Central Surrey Health Limited

Inspection report

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Ratings

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

Central Surrey Health was established in 2006 as an employee owned social enterprise company to provide community healthcare services. The provider employs 1675 staff. When staff have worked for the company for a year, they become co-owners. The core services provided by Central Surrey Health are:

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

Central Surrey Health provides services from 34 sites. The provider delivers NHS community nursing and therapy services for adults living in north west Surrey. These include services into patient homes such as district nursing as well as a wide range of community services in GP surgeries, schools, community health centers, community clinics and community hospitals within north west Surrey.

Central Surrey Health provides NHS children's community health services across Surrey through the Children and Family Health Surrey Partnership.

Community inpatient services are provided at Walton and Woking community hospitals. Each hospital has a 22 bedded ward – Hersham ward in Walton and Alexandra ward in Woking.

Urgent care services are provided at Woking Community Hospital and Ashford Hospital.

We carried out inspections of the four core services provided by Central Surrey Health and a well led inspection. The community health services for adults and community health services for children, young people and families were last inspected in January 2017. This is the first time we have inspected community health for inpatients and urgent care services as a core service. It was also the first time we had undertaken a well-led inspection.

Our findings

We last inspected Central Surrey Health in 2017 and rated them Good.

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

Although Central Surrey Health is not an NHS trust, the word trust is used erroneously in several places in the report as the word cannot be removed from the standardised inspection report template.

We rated Central Surrey Health as good because:

- We rated safe, responsive, caring and effective as good. We rated well-led for Central Surrey Health as good.
- We rated all four core services provided by Central Surrey Health as good.
- Leaders had the skills needed for their roles and understood the services they were providing. The non-executive directors (NEDS) offered the support and challenge needed to ensure the board remained focused on the organisation's objectives.
- The provider had a clear set of values which they had used to underpin the organisation strategy. The board had designed the service strategy to meet the needs of the communities they served. Senior leaders ensured that all stakeholders had the opportunity to influence the strategy and the development of services. Managers ensured services were flexible. The had swapped to virtual appointments where appropriate.
- The organisation had an inclusive and open culture that was patient centred. Senior leaders encouraged staff to innovate and recognised and rewarded the contributions staff made to developing services. Time to Shine awards recognised staff contributions to quality improvement. The provider had engaged patients and other stakeholders to make sure their services met the needs of the local communities.
- There were robust governance systems in place that involved staff from all levels of the organisation. Staff at all levels identified risks, mitigated them and highlighted them across the organisation and wider health community. There were clear pathways for escalating issues to more senior staff including the board. Any identified risk that could not be mitigated by the committee was escalated directly to the board.
- Services had enough staff with the correct training to keep patients and young people safe from abuse. Staff followed infection control procedures and had access to suitable PPE. Staff identified and mitigated risk to patients and recorded this in the patient record. Staff managed incidents well and used any lessons learnt to improve the standard of care the service provided. For example, if staff identified that an equipment part needed to be replaced regularly, they arranged spares for people to ensure their care was not affected.
- The organisation trained staff to ensure they could provide good quality care. There were policies and procedures in place for staff to follow that were based on national good practice guidance. Staff worked well together within their teams, across the providers services and with other care providers.
- Staff respected patients, young people, their families and other carers. They empowered people using their services to be fully involved in their care when appropriate. Staff always treated patients with dignity. Feedback from patients described staff as being caring and professional. The provider collected feedback to help improve services.
- The provider ensured people could give feedback so that staff could plan services to meet the needs of the communities they served. Staff designed services so that people could gain access to the care they needed when they needed it. Staff ensured that patients with the most serious needs were seen without delay.

However:

Our findings

- The provider had not made enough progress against its action plan to address the concerns identified by the Workforce Racial Equality Standard (WRES) report in 2021. For example, forums for black and minority ethnic staff were being set up during this inspection.
- Senior leaders were not sufficiently visible to staff in front line services, which left staff feeling disconnected from the organisation.
- The employee council, called the Voice, was not fulfilling its role to provide scrutiny and challenge to the board and at the time of the inspection they were not sending members to board meetings. However, the provider was working with them to gain confidence in this role.
- In the community inpatients core service, the provider had not ensured there were suitable evacuation plans in place for patients.

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:

• are services safe?

• are services effective?

• are services caring?

• are services responsive?

• are services well-led?

Community health services for adults

The inspection team consisted of one lead inspector, one support inspector and two specialist advisors who were nurses. An expert by experience also spoke with some patients remotely after the inspection.

Before the inspection visit, we reviewed information that we held about the service.

During the inspection, the inspection team:

- visited three community nursing team bases in Woking, Staines, and Weybridge
- visited a complex wound care clinic and podiatry clinic
- visited a Parkinson's disease group
- spoke with nine senior leaders including heads of service, operational and clinical leads.
- spoke with 19 staff face to face and 16 in an online focus group. These included nurses, students, HCAs (healthcare assistants), nurse associates, speech and language therapists, podiatrists, and students
- spoke with 27 patients and families who were using services or their carers/relatives.

Our findings

- reviewed 14 patient care and treatment records.
- observed three shift handover meetings for community nursing teams.
- Observed two staff allocation meetings
- observed 10 schedules of care in patients' homes.
- observed staff providing care to patients in clinic settings.
- held three focus groups to capture staff who were unavailable on the days of the inspection.
- looked at a range of policies, procedures and other documents related to the running of the services.

What people who use the service say

All patients were complimentary of the staff and care they had received from the teams.

Patients described caring and compassionate staff who always had time to listen to them even when they were busy.

Patients knew they were in safe hands and had good outcomes from care they had received.

Some patients described staff as outstanding and like family as they show such concern and go the extra mile to help them.

Patients did not have any complaints but felt able to raise them if ever they did.

Staff were well thought of, and patients spoke fondly about staff and the difference they made to their lives.

Community health services for children, young people and families

The team that inspected the children's and young people service comprised of two CQC inspectors, one CQC medicines inspector (remotely), two specialist advisors, and one expert by experience (remotely). The expert by experience had lived experience as a family carer of a child or young person (CYP) who uses health services. The specialist advisors had experience of health visiting, school nursing and children's community nursing.

Before the inspection visit, we reviewed information that we held about the service.

During the inspection visit, the inspection team:

- Looked at the quality of the premises, community clinics and school nursing environments that we visited
- Spoke with 16 parents and carers and two young people
- Spoke with two associate directors, a service manager, five clinical service managers and four clinical team leaders for the therapy, 0-19 services, specialist community children's nursing, school nursing and specialist school nursing teams

Our findings

- Spoke with 55 staff across the teams including therapy, children's community nursing, continuing care, continence, family nurse partnership, youth offending, immunisation, specialist school nursing, school nursing, nursery nursing, health visiting, safeguarding and administration. These were carried out via onsite interviews as well as virtual staff focus groups where staff could join and give feedback on the service
- Observed a sample of clinical practice and home visits including a new birth visit, tongue tie procedure, enuresis clinic, a school clinic and an Ages & Stages Questionnaire (ASQ) assessment
- Attended a transformation webinar for all staff
- Looked at over 10 treatment records of people including medicines records; and
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

They told us that staff went above and beyond in terms of their flexibility in meeting the needs of children, young people and their families.

Parents and carers told us staff were approachable, supportive and responsive and easy to contact. They reported that staff listened to them and kept in touch, they were knowledgeable and reassuring.

Parents and carers told us they were fully involved in decision making and received regular updates. All parents and carers told us that there was nothing they would improve on.

They all confirmed that there was good communication and that if they needed access to consultants, this was done in a timely way. They also described receiving carers support during difficult times.

Community health inpatient services

Our inspection team comprised two CQC inspectors, a specialist advisor with a nursing background and an expert by experience.

During the inspection visit the team:

- Conducted a tour of both wards to review the environment and observe how staff were caring for patients
- Reviewed eight care records
- Reviewed 12 medicines charts
- Observed a daily board round meeting and an infection outbreak meeting
- Spoke with 17 staff, including a ward doctor, the inpatients service manager, the therapy services manager, the senior matron, two nurses, healthcare assistants, a senior physiotherapist, a management graduate, a discharge co-ordinator, an occupational therapist, a matron, a ward clerk, the therapy team leader and a member of the domestic team
- Spoke with 14 patients
- Spoke with nine relatives
- Reviewed two incident reports and

Our findings

- Reviewed a range of policies and documents relating to the running of the service.

What people who use the service say

People who use the service were unanimously positive about the care they received and the staff. They told us that they were always treated with dignity and respect and that they felt involved in their care. They told us that the staff were very responsive, and that nothing seemed too much trouble. They told us that the hospital was always very clean.

Community urgent care services

Our inspection team comprised of two CQC inspectors.

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- Looked at the quality of the environment and observed how staff were caring for clients.
- Spoke with eight patients and carers.
- Spoke with the clinical leads at both Woking and Ashford walk-in centres.
- Spoke with the service manager.
- Spoke with 10 other staff members: we held two focus groups.
- Observed patient consultation with staff.
- Looked at 10 care and treatment records (paper records as the centres were experiencing a national outage of the electronic patient record system).
- Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that staff treated them with dignity and respect and explained their condition in a way they could understand. Staff had time for people even when they were busy and never tried to rush people.

