.

Managers accurately calculated and reviewed the number and grade of nurses, healthcare assistants and therapists needed for each shift in accordance with national guidance. There was a process for reviewing the required numbers and skill mix of staff needed to safely provide patient care.

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

Medical staffing

The service had enough medical staff to keep patients safe. Each ward we visited had a General Practitioner (GP) who visited the wards daily and a consultant who visited the wards once a week. The medical staff matched the planned number.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and reviewed this regularly. The service always had a consultant on call during evenings and weekends.

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.

The provider had an electronic care record system for patients' records. Prescription charts and some documentation such as treatment escalation plan forms were paper based and stored in patient's bays. We reviewed paper and electronic care records of 28 patients. These were complete and managed in a way that kept people safe.

Patients' notes contained a NEWS2 sheet, MUST sheet, care plan, drug administration record, pressure area care plan and information and a patient satisfaction survey. Although we found that therapy care plans were detailed, patient centred and goal oriented, the nursing and medical care plans were generic and lacked patient involvement. We found that staff were not completing detailed records for pain assessments and care plans were not complete for pain management.

The trust's resuscitation policy stated that the overall responsibility for making a do not attempt cardiopulmonary resuscitation (DNACPR) decision rests with the senior medical clinician. In the care records we reviewed which contained these forms, they were countersigned and there was evidence of a review by the patient's consultant.

Medicines

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

The organisation used systems and processes to safely prescribe, administer, record and store medicines. Medicines were prescribed by a doctor or the advance nurse practitioner. A GP and the advance nurse practitioners were responsible for prescription of medicine. Each ward had access to pharmacists who attended the ward and monitored medicines management. We saw evidence of pharmacist input to patient care and treatment and where possible pharmacists attended ward rounds and handovers. Pharmacy professionals visited the wards regularly and completed audits of prescription charts, discussing the outcome of audits with ward staff.

Staff were assessed as competent in the safe administration of medicine and there were a range of training courses available for staff to develop those competences. Staff recorded the administration of medicines in line with the trust policy.

Staff followed current national practice to check patients had the correct medicines. We saw evidence that staff administered medicines safely to patients. We checked records and noted that nursing staff checked blood sugar levels before giving insulin to patients in line with practice recommendations.

In preparation for discharge from hospital, staff worked with patients and families to support them with self-management of their medicines in the community. Staff provided patients and carers with a medicines prompt sheet on discharge.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Although staff told us they completed temperature checks for fridges and the clinic room; we saw that the fridge used to store medicines at Peakview ward and at Stroud Community Hospital were over the maximum range for nearly a month. This was escalated to the matrons and assurances given to address this.

Incidents

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

All staff knew what incidents to report and how to report them. Staff we spoke with told us there was a good learning culture and staff were actively encouraged to report incidents to support learning and improvement. Staff raised concerns and reported incidents and near misses in line with the provider's policy.

Staff understood the duty of candour. Duty of candour is a general duty to be open and transparent with people receiving care. Staff were open and transparent and gave patients and families a full explanation when things went wrong. Staff demonstrated a clear understanding of the duty of candour and discussed how they would be open and honest with patients.

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

Community health inpatient services

The trust kept a record of incidents related to pressure ulcers. This included the category of ulcer and whether the patient was admitted with the pressure ulcer. Ward managers submitted notifications to the Care Quality Commission and local authority safeguarding team for all patient pressure ulcers that developed while the patient was receiving inpatient care that were category 3 and above.

Is the service effective?

Good

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

Evidence-based care and treatment

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

The service provided care and treatment based on national guidance. Each ward had access to link nurse specialists, including specialist teams for continence, wound management, manual handling, risk and infection control. Staff in these roles accessed training and attended meetings to ensure they had up to date knowledge in these areas. The trust had a National Institute for Health and Care Excellence (NICE) assurance lead who disseminated relevant guidelines and updates to the wards. The trust had developed its own policies and these were based on guidance from NICE.

Nutrition and hydration

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

Staff gave patients enough food and drink to meet their needs and improve their health. Patient's nutrition and hydration needs were assessed and met. Patient's food and fluid intake was monitored during their first three days of admission and reviewed regularly thereafter. Staff used the malnutrition universal screening tool (MUST) for all patients and we saw that these were completed in full and necessary action taken when issues were identified.