The well led inspection team comprised of two executive reviewers, one for one day and one for two days, who were executives of NHS trust, one specialist advisor with professional experience in board-level governance, one CQC head of hospital inspection, one CQC inspection manager and two CQC inspectors.

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.

Outstanding practice

Community health services for children, young people and families

- Staff showed outstanding consideration and kindness in their work with children, young people and their families. They recognised the emotional impact on families and proactively offered additional support. They also had staff

trained in baby massage to be able to provide this additional therapeutic intervention. They had professional links with charities that provided families with clothes, shoes, toys and toiletries, as well as advocacy and financial support. They had a peer wheelchair user to provide both practical and emotional support to other young wheelchair users.

- The inclusion team thought creatively about how to reach vulnerable children, young people and families from the local Gypsy, Roma and Traveller communities, asylum seeker and refugee communities. The service worked with all members of the family to identify potential unmet health needs within the family. Children, young people and families with additional needs were signposted to other services to assist including visa support and helping families to learn English.

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. One action related to one service and one action related to the as a whole.

Action the trust MUST take to improve:

Trust wide

- The service must introduce mandatory learning disability and autism training for staff. (Regulation 18 (1) Staffing).

Community health inpatient services

- The service must ensure that evacuation plans are in place that meet the needs of both the environment and individual patients [Regulation 12 (2) (b) Safe care and treatment].

Action the trust SHOULD take to improve:

Trust wide

- The service should ensure that they continue to develop their action plan to address inequalities within the workplace and improve the experience of all staff working for the organisation.
- The service should ensure that the senior leadership team and the non-executive directors have a more visible presence within the services.

Community health services for adults

- The service should ensure they continue with their recruitment programme to employ more substantive qualified nurses across the teams.

Our findings

- The service should ensure communication around their lone working app is made available to all staff across community services.
- The service should ensure they continue to monitor demand vs capacity across their services.

Community health services for children, young people and families

- The service should ensure leaders monitor whether staff are receiving consistent and adequate managerial and clinical supervision and whether this is meeting staff's needs, especially those delivering palliative end of life care.
- The service should reinstate the schedule of routine clinical audits and capture feedback from local review practice where relevant to ensure consistency and quality across the services.
- The service should consider the introduction of mandatory learning disability and autism training for staff, where relevant.
- The service should ensure consent, and capacity of the child or young person is explicitly recorded in care records.
- The service should ensure safe lone working practices are implemented consistently across the teams to ensure staff safety.

Community health inpatient services

- The service should ensure that controlled drugs are managed in line with the provider's medicines management policy.
- The service should ensure that staff have access to dementia training.
- The service should consider alternative places to store the large equipment which is currently kept in the conservatories on both wards.
- The service should consider following up with the stoma nurse from the acute hospital around providing a link nurse.

Community urgent care services

- The provider should address the rates of pay for bank staff and should address the need to use agency doctors as EPs
- The provider should address patient and staff concerns about the safety of the external environment between the walk-in centre and the car park at Woking.
- The provider should ensure that the senior leadership of CSH are more visible, and they understand the issues facing the walk-in centres.

Is this organisation well-led?

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

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they provided.

Our findings

The provider board consisted of the chair, chief executive officer (CEO) and four non-executive directors who have voting powers and nine other executive directors who do not have voting powers. The chair had been in this post since July 2019, and had a variety of experience including military service, working in the private sector in several roles including as a Chief Operating Officer and was also currently the chair of a local acute NHS trust. The non-executive directors (NEDs) had experience as senior leaders in a range of organisations including the finance sector and a wide range of health services. The board also included the Medical Director and Chief Nurse.

The board was going through a period of change as several board members had left and been replaced. The CEO had used this as an improvement opportunity to encourage more integrated working and organised executive development training focusing on enhancing their skills as directors. For example, the provider had worked at developing the quality of papers presented to the boards so more time can be spent scrutinising them rather than clarifying information.

The provider board and senior leadership team displayed integrity on an ongoing basis. We observed both the open and closed board meeting and saw that the provider conducted the meeting in a professional manner. Members of the board provided challenge and scrutiny to ensure that the best interest of people using services was always central to decision making.

The provider ensured that fit and proper persons checks were completed for all board members. The provider followed a process for ensuring all necessary checks were carried out, in line with their responsibilities under the Fit and Proper Persons Regulation. The provider had all the information recorded in an electronic record, which identified what they needed to complete and when. We reviewed these records and found that they were comprehensively completed.

The provider reviewed leadership capacity and capability on an ongoing basis. The board had recently undergone a well-led review from an external auditing organisation and had developed an action plan to address the recommendations. For example, the current NEDs identified that when appointing future NED's, they should look to appoint people with more direct experience in delivering community health services.

The leadership team had a comprehensive knowledge of current priorities and challenges and took action to address them. The provider was actively looking at how it linked up with other stake holders to ensure people using their services achieve the best possible treatment outcomes. For example, they were partners in the Children and Family Health Surrey, which provides services across Surrey.

During the core service inspection staff told us that they did not see senior leaders very often at local services. The board's level of engagement with teams providing services had been affected by the Covid-19 pandemic, this had been recognised by the board and they had plans to reintroduce an ongoing programme of regular visits to front line services.

The service had recently reintroduced the annual staff recognition awards.

The board recognised there was a need to strengthen its succession planning and were looking at how they could identify people with the skills required. Leadership development opportunities were available, including opportunities for staff below team manager level. The provider encouraged staff to take on leadership opportunities and provided training to staff to help them develop their skills. For example, the provider had adopted the Athena programme designed to help develop female leaders.

Vision and Strategy

Our findings

The provider had a vision and set of values with quality and sustainability as priorities. The vision of the provider was to ensure that everything they do, they do with care. The providers values focussed on ensuring they make a difference for not just people using their services but also their families, colleagues, the wider community and partners. The providers values were:

- We care with **C**ompassion
- We take **A**ccountability
- We show **R**espect
- We deliver **E**xcellence

The provider had a strategic plan which prioritised their goals and described how they would achieve them. The board reviewed the plan regularly at board meetings against their progress and if changes needed to be made or goals updated. Their three main goals were to retain their existing services, grow new services that can meet the needs of the NHS and develop their current services. However, the provider recognised that the strategic plan needed to also focus more on development of the services it delivers.

Staff, patients, carers and external partners had the opportunity to contribute to discussions about the strategy, especially where there were plans to change services. Central Surrey Health had an employee-ownership structure which meant that employees could represent their views within the organisation. This gave employees a higher level of engagement with the organisation. There was an employee council known as the Voice which can send members to board meetings and enable the workforce to scrutinise and challenge the senior leadership team. However, during our inspection members of the Voice told us that currently the Voice submitted questions to the board via one of the NED's, this was a decision by the members of the Voice. The provider told us that the Voice's questions tended to focus on employee welfare questions rather than strategic business matters.

The organisation aligned its strategy to local plans in the wider health and social care economy and had developed it with external stakeholders. The trust had planned services to take into account the needs of the local population. As well as being a member of Children and Families Health Surrey the provider was also a member of the North West Surrey Alliance, and Surrey Downs Health and Care which were strategic alliances of NHS, local authority and independent health providers working together to meet the needs of the local community in which they provided services. The provider was developing services to address needs and free up more clinical time. For example, they had developed a phlebotomy service and were about to start a community insulin service. These services were designed to free up clinical time for community nurses whilst still providing a high-quality service to the community it served.

The leadership team was working towards improving their oversight of the strategic development of the organisation. The recent well-led audit had identified a number of areas where oversight should be improved. For example, staff needed to produce assurance reports following the Alert, Advise and Assure model. The board had signed off a plan to address these areas in July 2022.

Culture

Staff felt supported by their local management but not always by more senior leaders in the service. Most staff we spoke to told us that they liked working for the organisation and were positive about their teams they worked in and their line

managers. Staff did not feel they had the same connection with more senior managers, and this view was mirrored in the staff survey conducted in 2021. This meant staff felt they got more support and felt more connected to the local team than the wider organisation, which was also identified in the 2021 staff survey. The board had a plan in place to address this which included increasing the visibility of the executive and non-executive members of the board.

The organisation's strategy, vision and values underpinned a culture which was patient centred. The needs of people using the services were central to the organisation. For example, the community children's and family's teams continued all appointments and visits during the pandemic. The staff decided to work in this way as they felt this was essential to the wellbeing of the young people and families using their services. Staff also continued to offer face to face appointments for adults when needed. Staff we spoke with throughout the inspection process talked positively about their patients and how they would involve them in planning their care.

Staff had mixed feelings about working for the provider. Staff we spoke to during the core service inspection told us they felt proud to work for their teams. However, staff did not report feeling the same about the wider organisation. The staff survey from 2021 reported that only 49% would recommend CSH as a place to work, the national average for similar organisations is 60%. Senior managers were aware of this and were determined to change this. For example, they had increased the mileage allowance for staff to help with the cost of living crisis. The provider had also arranged to change the payment date for bank shifts, so they were paid on the day they worked the additional shift.

The provider had a freedom to speak up guardian (FTSU) who worked with the Voice to ensure that staff views and concerns were heard. Staff we spoke to were aware of the organisations whistle blowing policy and felt that they could use this if needed. The FTSU guardian had links with staff throughout the organisation who promoted the function of the FTSU process. The provider had supplied the FTSU with a secure email and telephone that only they had access too, so staff could raise concerns in confidence.

The provider recognised staff success by staff awards and through feedback. Staff we spoke to felt valued by their line managers more than by the senior leadership team. The staff survey also demonstrated this, 67% of staff said that their manager sought their opinion before making decisions that affected their role, but only 36% of staff felt that the organisation valued their work. The board had recognised this and had a number of initiatives in place to promote staff well-being such as the STAR awards and improving communication.

Governance

The provider had structures and systems in place to support the oversight of their service delivery. implementation of its strategy. The provider had six subcommittees that had oversight across the organisation and reported directly to the organisation's board. They included the audit and risk committee, the quality and safety committee, the putting people first committee and the finance digital and innovation committee. The terms of reference for each committee was reviewed regularly. Currently the committees provided written reports to the board every six months and verbal reports at each board meeting.

In addition to the committees, further governance oversight effectiveness was provided by meetings and forums. The Executive Team meeting, Operations Board, quality governance, workforce planning and Serious Incident Review meetings. Any issues that were not relevant to these committees and groups were escalated directly to the board. There was robust governance processes across the core services and the senior leadership team were able to feed back any key messages via local governance arrangement such as team meetings.

Our findings

The provider told us that the well-led review it had commissioned had identified that the committees were aligned with recognised good practice. However, they recommended that the committees provided a written assurance report to the board monthly rather than six monthly, which was the practice at the time of the inspection, which would improve the oversight and assurance they offered to the board. The board had accepted this recommendation.

Senior leaders from Central Surrey Health, including the CEO, joined with their partner organisations to attend operations, transformation and partnership boards. This meant that CSH worked with their partners to ensure they provided high quality services throughout the county.

The providers were in the process of recommencing its full audit programme which had been suspended due to the COVID-19 pandemic.

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

Non-executive and executive directors were clear about their areas of responsibility. However, the provider acknowledged that some board development was needed and a plan was in place to address this. In addition, the provider had agreed that the appointment of a NED with more experience in community services would enhance the existing team.

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. For example, staff had identified that a piece of equipment broke regularly so they arranged for spares to be sent out so that people's care was not affected.

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

Managers shared any risks identified by audits with the relevant subcommittee who then took responsibility for the risk and mitigation of it.

The provider worked with third parties effectively to promote good patient care. We heard how the provider had worked flexibly within the local health and care system to improve patient care. For example, during the pandemic they had set up the first mass vaccination hub and had taken on other vaccination roles within GP surgeries. They had also set up a care home team who worked directly with local care providers.

Management of risk, issues and performance

The provider had processes and procedures in place for managing risks, issues and performance.

There was a risk register in place at a local service and at corporate levels.

There were systems in place for identifying, recording and managing risks, issues and ensuring risk management and mitigation plans were in place.

Our findings

The risk management process identified everyone's role in recognising, assessing and addressing risks. Staff escalated risks as needed and all staff could access the risk register and submit any concerns. Concerns raised by staff matched what had been recorded on the risk register.

The provider had a Board Assurance Framework (BAF). The BAF provided a structured approach for ensuring that the board got the right information in a timely fashion to give them assurance that risk is being managed safely. The audit and risk committee managed the BAF and linked to the provider's Strategic Delivery Plan. The committee reviewed risk and then provided assurance to the board that the systems in place to manage the risk were robust and offered mitigation of any risks throughout the organisation. The executives formally reviewed any risk that had a score of 15 and above, every month. The board were in the process of approving a new Risk Management Strategy for 2022 – 25.

The highest risks identified were around staffing and the organisation's ability to recruit and retain suitably skilled staff to ensure they could provide a safe and effective service. We saw that the senior leadership team were fully aware of these concerns. The senior team were supporting initiatives to address the issue such as overseas recruitment and developing services that could free up more qualified staff time.

The organisation had effective systems in place to identify and learn from any unexpected deaths.

Senior managers reviewed incidents on a regular basis and identified any that they needed to be investigated as serious incidents. Staff understood the term duty of candour and knew what their role was within it. For example, they could give clear accounts of when they have needed to offer support and apologise to families.

The provider had an appropriate system in place to carry out pre-employment checks on new staff. The provider ensured all staff had disclosure and barring checks completed before they were employed to help ensure the safety of patients using their services. The provider had an electronic system for monitoring all other necessary checks needed before employment could commence, including professional registration and employment history.

The organisation managed finances well, with an annual turnover of £82million and had enough cash flow to meet their liabilities. During the COVID-19 pandemic there had been increases to funding to meet the different challenges the provider faced. As the provider returned services to a business as usual approach the COVID-19 funding was reduced by 60%. The provider had mitigation plans in place that included additional revenue generation within contracts and alternative funding for capital expenditure.

The provider did not own its estate, the principal landlord was NHS estates. The provider met regularly with the landlord to address any concerns and had a good working relationship. The provider had arrangements in place that ensured the environment was fit for purpose and complied with fire and health and safety regulations.

The provider had robust arrangements in place for safeguarding adults and children. There was a clear governance process and leads for adult and children's safeguarding. During the core service inspections staff told us they knew who the safeguarding team were and that they were accessible to staff.

The provider had effective systems in place to manage and monitor the prevention of infections and ensure appropriate resources were allocated to enable compliance and effective infection prevention and control. Staff had access to appropriate personal protective equipment (PPE) for their role and procedures to follow to contain infections on the ward.

Our findings

The provider had robust plans for emergencies and other unexpected events. The emergency planning lead worked closely with partner organisations and commissioners to ensure that response plans addressed the needs of the wider population, in the event of an emergency that affected service delivery. However, at the time of the core service inspection of the community inpatient services, patient did not have personal emergency evacuation plans.

Information Management

The provider had recently invested in new information technology, including software and hardware to improve staff access to information and improve the analysis of the information they held.

At the start of the pandemic the provider adopted a new electronic information system EMIS which replaced the three systems that the provider had previously used. This gave staff greater access to information to help them work more flexibly and to manage risks and complaints at a local level. Team managers could access information to help them in their role. For example, they could analyse community staff's caseloads and adjust as necessary. The staff team were still learning to use these systems to their full potential. However, the EMIS system was not compatible with local social care systems and the provider was looking at how they can improve the staff access to these records and reduce the need for patients to repeat themselves.

The provider was continually improving how digital technology could assist the delivery of patient care. Community staff had been issued with tablet computers, allowing staff to update patient records without returning to the office. The provider had replaced their telephone system with a cloud-based system. The cloud-based telephone system offered better value for money and greater flexibility for a mobile workforce.

The provider had in place an executive-level Caldicot guardian. A Caldicot guardian is a senior person responsible for protecting the confidentiality of peoples' health and care information.

The provider met the mandatory requirements of the Data and Security Protection Toolkit (DSPT), which is based on the national guardian's 10 data standards as the provider had a cyber essential plus certificate. The cyber essential plus certificate was a government-backed scheme that helps organisations protect themselves against the threat of cyber-attacks by ensuring they had the basic controls organisations need to protect themselves.

The provider ensured that all notifications they were required to submit to external bodies were done so in a timely manner and had robust systems in place to ensure this was done.

Engagement

The provider actively engaged with people using their services and their family, friends or others representing them. Staff gave Friends and Family Test questionnaires to complete and they were rolling out a phone app called "I want great care". Returns from the Friends and Family Test showed that 90% of patients were likely to recommend CSH. The provider also arranged patient focus groups and attended patient groups to get feedback about services and find out how people would improve the existing services.

The provider actively engaged with their local partners and was part of North West Surrey Alliance, Children and family Health Surrey and Surrey Downs Health and Care. These bodies consisted of local health and care providers working together to ensure patients receive appropriate care across the regions they covered.

Our findings

The provider responded to the COVID-19 pandemic and set up a mass vaccination centre and was able to take over other vaccination services when partners needed assistance.

The provider engaged with its staff teams via a number of methods including the intranet, emails, newsletters and the elected members forum the Voice. Staff members became co-owners of the provider once they had worked for the organisation for a year. The Voice had 14 members and a chair that covered all the services across the provider. All staff could vote for a local representative but only co-owners could stand for election. Staff were aware of the freedom to speak up guardians and how to access them if they needed to. The board recognised the need for the members of the board to be more visible to the staff teams, which had been affected by the pandemic, but had addressed this in their plan following their well-led audit.

Sickness and absence figures were lower than the national average. The sickness absence rate was reported at 4% while the national average was 4.6%. There had been an increase in turnover rates for staff and was approximately 20% at the time of the inspection. The provider recognised this as a concern and had identified several factors that contributed to this and were working to reduce the turnover rate. For example, making the board more visible and showing that they listen to concerns and addressed them.

Vacancy rates were increasing and were at 27% at the time of the inspection, the provider was managing this risk with the use of long line agency staff.

The provider's Workforce Racial Equality Standard (WRES) findings were last reported to the board in August 2021. The number of black and minority ethnic staff experiencing harassment, bullying or abuse from patients, relatives or the public was at 22% against a national average of 36%. The likelihood of black and minority ethnic staff entering the formal disciplinary process was at 3.61 versus a national picture of 1.14. WRES data for 2021 showed that the black and minority ethnic representation on the board made up 13% where the national average was 25.6%. The percentage of black and minority ethnic staff experiencing discrimination at work from a manager, team leader or colleague was 11% whereas it was 5% for white staff but lower than the national average of 17%. The provider had produced an action plan to address the disparity demonstrated by WRES finding. It was clear that the provider was considering how to improve the experience of black and minority ethnic staff working for Central Surrey Health. However, actions to address the issues were not as advanced as the provider would have liked.