Speech and language therapists (SALT) attended multidisciplinary team meetings and regularly visited the wards to review patients. SALT team members provided support to people who had speech, language, communication or swallowing difficulties. Patients who experienced difficulties in any of these areas had comprehensive risk assessments and care plans in place.

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 and monitored patients regularly to see if they were in pain. However staff were not using a pain assessment tool to document the assessment and management of pain. We saw evidence of staff discussing pain with patients and taking action to reduce this. Nursing staff discussed patient`s pain with doctors during the morning ward rounds; the doctors would review the patient and pain relief medications.

Patient outcomes

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

Managers monitored the effectiveness of care and treatment and used the findings to improve them. Managers monitored outcomes through national and local audits. This included monitoring results of safety thermometers, hand hygiene audits and friends and family tests. The wards carried out a number of local audits that demonstrated use of audit as a tool for improvement and safety. These included: annual programme of infection control audits, antimicrobial prescribing audit, record keeping audit, medicines management audits.

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 skilled to meet the needs of patients. New staff had an induction before they started work to prepare them for the role they were employed to undertake. Supporting staff told us there was a lack of progression for them. Staff had the right skills and knowledge to provide safe care and treatment for patients. However, some staff explained that training was not a priority when busy and the training sessions were often delayed.

There were varied levels of supervision to support staff. Managers told us they had commenced regular supervision which was confirmed by staff. Staff did not always receive regular appraisal by their managers. Appraisal had been impacted by the increased demands of the Covid-19 pandemic. Managers told us they had recommenced staff appraisals, and this continued to be a work in progress.

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.

All members of the multidisciplinary team worked together to provide care and benefit patients. Patients received care and treatment from a range of health care professionals which included doctors, occupational therapists, physiotherapists, registered nurses, nursing assistants, pharmacists, social workers, and speech and language therapists. All members of the multidisciplinary team attended weekly meetings with patients and daily goal setting and safety briefings. Staff told us they worked well as a team and patients and carers agreed with this. There was a collaborative approach to assessing patients' needs, setting individual goals and providing patient-centred care.

Nursing and therapy staff met daily to discuss patient needs and identify therapy goals that nursing staff could support with. We observed multidisciplinary meetings and noted these to be collaborative, with patients' and carers' thoughts and preferences being considered. Nursing and medical staff told us they assessed patients' needs holistically and worked with patients to identify goals and interventions to work towards recovery.

Community health inpatient services

The wards completed a daily ward round where the staff team discussed daily goals with patients. The wards had social workers and discharge coordinators who supported the team by identifying potential discharge accommodation and packages of care. Where the team could not meet patient needs, referrals were made to other specialist departments. This included an in-reach diabetes team and mental health liaison teams.

Health promotion

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

Staff assessed patient's health and wellbeing on admission, including smoking status and alcohol consumption. Staff offered patients support as necessary and some staff had completed smoking cessation training. A dietitian was available to attend the wards and provide health promotion in relation to obesity. We saw staff had supported a patient with safe alcohol withdrawal alongside rehabilitation on Peakview ward.

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.

There was a clear policy on the Mental Capacity Act. Staff knew how access the policy and they had a good understanding of the five principles. Patients' capacity to consent was assessed during their admission and recorded in their care records. We saw staff talking with patients and obtaining consent when providing care. We heard staff asking patients for their understanding of the care to be given.

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

Staff implemented Deprivation of Liberty Safeguards (DoLS) in line with approved documentation. We saw evidence of this on Coln ward where staff had applied for and were awaiting the outcome of a DoLS authorisation on behalf of a patient who lacked capacity to consent to their admission.

Is the service caring?

Good

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

Compassionate care

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

Community health inpatient services

Most of the thirteen patients we spoke with told us staff treated them with respect, kindness and maintained their dignity. Staff took time to listen to patients and were responsive to their needs. Most patients felt safe on the wards and told us that staff maintained their privacy when providing personal care and discussing their treatment. Staff used curtains to maintain privacy in bay areas and used bathrooms, where possible, to provide personal care.