The provider was in the process of setting up staff networks such as black, Asian and minority ethnic, disability and LGBT+ to improve the engagement, better understand the experience and meet the needs of these staff groups.

As a social enterprise the provider retained all profits to reinvest in services to benefit the local communities it serves.

Learning, continuous improvement and innovation

There were systems and processes in place for learning and continuous improvement. Staff understood quality improvement (QI) methods. Senior leaders believed QI needed initiatives to focus more on improving patient care and cost improvements. The provider had recently replaced its "dragon's den" style panel to its "time to shine" panel, with an expectation that staff could bring more service improvement ideas forward.

External organisations had recognised the providers improvement work. Individual staff and teams received awards for improvements made and shared any learning. The services had worked successfully with harder to engage groups such as refugees and traveller communities, they had designed services to work with whole families so they could find unmet

health needs and supported them to access appropriate services. They had also developed a dedicated community phlebotomy team to reduce pressure on the community nurses. The organisation had also set up a dedicated care home team that worked to reduce the demand on community nurses by offer support to care homes and help upskill their care teams.

The provider had a planned approach to taking part in national audits and accreditation schemes and shared learning. While the provider had temporarily halted audits due to the pandemic, they had now commenced planning a full programme of national and internal audits for this year. For example, national audits relating to diabetes, stroke and learning from lives and deaths of people with a learning disability and autistic people. The children's and family core service had received the "Baby Friendly" accreditation award from UNICEF for work around supporting and educating mothers around breast feeding.

Key to tables

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

Month Year = Date last rating published

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↑ Nov 2022	Good ➔➔ Nov 2022	Good ↓ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022	Good ➔➔ Nov 2022

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

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community	Good	Good	Good	Good	Good	Good
Overall trust	Good ↑ Nov 2022	Good →← Nov 2022	Good ↓ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 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 acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Central Surrey Health (CSH) Limited	Requires improvement Jun 2017	Good Jun 2017	Outstanding Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Overall trust	Good ↑ Nov 2022	Good →← Nov 2022	Good ↓ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good →← Nov 2022

Ratings for the trust are from combining ratings for hospitals. 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 Central Surrey Health (CSH) Limited

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017
Community health services for children, young people and families	Requires improvement Jun 2017	Good Jun 2017	Outstanding Jun 2017	Good Jun 2017	Requires improvement Jun 2017	Requires improvement Jun 2017
Overall	Requires improvement Jun 2017	Good Jun 2017	Outstanding Jun 2017	Good Jun 2017	Good Jun 2017	Good Jun 2017

Rating for community health services

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

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

Mandatory training

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

All staff received and kept up-to-date with their mandatory training. Data provided by the service showed that staff were above 90% compliant with their mandatory training, with most staff above 95%.

The mandatory training was comprehensive and included safeguarding, infection control, consent, medicines management, basic life support and anaphylaxis. Most staff we spoke with across the service told us that they did not receive any training on learning disability and autism, although some of the 0-19 teams had done previously. Most staff told us that this would be useful to better meet the needs of children and young people within their roles, specifically continence and early years teams.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers demonstrated how they identified when a staff member's training was out of date or required through the electronic system. This was also reflected on staff's individual profiles.

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.

All staff received training on how to recognise and report abuse. Where relevant to their role, staff were trained to level three safeguarding in both children's and adults. Safeguarding training was part of the service's mandatory training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff gave us examples of how they worked with other agencies to protect children and young people at risk of harm. All staff also attended regular safeguarding supervision with a safeguarding supervisor. This took place as a minimum every three months and gave staff the opportunity to discuss relevant safeguarding cases. Staff and managers fed back that they found great benefit from this supervision.

The record system used within the service enabled staff to raise 'warning flags' when a child or young person was known to have safeguarding risks, so staff were immediately aware of these risks when they opened the record.

Community health services for children and young people

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The service had a dedicated safeguarding team who worked in partnership with colleagues from a neighbouring community health trust to provide safeguarding support to staff for the geographical area. All staff were aware of the role of the safeguarding team which was led by named nurses, and all were aware of how to contact them.

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.

All clinic environments observed were clean and safe. Cleaning records were up-

to-date and demonstrated that all areas were cleaned regularly. We saw housekeeping staff

at some of the clinic sites during the inspection.

Staff followed infection control principles including the use of personal protective equipment (PPE). Whilst staff were no longer required to wear masks in line with the provider's policy and national guidelines, we observed staff asking parents, carers and young people for their preference in whether they would like them to wear one. In observations of clinical practice, we observed nursing staff following infection control principles including hand washing regularly, bare below the elbow, and cleaning of equipment after each patient contact to minimise the risk of infection. The service carried out regular hand hygiene audits.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept children and young 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.

Clinics took place in various locations such as community clinic spaces, schools and children and young people's homes. Risk assessments were carried out prior to any venue being used. Whilst the service had suitable facilities to meet the needs of children and young people's families, some of the clinic environments were tired and worn. The service informed us that the clinic spaces that they used were generally leased from external partners who owned these buildings and therefore they were limited in their ability to make changes to the environments.

All the clinics visited were accessible for families with prams or wheelchairs. The clinic rooms were spacious and comfortable. Leatherhead clinic had a shelf of books to keep children occupied and some children's chairs in their waiting room.

Staff disposed of clinical waste safely. Clinical waste was secured in clinical waste bags and disposed of appropriately. Sharps, such as used needles, were placed in secure sharps bins. Although, some of the clinic rooms in the Jarvis community clinic did not have clinical waste bins. Managers informed us that they were waiting on clinical waste bins to be delivered. They were using the general clinical waste bins available within the site to dispose of any relevant waste.

Staff carried out safety checks of specialist equipment. For example, we observed staff undertaking checks on all medical equipment during a home visit and saw that associated documentation of daily checks had been completed to show that these had been undertaken. In addition, some specialist equipment for specific patients was serviced annually by the overseeing NHS acute hospital.

Community health services for children and young people

Assessing and responding to patient risk

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

Staff identified children or young people at risk of deterioration and escalated them appropriately. Specialist school nurses ensured that where required children had escalation and deterioration plans in place. For example, a child who required oxygen had an emergency oxygen escalation plan in place, and another child who experienced seizures had an epilepsy escalation plan put together with the mother of the child and an epilepsy nurse specialist. Staff also shared deterioration and escalation plans with teaching staff, as well as transport drivers and escorts due to incidents that had happened during transport to and from school. In the event of an emergency, staff were aware to call an ambulance.

Staff knew about, and dealt with, any specific risk issues. Staff were aware of the risk registers which were managed at a local level and had a good level of awareness regarding the reporting and recording of risk. For example, a local risk for school nursing and specialist school nursing was the management of high temperatures in school medical rooms. They recorded this as a risk on their risk register and identified ways of mitigating the risk as much as possible within their control.

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. For example, they referred children and young people to the local child and adolescent mental health team (CAMHS) where this was appropriate, and staff told us that they carried out joint visits where possible.

Shift changes and handovers included all necessary key information to keep children and young people safe. We saw evidence of a communication book for continuing healthcare staff which was completed to provide necessary handover information on patients.

Most staff spoke to us about the lone working risks within their roles in the community. All staff were aware of the lone working policies and the importance of reviewing records for any identified risks before visits, although for some teams there were not effective lone working practices in place. For example, some staff told us that due to the small size of teams, they would need to contact colleagues who would be on non-working days to inform them of their safety following visits. Following feedback from staff, the service had invested in a lone working app which enabled more robust oversight when lone working, though managers told us that the uptake from staff had not been as successful as expected.

Nurse staffing

The service had enough nursing 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 and agency staff a full induction.

There were staff vacancies across the children, young people and families teams, although these were mostly in the health visiting, children's community nursing and therapies teams. Managers told us that retention of staff was difficult due to the proximity to London boroughs and the increased wage. The teams proactively managed these vacancies using bank and locum staff to help meet the needs of patients and assist in improving the waiting times for therapies. In addition, the speech and language therapies (SALT) and occupational therapy (OT) teams were also promoting 'return to practice' roles and upskilling staff with apprenticeships to improve the levels of staffing and retention in these areas. The service had also rolled out additional incentives including a financial reward for those bringing colleagues into the service.

Community health services for children and young people

Leaders were aware of the staffing recruitment challenges and it featured on the organisational risk register. The provider discussed staffing levels and recruitment strategies with commissioners. Staff told us that the retention and recruitment issues placed pressure and additional stress on them, although, they did feel listened to by managers. The data provided to us showed the higher turnover rates over the last three months within looked after children health services, physiotherapy, occupational therapy and immunisation teams.

Bank and locum staff were given a full organisational induction when they started, and most of these were familiar with the service. Managers told us that they received an orientation on how to use the systems, and long-standing bank and locum staff also attended team meetings and internal safeguarding training. They also stated that each bank or locum member of staff was interviewed and recruited as if they were permanent staff to ensure that their competencies and experience were relevant for the service need.

Records

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

The service used an electronic care records system. The continuing healthcare teams operated with paper records within patients homes, but the service was rolling out new tablets to all staff to make access to records easier whilst working remotely.

The care records we reviewed were all up to date, comprehensive, holistic, had appropriate risk and needs identified and included the voice of the child, even when non-verbal. Where able, staff used pictures to make this communication easier. All contacts were recorded on the electronic system and all staff could access them easily. Staff added a red flag alert to the system if there were any key issues others would need to know about when reviewing the record, for example, if there was a child under a child protection plan.

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

When children and young people transferred to a new team, there were no delays in staff accessing their records. Some of the local GP surgeries also used the same electronic system which made access to information and referrals more straightforward.

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. The specialist children's community nurses and assistant nurses and practitioners in schools all administered medicines. They had a lead pharmacist who supported with the medicine optimisation across all these services and provided guidance.

Managers had oversight of medicines management competencies. We saw evidence of completed Medication Administration Record (MAR) competencies within the children's community nursing teams. The service also ensured all nursing staff were up to date in their understanding of the medicines management policy. Managers worked with pharmacists to ensure these checks were being done. They completed single checking for administration and we observed a nurse check the MAR on a home visit ensuring the correct strength, dose, date of the medication had been administered.

Community health services for children and young people

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines. We saw evidence of nursing staff review and discuss medicines with young people and their carers during clinical practice. The service does not have any nurse prescribers so all end of life medicines were prescribed by the acute or tertiary teams. As such, all the medicines in the syringe driver were prescribed and arranged according to the care plan, including any advised increases or decreases from the authorised prescriber.

Staff completed medicines records accurately and kept them up-to-date. Staff used MAR charts and the service carried out a MAR chart peer review audit between the school and clinical teams. The medicines management audit had not been completed in recent years due to COVID-19, but the lead pharmacist explained that this would be starting again soon.

On the service risk register they had recorded a tolerated risk for the room temperatures of medicines storage in schools. Staff told us that this was an issue across two schools where they did not have the capacity for air conditioning units. They had put in place mitigations to manage this risk, including ice packs and fans to bring temperatures down, checking the colour and consistency of liquid medicines and receiving a new supply of medicines each term. They had also asked for parents to monitor any changes in children's conditions. They reviewed this risk every six months.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services. They did not carry out a full medicines reconciliation for children's services and instead focused on gathering information on medicines that they administered and ensured that families or schools were using them appropriately.

Staff learned from safety alerts and incidents to improve practice. Staff recorded all medicines errors on the electronic incident reporting system. Staff also contacted the lead pharmacist in the event of any medicines incidents. Information surrounding the incidents and any lessons learnt were disseminated at team meetings.

Incidents

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

Staff knew what incidents to report and how to report them. Staff were aware of what incidents to report and how to report these on the electronic system. Managers told us that all clinical team leaders, clinical service managers and associate directors were sighted on incidents. Managers investigated incidents thoroughly and these were reviewed at the monthly serious incident review meetings.

Staff understood the duty of candour. They were open and transparent, and gave children, young people and their families a full explanation when things went wrong. We saw evidence of where staff contacted parents to apologise when things had gone wrong, such as when a child had been administered a third dose of a vaccine by accident. Staff learnt from this incident and discussed ways in which they could minimise the risk of this happening again.

Managers were proactive in learning from incidents and any lessons learned were shared in team meetings, and we saw evidence that these were documented in meeting minutes and the provider's newsletter which were sent to all staff. Managers also told us that as part of the governance process across the Child and Family Health Surrey group, they shared wider learning across the partnerships with another community health service and the local NHS mental health trust.

Community health services for children and young people

There was evidence that changes had been made as a result of feedback, for example in the specialist children's community nursing teams there had been incidents raised on a fault with a specific equipment part that kept breaking. Consequently, children were provided spares to prevent this affecting the delivery of their care.

Managers debriefed and supported staff after incidents. Staff told us that the service provided feedback and wellbeing support to staff, and the families involved in incidents, and that there was not a blame culture.

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

The service delivered care in line with the Healthy Child Programme and best practice guidance. The Healthy Child Programme provides families with a programme of screening, immunisations, health and development reviews. A dedicated inclusion team provided a 0-19 service to children, young people and families from the local Gypsy, Roma and Traveller communities, asylum seeker and refugee communities. The core aim of this service was to bring young people up to speed with the requirements of the healthy child programme. The service also worked with all members of the family to identify potentially any unmet health needs. Patients were then signposted to other services to have these needs addressed as necessary and the team kept the family member's GP informed.

The service developed the Community Health Early Support (CHES) following a one-year pilot study. This service, currently provided in one of the four quadrants, is an early support team who put in early intervention and packages of care matched to the identified needs of a child in order to prevent further interventions at a later stage. The team included speech and language therapists (SLT), occupational therapists (OT), physiotherapists, and community nursery nurses and they also link in with other services to work holistically with the family. Children may be referred into this service from early years and pre-school settings or through the health visitor's assessments at 1 year or 24-27 months old. For example, we observed work with a child whose speech delay had been identified by pre-school nursery and an OT was working with the child to encourage 2-word phrases. The nursery staff were present so they could continue the same strategies in the nursery setting with this child. The nursery staff gave feedback that they had already observed a difference in the speech development since this early intervention was put in place.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff regularly had updates sent to them via their weekly newsletter or through their real time electronic communication portal. Updates were also discussed in team meetings when there was any change to guidelines. Staff had access to policies on the staff intranet.

Nutrition and hydration

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

Community health services for children and young people

Staff supported children and their families to ensure their nutrition and hydration needs were met. This support was given to families at their first contact with the service, where staff offered advice to new mums about breastfeeding their babies. Health visitors and nursery nurses gave advice to parents about weaning their babies. School nurses gave advice to children and young people of school age around appropriate nutrition and referred into the obesity clinics if required.

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 was currently accredited at top Level 3 'Baby Friendly' accreditation from UNICEF for their support and education for breastfeeding mothers.

The service provided a list of clinical audits including safeguarding, record keeping, hand hygiene, compliance with complaints policy, environmental infection control, transition of young people with complex conditions from child to adult health services, tongue tie and education, health and care plan (EHCP) audits. Although, at the time of the inspection, managers and staff told us that most of these clinical audits, apart from hand hygiene and record keeping, had not been carried out due to the increased demands of the pandemic or due to staff leaving. The service told us that these would be starting up again soon.

We did see evidence of a recent EHCP quality assurance audit which reviewed the advice template completed by therapy staff to see whether needs were identified clearly, outcomes were recorded and whether there was evidence of the child's voice. In addition, we saw another audit as part of the overarching Children and Family Health partnership which reviewed the quality of the Review Health Assessments (RHAs). Some services also gave examples of local level reviews that were taking place to improve care and treatment; although these were not always being identified as clinical audits by managers. For example, the tongue tie service was undertaking a review of their procedures, speech and language therapists were looking at their report templates for where improvements could be made, and a health visiting team was reviewing the timeliness of their allocations.

Therapy staff explained that outcome recording was recorded within their report template and they were able to identify whether assessment targets had been achieved or not. Although, some staff in other teams within the service felt the electronic system records did not always make clear patient outcomes and felt this could be strengthened.

Competent staff

The service made sure most staff were competent for their roles. Managers appraised staff's work performance. Supervision meetings were held to provide support and development, although these were not consistent across the teams.

Most staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. All staff, including locum and bank staff, were interviewed and recruited in the same way to ensure that their experience and competencies met the needs of the service. Most of these nursing staff had completed a specialist practice children's community nursing course at master's level. The team could also call on support from the local NHS acute hospitals if needed. This support included a paediatric palliative care consultant and a pharmacist with specialist expertise in this area.

Managers gave all new staff a full induction tailored to their role before they started work. New staff received a full induction tailored to their role when they started with the organisation.

Managers supported staff through annual appraisals. All staff told us that they received yearly appraisals, with some also receiving six monthly interim catch ups. Data provided by the service for June 2022 showed an average of 73% compliance with appraisals across the various teams and evidenced that these were happening regularly.

Managers and staff told us that the service worked within a professional supervision policy which supported a few different models of supervision and could be adapted to meet the specific service needs. This included supervision as part of a one to one meeting, reflective practice, coaching, group supervision and safeguarding supervision. The minimum supervision requirements within the policy were eight hours per year, which could be four group supervisions. Most staff we spoke with were confident they were receiving supervision in some form, although this varied in frequency. Staff within community children's nursing teams, who provided palliative end of life care, were receiving group supervision rather than one to one clinical supervision and told us this was not always happening regularly.

The provider did not have a recording system for managers to monitor whether staff supervision, other than safeguarding supervision, was being completed regularly as these were held locally. Within their policy it stated that to monitor compliance and review each professional supervision, an annual audit would be carried out. We requested the recent audit from the provider but did not receive this back in time to consider as evidence for this inspection. The provider told us that the lack of oversight of supervision was on their corporate risk register due to their lack of assurance on staff having access to support at the time when they needed it. They told us that their action to address this was stalled due to the pandemic and the ensuing recovery from this, although they advised that since the inspection they have held a supervision workshop, an audit of managers assurance in regard to their teams needs and a staff experience survey to confirm how the current supervision feels from their perspective. They told us that supervision was an area that they were still planning to develop further and this remained on the risk register.