Carers we spoke with told us that staff interacted with them and patients in a sensitive and supportive manner. Patients told us they felt 'lucky' to be on the wards and staff were supportive in encouraging them to achieve their goals and become more independent. Staff felt able to raise concerns about disrespectful, discriminatory or abusive behaviours and attitudes.

We observed staff assessing and discussing patients' psychological health, discomfort levels and pain in a compassionate and timely way. Patients told us that staff were interested in their wellbeing and responsive to their needs. Staff were perceptive to changes in patients' presentation and discussed changes in team meetings.

Emotional support

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

The organisation met patients' religious needs and patients could request visits from religious leaders of their choice and access religious items. Staff supported patients who were well enough to attend their place of worship such as the multi-faith room and chaplaincy service as required. Staff showed an understanding of patients' personal, cultural and dietary needs, and ensured these needs were met.

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 used different techniques to communicate with patients to ensure they understood their care and treatment. This included using pictures and accessing interpreters. We saw evidence of staff using different communication techniques to encourage patients who had difficulty interacting or communicating with staff on Peakview ward. We also saw the use of simple pictures and a writing board being used for patients with non-verbal communication.

Staff were compassionate and supportive with patients who declined support and treatment from staff. Patients and those close to them were involved in daily multidisciplinary meetings. During this meeting patients were involved in goal setting and planning towards discharge. Patients were aware of the goals of their treatment and felt supported to achieve these.

Is the service responsive?

Good

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

Community health inpatient services

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.

The trust and managers were able to advise us how they worked with commissioners of care and external providers such as the general hospitals, care homes and other voluntary agencies such as Age UK to plan and develop services to meet the needs of local people. For example, the manager on Abbeyview ward had trialled a sub-acute pathway for patients. Prior to this, patients were transferred to the local general hospital for treatment of ailments such as chest infections. Being able to offer a sub-acute pathway meant that less patients were transferred to another hospital for treatment.

There were clear admission criteria for services and the organisation worked well with the local acute hospital and GPs to ensure smooth care pathways from acute services and the community. Referrals from the local acute hospital were triaged and assessed by the ward team before admission. Local GPs referred patients directly to the ward and ward staff assessed the referrals. Admission criteria included a need for rehabilitation and identifiable admission goals. The ward teams ensured patients were medically fit for rehabilitation before admission.

Managers signposted patients to alternative services if their needs could not be met by the wards. For example, managers signposted patients from the community to acute services for investigation if the medical cause for their rehabilitation need had not been investigated.

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.

Staff engaged with and were responsive to patients in vulnerable circumstances. There was access to specialist link nurses and teams, from within the organisation and external providers, such as dementia nurses and a mental health liaison team. Staff engaged with the relevant specialist link nurses and teams to improve the care provided. Staff collaborated with workers from other teams involved in patient care, such as mental health teams and social workers, throughout decision making and discharge planning.

Managers could access translation and interpretation services and we were provided with an example of interpreters regularly attending the ward rounds for a patient whose first language was not English. Speech and language therapists and staff developed techniques and methods to communicate with patients who could not communicate, such as using pictures, writing on whiteboards and use of electronic translation devices.

Wards were accessible and contained the necessary equipment to provide care for patients in wheelchairs or with mobility issues.

The trust had a chaplain available to visit patients, and staff supported patients to access religious places of worship or receive visits from religious leaders during their admission.

Staff were respectful and mindful of patients' wishes relating to their visitors.

Access and flow

Community health inpatient services

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

Staff were aware of the admission criteria, which was adults over the age of 18 who required rehabilitation and were fit enough to partake in therapy. Referrals from the local acute service were triaged by senior staff and placed on a list for assessment which was accessible to the acute team and the trust's staff. Managers were able to review the number of patients on the waiting list, how long the patient had been waiting and whether there was a delay in admission.

The trust had an agreement in place with the local acute service that they would accept all referrals when there was a bed crisis within the acute trust and for sub-acute patients. The wards were able to flex their criteria to accommodate as many patients as possible and support patient flow in the system as needed.

When patients were referred from another ward, staff ensured they were transferred with their medication, medication charts and relevant information such as treatment escalation plans. The ward doctors reviewed and transferred this information to the trust's documents when completing admission paperwork for patients. The organisation used a computer system allowing acute trusts, GPs and social care to see essential information extracted from patient records in real time. In turn the trust was able to view essential information from these organisations. This enabled access to referrals, test results and outcomes.