Managers made sure staff attended team meetings or had access to minutes when they could not attend. Managers showed evidence of these sent out to staff and saved on the local computer drives.

Staff felt the organisation was dedicated to investing in its staff with many staff carrying out additional training specific for their role. For example, staff within the community nursing teams accessed training centres through London NHS acute specialist hospitals for children and had a clinical skills training room which was equipped and fully functional. This enabled staff to refresh skills and improve their confidence by training in a less stressful environment, rather than on the child or young person. Staff could also apply for funding to attend conferences and to complete further academic training, and managers told us that a therapist had recently applied for funding to complete a hydrotherapy course.

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.

The service formed part of Children and Family Health Surrey. This was the overarching partnership responsible for delivering the 0-19 service across the county of Surrey. The contract was delivered alongside another local community health trust and in part by the local mental health NHS trust. Leaders operated across these organisations and split their responsibilities accordingly. For example, two associate directors within Central Surrey Health led on the delivery of therapeutic services and specialist children's community nursing across the county, whilst their counterpart who was employed by the neighbouring community health trust led on the delivery of 0-19 services across the county.

Community health services for children and young people

Across this partnership and within Surrey, many multidisciplinary teams worked together to meet the needs of children and young people and improve their care. For example, the service had an inclusion team and a 0-19 advice line, and these services hosted staff from Central Surrey Health as well as the neighbouring community health trust and other agencies in order to support delivery across the county.

In addition, the service employed a nurse who worked as part of the local authority Youth Offending Team (YOT) and provided physical health and lifestyle support to children and young people currently within the youth justice system.

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

Staff held regular and effective multidisciplinary meetings to discuss children and young people and improve their care. Staff told us that they were involved in multidisciplinary team (MDT) meetings around the child or young person. This included meetings with other teams within the service, school teams and external partners.

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 within waiting rooms including support around healthy eating, smoking cessation and mental health.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. For example, school nurses reviewed all health assessments to identify any needs. The YOT nurse completed a health assessment of all children and young people within three weeks of being placed with the youth offending service. This led onto signposting or referrals into dentists, opticians, and mental health support, or resulted in advice and support around sleeping, sexual health, and nutrition.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff gained consent from children, young people or their families for their care and treatment in line with legislation and guidance. Staff told us that consent would be obtained from parents but if the child or young person was Gillick competent they would ask them directly. Gillick competence is where children under the age of 16 can consent to their own treatment if they are believed to have enough intelligence, competence and understanding to fully appreciate what is involved in their treatment. We observed clinical practice where consent was obtained from families or the young person where able.

When we reviewed care records, most showed evidence of young people or their families consenting to care and treatment, although, there were occasions when the consent and capacity of the child or young person was not recorded or explicit within the records.

Community health services for children and young people

Is the service caring?

Outstanding ☆

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

Compassionate care

Children and young people were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by a service that went above and beyond to meet the needs of its patients.

Feedback from young people and their families was continually positive about the service, staff and their care and treatment. They all described the service as “excellent”, “amazing”, “brilliant”, “outstanding”, “lovely”, “responsive”, and “effective”. All parents and carers told us that staff had gone above and beyond in their care and treatment for their loved one and that they had exceeded their expectations. They told us that staff always accommodated their needs first when arranging appointments. For example, a young person engaged in an extracurricular activity every week, so staff ensured that appointments were never scheduled at the same time in order to avoid affecting this positive activity in the young person’s life.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted children and young people’s dignity. Staff took time to interact with children, young people and their families in a respectful and considerate way.

Relationships between children, young people, their families and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. When we observed interactions between staff and parents and children, staff treated them in a caring and compassionate manner and quickly built a rapport with new families. Staff listened to what they had to say and showed a genuine interest in both parent and child. Staff and parents also told us that where possible, they maintained consistency with families so that they did not have to keep meeting new members of staff and it allowed the families, and importantly the children and young people, to feel comfortable.

Emotional support

Staff recognised and respected the totality of children and young people’s needs. They always took personal, cultural, social and religious needs into account, and found innovative ways to meet them. Children and young people’s emotional and social needs were as important as their physical needs.

Staff recognised that children and young people needed to have access to, and links with, their advocacy and support networks in the community and they supported them to do this. Staff had professional links with charities that provided families with clothes, shoes, toys and toiletries where needed. Staff also told us how the inclusion team supported patients to access their religion within the community, provided advocacy at the local council and signposted to other support agencies including financial and visa support for local refugees. The service also had access to a peer supporter who was a wheelchair user. Their role was to help young people who were also wheelchair users in providing both practical and emotional support, guiding them to access extracurricular activities and to be a role model.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. During a clinical procedure, a practitioner was observed to manage a distressed parent sensitively, providing them the appropriate support and information by explaining the steps that would take place, and allowing them the time to phone their partner whilst they left the room.

Community health services for children and young people

Staff demonstrated empathy when having difficult conversations. We observed a transition meeting with a family in which the staff member demonstrated transparency and honesty, as well as providing reassurance to the family and allowing them the opportunity to ask questions.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing and gave support and advice when they needed it. Parents and carers told us that at times when they had felt mentally exhausted and overwhelmed, staff recognised this and reached out to them and offered them support.

Understanding and involvement of children and young people and those close to them

Children, young people and those close to them were active partners in their care. Staff were fully committed to working in partnership with children, young people and their families.

Staff showed determination in overcoming obstacles to delivering care and individual preferences and needs were always reflected in how care was delivered. Parents and carers told us that visiting nurses and school nurses carried out blood tests so that the children, young people and their families did not need to travel to the hospital or miss any schooling for regular blood tests to take place. Staff also told us how they would carry out appointments at home and community centres to assist parents who were unable to access clinics. There was also a chat line for school aged children and young people to access support or advice on a range of health and development information. This meant that if any children or young people did not feel they could approach a school nurse, they could access this service for support.

Staff ensured that children and young people's communication needs were understood. Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Staff told us that for some patients with communication difficulties they utilised pictures to make communication easier. Staff gave an example where they showed a young person a picture of carer that would be working with them both without a mask, and with a mask, so that the child could recognise and understand that these were the same person.

The service took account of the family's needs and ensured that these were considered in the delivery of care. For example, staff gave example of a parent who had a learning disability and struggled with written communication, so they ensured that communication was provided to them by phone. They also ensured that any communication with other professionals was done so that families and carers did not need to repeat information to more than one professional at a time.

Staff empowered children, young people and their families to have a voice and to realise their potential. They ensured a family centred approach.

Staff supported children, young people and their families to make informed decisions about their care and found ways of working with the parents to support the child holistically. All parents and carers told us that they were fully involved with any decision and that staff always kept them updated. They also told us that staff listened to them and ensured that they understood information given to them. We also saw the child and young person's voice made a priority when being recorded in care notes and within clinical practice as staff sought the preference of the child where possible.

Community health services for children and young people

Staff enabled children, young people and their families to manage their own health and care when they could and to maintain independence as much as possible. Staff made sure children, young people and their families understood their care and treatment and we observed staff involving a young person in the fitting of their mask. Both young people that we spoke with said that they felt involved in their care. They also had staff trained in baby massage to be able to provide this additional therapeutic intervention and to show parents how to do this.

Children, young people and their families were aware of how to give feedback to the service and all told us that they were aware of the friends and family survey. In addition, they had a phone app called "I want great care" which enabled direct feedback for services. The service also provided feedback sheets based upon pictures and easy read for children and young people who would benefit from feeding back in this way. Staff told us that capturing feedback from the children, young people and their families was important to them and were looking at ways to strengthen this within the service.

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 children and young people

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

Managers and staff planned and organised services so that they met the changing needs of the local population. Staff in the inclusion team thought creatively about how to reach vulnerable children, young people and families from the local Gypsy, Roma and Traveller communities, asylum seeker and refugee communities. The service also worked with all members of the family to identify potentially any unmet health needs. Patients were then signposted to other services to have these needs addressed as necessary and the team kept the family member's GP informed. Staff worked flexibly within this service to attend church services to help support children, young people and their families and visited local hotels which housed refugee and asylum seekers to provide outreach health and care.

The service was proactive and made timely adaptations to their ways of working through the COVID-19 pandemic to ensure that there was a prompt response to any factors which may impact service provision. For example, whilst most staff were required to conduct virtual visits rather than seeing children and young people in person, the 0-19 services and the children's community nursing teams continued to deliver face to face contacts to provide support through this difficult time. In addition, the service introduced 'attend anywhere' which enabled children, young people and their families to have appointments and initial assessments virtually.

The service also operated a dedicated advice line which provided prompt access to advice from qualified health visitors. This service was delivered across the county in partnership with colleagues from a neighbouring NHS community health trust. The line was used by families and other professionals including GPs who wanted to seek professional advice. The advice line was an innovative way of working that had various benefits. It freed up health visitors working within the 0-19 teams to focus on their work rather than handling routine queries that came to them via their duty system. The

advice line enabled professionals like GPs to get support and reduced the likelihood of inappropriate referrals to services being made. Families were also promptly signposted to the most appropriate service to meet their needs, such as emergency departments or their GP. Leaders had shared their successes in relation to the advice line at a national professional advisory group so that national colleagues could consider its benefits.

Managers monitored and took action to minimise missed appointments. When missed appointments happened, the service contacted the children, young people and their families. If necessary, they visited them at their address.

Meeting people's individual needs

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

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Staff told us that they could translate all information into required languages so that families and young people could understand information being given to them. Staff told us that they recorded any communication and language needs at the referral stage.

Managers made sure staff, children, young people and their families could get help from interpreters or signers when needed. Staff knew how to access translation services and interpreters for children and families who did not speak English as their first language.

As part of the inclusion team, the service had a nurse working in a role as an Asian health link worker. These roles were invaluable in building relationships and understanding and improving engagement and communication with families accessing necessary early years health services. In addition, this team had key links with other professionals and held regular multiagency drop-in clinics which enabled additional help to be put in place for families. For example, helping families to learn English. Staff had good knowledge of other services available locally and signposted people to these, such as the food banks, a charity that helped families access baby or child equipment and home start which was a local authority run service where parents can access a support buddy.

Staff were also flexible, and patient led when working with children or young people who had literacy difficulties. Staff told us how they would ensure that they were able to access the information being given. This included use of videos and dolls to demonstrate activities, videos which gave a verbal summary of information, or increased font size on written communication.

Staff used transition plans to support young people moving on to adult services. We observed this in practice and saw nurses discussing with families so that any questions or concerns they had regarding this could be managed sensitively.

Access and flow

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

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets.

The Healthy Child Programme mandated contacts data showed that at the time of inspection, 90% of new baby reviews were carried out within the 14 day target, which was above the service target, and eight week reviews were at 86% compliance, which was just below the service target. The one-year reviews were at 69%, and two and a half year reviews

at 56%, both below the service target. The service reviewed this data weekly to identify where they had not met targets. Managers identified that in order to improve this data, especially the engagement with the one year and two- and half-year reviews, they were looking to offer face to face appointments, instead of questionnaires that were sometimes not returned. In addition, they implemented integrated appointments with early years and began sending texts and phoning parents to remind them of these reviews.

The service regularly reviewed waiting lists and ensured that where needed, prioritisation and escalation was in place to reduce waiting times. For therapies, this included the recruitment of locum therapists to offer assessments to those on the waiting lists and having support from therapy assistants to carry out pre assessment work. Throughout the pandemic, therapists also created videos for parents and families to access at home in order to empower parents to deliver these strategies. They were continuing with these so that parents could use these whilst waiting for treatment to begin. They had seen reductions in occupational therapy waiting lists through these methods. However, there was a current waiting list of 294 children and young people waiting, and over eighteen weeks wait for their first appointments with speech and language therapy across the service. The clinical team leaders reviewed caseloads and waiting lists and prioritised children and young people where deterioration was identified and those who required Education, Health and Care Plans (EHCP).

Managers worked to keep the number of cancelled appointments to a minimum. Parents and carers that we spoke with told us that they never experienced cancelled appointments, even during the COVID-19 pandemic. Some told us that on occasions there may have been delays due to traffic, but that staff immediately sent a text or gave a call to advise of the delay.

Staff supported children, young people and their families when they were referred or transferred between services. Local maternity services referred to the service for tongue tie procedures. At the time of inspection, there was a three-week waiting list, which had reduced recently from four weeks, despite the increased demand.

Learning from complaints and concerns

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

The service clearly displayed information about how to raise a concern in patient areas. For those who were visited outside of a clinic, parents and carers told us that they knew how to complain or raise concerns as this information was given to them by staff, although none said that they had any concerns to raise. We reviewed data provided on complaints received in the last three months and saw that there had been no formal complaints recorded within the service. Staff understood the policy on complaints and knew how to handle them, and managers investigated complaints and identified themes. Managers told us that the main theme previously had been around the waiting lists for therapies. Managers received notification of complaints via the incident reporting system and investigated these. Any feedback was given to families and learning was shared with staff.

Staff gave an example of how they used patient feedback to improve daily practice. A recent issue had arisen whereby a staff member was due to visit a family to deliver oxygen training for their child, but this staff member fell ill and alerted another team member of their illness, yet this second staff member was also ill. As such, the cancellation message did not get through to staff members on duty to inform the family. They had since implemented a duty call system to enable communication to be picked up.

Community health services for children and young people

As well as an incident reporting system, the service had a system in which positive feedback and compliments could be recorded and shared amongst teams for both learning and practice.

Is the service well-led?

Good

Our rating of well-led improved. 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.

There was a clear leadership structure within the service. Clinical service managers (CSM) reported directly into the service managers. Service managers were supported by the associate directors for children, young people and families and worked closely together.

CSM's were in place for 0-19 services and therapies and sat above clinical team leaders and the rest of the staffing teams. They were responsible for the day to day management of the services. The exception to this was the children's community nursing, children's continuing care, specialist school nursing, immunisation and continence teams who fed directly into a service manager who was responsible for the day to day management of these services. Staff told us that they always knew who they needed to contact, especially in the absence of their direct line manager.

Senior leaders were visible, readily contactable and approachable within the service and staff consistently told us that they felt well supported by leaders. Managers told us that executive directors had spent time visiting the teams and observing the teams' practice.

Managers and team leaders supported staff to develop their skills. For example, the organisation had supported and encouraged staff to access further external or academic training to progress their career and development, where relevant to their role. There was evidence of career progression within the service, for example several staff had been promoted to more senior roles throughout the organisation and leaders supported staff with accessing leadership and management courses.

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 services were undergoing a transformation process as they were due a contract review in 2024. We observed an all staff transformation webinar led by the director of children, young people and families services. The transformation process formed a review of the service priorities and aimed to identify what services they would continue to deliver and the future of these, and what services may go to other providers to deliver. The service had two transformation leads, a transformation board and transformation volunteers. Staff felt that leaders kept them informed and updated about this

process and that they received good support. Although, staff were evidently concerned about the insecurity and potential changes this may lead to within their roles. Staff explained that the current organisation and its values had enabled stability and continuity in knowing where they were and what their strategies and responsibilities were as a service.

Culture

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

All the staff we spoke with told us they felt respected and valued within their roles. Staff were overwhelmingly positive about their work for the provider. They described a strong sense of teamwork and supportive leaders.

Morale within the team was generally good but could fluctuate due to the demands, long wait times in some services and high caseloads in the health visiting teams, which were currently averaging 476 patients on a caseload. This was reflected within the staff survey which showed that only 35% felt able to meet their conflicting demands on time. Most staff told us that the staffing issues made it difficult for staff and although they did their best within their roles, they all felt that improvements in staffing would improve their roles overall and the service. This was again reflected in the recent staff survey where only 22% felt that there were enough staff within the organisation to do the job properly.

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

Staff told us they felt well supported and valued by leaders. Staff told us that everyone's opinions, idea's and contributions were equally valued. The service offered "Standout, Talented, Achievers, [and] Respected" (STAR) awards as a recognition of peoples hard work and peers were able to nominate their colleagues for these awards. All staff said that having this made them feel appreciated for their work.

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

Staff told us that their wellbeing was a priority of the service and its leaders. Staff told us that managers always checked in and ensured staff were taking lunch breaks. Staff had access to wellbeing support at work which included the introduction of wellbeing conversations which were one to one meetings between team leaders and staff, as well as access to an external counselling service. There were opportunities for staff to engage in extracurricular wellbeing sessions including mindfulness and Zumba. The service had also recently developed new staff networks including cultural and ethnic minorities, Lesbian, Gay, Bisexual, Transgender, Queer/ Questioning+ (LGBTQ+) and a disabilities, carers and ally network.

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

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.

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

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

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

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

The service had not yet resumed its full programme of routine clinical audits. Leaders explained that routine audits had mostly been put on hold because of the COVID-19 pandemic. The service told us that these would be starting up again soon. We did see evidence some local level reviews that were taking place to improve care and treatment; although these were not always being identified as clinical audits by managers.

The provider did not have a recording system for managers to monitor whether staff supervision, other than safeguarding supervision, was being completed regularly as these were held locally. This meant that leaders could not monitor whether all staff received the support they required.

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.

As well as local risk registers, the provider maintained a strategic risk register at corporate level which covered all the children's and young people's services and maintained a good awareness of risk amongst senior leaders. Leaders reviewed risks on a monthly basis and actions were in place to manage and mitigate risks. Risks being added onto the corporate register were reviewed by governance leads who approved the ratings of logged risks. These had to meet a threshold before they were added on. The service also had local team risk registers which fed into the corporate service register. Items such as; staffing recruitment and retention, capacity across the service, Occupational Therapy and Speech and Language Therapy waiting lists, and COVID-19 were included in the register.

Some staff and managers we spoke with identified finances as a barrier and risk within the service, especially when considering the future service improvement. For example, the use of agency had a significant impact on the budget across the service. Leaders were aware of this risk and how this placed pressure on the services to be innovative and effective within the current budgets.

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.

The service used intelligence software to provide analytics and data on performance, although this was still in its infancy and staff and managers were still learning how to use and understand the data on this platform.

Staff could access policies and procedures easily and updates to these were notified to staff in the weekly staff newsletter. Staff and managers were aware of what information needed to be sent to other organisations, including CQC notifications, as required.