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.

The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with all staff. Patients and carers were aware of how to make a complaint and felt comfortable to do so. Leaflets and information were displayed on the wards which explained how patients could complain. The wards dealt with concerns and complaints appropriately. Formal complaints were reviewed by the central complaints team. They were investigated by managers and lessons learned from the outcomes of complaints were fed back to staff.

Staff received feedback through emails, at handover meetings and team meetings. However, none of the wards could provide examples of learning from complaints that had resulted in improvement in care.

Is the service well-led?

Good

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

Leadership

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

Community health inpatient services

Managers at all levels had the right skills and abilities to run a service providing high-quality sustainable care. Staff spoke positively about their ward managers and locality senior managers. Staff felt supported by their managers and able to raise any issues or concerns. Managers had the skills, experience and knowledge to undertake their roles effectively. Managers had the opportunity to undertake leadership training. Staff and managers were aware of who board, and senior members of the trust were. Staff told us that board members and directors were visible and accessible.

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 had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The vision and strategy had been developed in consultation with staff, patients and other stakeholder groups. Staff knew where to find the vision and strategy and agreed with it.

Culture

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

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Morale amongst most staff was good and staff felt supported through challenging times on the wards, such as when staffing levels were low. However staff morale at Peakview ward was low. Staff attributed this to the recent Covid-19 outbreak and when staffing levels were low.

The trust had processes and procedures to ensure staff met the duty of candour. Training was included in the corporate induction and further training was available for senior staff. Incident forms prompted staff to ensure they had met the duty of candour with incidents. Staff told us there was a 'no blame' culture, and all incident investigations were approached in terms of how to learn and improve practice.

Staff knew how to speak up and where to access the Freedom to Speak Up policy. The Freedom to Speak Up Guardian was advertised around the trust including a dedicated page on the intranet. There was an emphasis on development and staff were encouraged to engage in training and personal development opportunities.

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 trust used a systematic approach to continually improve the quality of its services and safeguard high standards of care by creating an environment in which excellence in clinical care would flourish. The trust provided a governance

framework through meetings at team and management level. There were systems in place to ensure monitoring of services and appropriate action taken to make improvements. The information gathered was used to manage quality and performance. Matrons and managers attended the monthly local managers meetings and ward performance reviews. Ward managers created reports on key performance indicators and developed action plans to meet any areas of concern.

Data to inform key performance indicators were collected for infection control, audits, appraisals, supervision sickness, training and admission data collection. Staff undertook audits at ward level in a number of areas such as infection control, hand hygiene and mattresses. Ward staff created effective action plans to respond to audit outcomes.

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 trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The trust had a risk register and wards had a local and ward based risk register. Managers regularly reviewed their local risk register and could add to this. The trust had contingency plans for when the service could be disrupted, such as through adverse weather.

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.

Staff had access to enough computers to undertake their roles. Computer systems were secure and staff had individual passwords to access the systems. Managers had access to information that told them about the individual unit's performance, including incidents, supervision and training data. The trust used an electronic record system that could be accessed by GPs and other relevant agencies, such as district nurses.

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.

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. Managers attended locality meetings between other agencies such as the council, acute trust and GPs. The trust completed staff surveys and made improvements based on these results, such as increasing board member presence on the wards. Patients and carers were encouraged to participate in surveys, including the family and friends test. The trust engaged with local volunteer services and charities which had led to volunteers visiting the wards to provide befriending services on the ward and following patients' discharge.

Learning, continuous improvement and innovation

Community health inpatient services

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.

There was a real drive for quality improvement projects. We saw that following a period of tutoring, ward level staff were taking on quality improvement projects to benefit patients on the ward, based upon the trust`s main objectives. This included improvements to the multidisciplinary team meetings with the introduction of daily ward rounds, handover paperwork, harm free care, falls prevention work and work to promote hydration and reduce dehydration amongst patients. Staff explained how the quality improvement project around fall prevention helped them to identify the time and place of patient`s fall. This enabled staff to identify trends in patient`s falls, for example after visiting time or in the evenings. Staff and managers were able to use this data to respond to the trend in falls and made staff more available for patients around the identified times.