However, the service was not currently completing audits to gather information and data to inform quality improvement initiatives and make decisions on effective changes to practice.

Engagement

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

Staff were able to provide feedback to the provider via a staff survey. 64% of staff across the organisation completed the most recent staff survey. The service also had a staff council called "The Voice" which enabled representatives from each team to feed up to the board. Staff told us that they found this to be effective and gave some examples of issues they had reported to the board through this process. One example being concerns shared by staff as to the cost of fuel and the mileage they received. This was actioned by the board, which saw an increase to the mileage given per mile for all staff.

The service held team meetings regularly and managers updated staff with information about learning from incidents, compliments, complaints and feedback. The service also sent out updates to practice, guidance or policies, as well as general service updates via weekly newsletters, a real-time message communication system and use of their intranet pages.

Staff helped families to give feedback on the service by providing a friends and family questionnaire and were rolling out a phone app called "I want great care" which enabled feedback for specific service codes. Leaders advised that they had not been prioritising seeking feedback during COVID-19 but were keen on increasing this again.

Staff also told us that there was a maternity voices group which was run by parents. They were also starting a health visiting voices group. Staff attended these groups to seek feedback and understand what parents wanted. A recent example was around the drop-in clinics which had been stopped due to COVID-19 and parents wanting these back. The service were starting these again in July as a result of this feedback.

Managers engaged effectively with other local health and social care providers to ensure that patient needs could be planned for and met. The partnership working process across the Child and Family Health Surrey group also enabled far greater collaboration across organisations.

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 health services for children and young people

The service continuously aspired to improve the experience of their patients by reviewing opportunities and adapting aspects of the service to meet the needs of groups of patients. For example, the service had been proactive in responding to the COVID-19 pandemic. Staff quickly adapted to different ways of working such as virtual assessments and appointments with patients while still continuing face to face contacts. The therapy teams also created videos for parents and families to access at home in order to empower parents to deliver these strategies. They were continuing with these so that parents can use these whilst waiting for treatment to begin.

Additionally, one of the nursing teams won an award for nursing innovation of the year through their introduction of sleep clinics within a special school. We also saw an advice booklet for families which assisted with continence issues in children and young people. This was designed by a student school nurse and not only contained information on bed wetting but also contained logs for drinking and an interactive progress chart which children could complete with either green, yellow and red to show their toileting. This could then be taken to appointments to assist continence nurses with identifying the next stages of their care.

At our last inspection the 0-19 team had been awarded the UNICEF award for breastfeeding advice and support. They had continued to receive this award on a yearly basis, currently with a silver award and striving for gold.

Community health inpatient services

Good

Is the service safe?

Requires Improvement

We rated safe as requires improvement.

Mandatory training

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

Staff received and kept up to date with their mandatory training. Staff across the community wards were 91.77% compliance with their mandatory training courses.

Staff were required to complete various mandatory training courses, however training in dementia was not mandatory, despite a lot of people with dementia being cared for on the wards. Some staff told us that they felt there should be more dementia training available and that some people were looking to source this themselves online. We discussed this with managers who acknowledged that the dementia and cognition steering group had been put on hold during the pandemic, but that this had recently restarted. They had plans to implement dementia and delirium training for staff, and to arrange for a dementia bus to visit the wards later in the year, which would provide a sensory experience for staff.

Training in learning disabilities and autism was also not mandatory for staff.

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.

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. We observed a daily board round meeting on Alexandra ward where staff discussed a safeguarding concern that had arisen.

Staff knew how to identify adults 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 knew who the safeguarding team were, and they visited the wards once a week. When we reviewed incidents, we saw that safeguarding referrals had been made as appropriate.

Cleanliness, infection control and hygiene

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

Ward areas were very clean and had suitable furnishings which were clean and well-maintained. The chairs on the ward were all wipeable and we observed staff wiping them down after use.

All the patients we spoke with told us they felt the ward was very clean.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeeping staff had a rota to deep clean one bedroom per day.

Staff followed infection control principles including the use of personal protective equipment (PPE). Hand washing posters were displayed above handwashing stations and staff completed monthly hand hygiene audits. The infection control team visited the wards regularly and sent out infection control bulletins. At the time of our inspection two patients on Hersham ward had tested positive for COVID-19 and were being cared for in individual side rooms on the ward to reduce the risk of other patients becoming infected. Three patients in total had tested positive for COVID-19 as part of that outbreak. All of the patients had been located in the same bay originally. Staff had prevented the infection from spreading further. There had also been a norovirus outbreak on the ward, and staff managed to contain this to a small number of patients. Managers held frequent outbreak meetings with the infection control team for advice and monitoring of the situation.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used "I am clean" stickers to make it easy to see which equipment was clean and ready to use. However, there were no 'safe handling of chemicals' posters displayed in the cleaning cupboard on Hersham ward.

Environment and equipment

We were not assured that the design, maintenance and use of facilities, premises and equipment could always keep people safe. Staff managed clinical waste well.

The environment on Alexandra ward was pleasant with some pictures on the walls. Hersham ward was more stark with little décor on the walls. Both wards looked tired with lots of chipped paint on the walls. There was a sharp bend in the layout of Alexandra ward, meaning that the long corridor area of the ward could not be seen from the nursing station. Staff mitigated risk by placing patients at higher risk of falls in the bays that could be seen more clearly from the nursing station. The doors on the rooms on Hersham ward were too narrow for beds to fit through which could lead to delays in evacuating patients in the event of a fire. However, all the beds had ski sheets fitted to mitigate this risk. A ski sheet is an evacuation aid used to transfer patients in an emergency. The organisation had a Fire Safety policy which stated that "a Personal Emergency Evacuation Plan (PEEP) must be defined and put in place for individuals who may have any disabilities, or have a restricted ability to ensure a safe means of leaving the building, e.g. bed bound patients". However, at the time of the inspection no patients had a PEEP in place. The PEEP document had been introduced in 2018 and recently updated and ratified. Staff completed an annual environmental audit on each ward and developed action plans to address any issues.

The service had enough suitable equipment to help them to safely care for patients, however we saw that some equipment required calibration or was overdue for servicing. This included the tympanic thermometer kept in the store room, the urinalysis machine and the bladder scanner on Hersham ward, and the scale in the clinic room on Alexandra ward. The provider told us that an external company had serviced equipment in May 2022 but the equipment in the store room had not been included in this. They told us that the equipment in the store room would be included in future. A piece of equipment in the inpatients gym at Woking Community Hospital had also not been serviced since 2019. We fed this back to managers who told us that they had servicing contracts in place for their equipment, and that they would check their records and contact the servicing team to ensure the items were checked.

The wards had access to lots of large equipment required to meet the needs of the patients, however, did not have enough storage space for it. On both wards the conservatories were cluttered with large pieces of equipment such as hoists and drip stands, which could pose a health and safety risk. This was included on the service's risk register which was regularly reviewed by senior managers.

Staff carried out daily safety checks of emergency equipment.

Patients could reach call bells and staff responded quickly when called. The call bells were located within easy reach of patients. Patients told us that staff responded promptly when they were pressed.

The wards had a variety of room options available to meet the needs of patients. Each ward had an enhanced care bay which was constantly supervised by a staff member. Patients could be moved to this bay if their needs indicated this was necessary. There were also individual side rooms on each ward. During our inspection some of the side rooms on Hersham ward were occupied by patients who had tested positive for COVID-19 to ensure they were kept separate from the other patients.

The service had suitable facilities to meet the needs of patients' families. Patients told us that staff brought chairs for visitors and gave them refreshments.

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.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning System (NEWS2) to monitor patients for signs of deterioration. There were notice boards on both wards which contained information about managing emergencies and deteriorating patients. This included information relating to resuscitation, anaphylaxis, choking, sepsis and NEWS2 trigger thresholds.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff completed various risk assessments following admission, including a bed rail risk assessment, moving and handling risk assessment and falls assessment.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe. Staff were given a handover sheet to keep with them during their shift which included key details about each patient including recent COVID test results, diagnosis, past history, continence issues, cognition issues, activities of daily living, mobility, skin issues, Waterlow score, Malnutrition Universal Screening Tool (MUST) score, night needs, dietary needs, action plan and discharge plan.

Community health inpatient services

Staffing

Nurse staffing

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

The service had enough nursing and support staff to keep patients safe. Usual staffing on each ward was two nurses on each shift, plus five healthcare assistants for the early shift, four for the late shift and three at night.

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. Senior leaders had recently ratified a safer staffing policy which included details of what safer staffing levels were on the wards and who to escalate any concerns to. Staff in business intelligence were also in the process of developing a safer staffing dashboard.

The ward manager could adjust staffing levels daily according to the needs of patients. Managers calculated the number of staff required based on the acuity/dependency of patients and requested extra staff as needed.

The number of nurses and healthcare assistants matched the planned numbers. Managers conducted a safer staffing audit every six months to review establishments.

The service had high vacancy rates for nursing staff. The vacancy rate for healthcare assistants was 44% and for qualified nurses was 37%. Managers were in the process of recruiting international nurses to work on the wards and two nurses were due to start in post shortly. A programme of support was in place for these nurses, including emotional and wellbeing support. Managers were holding a rapid recruitment day for healthcare assistants in July 2022. There used to be two wards in operation at the Walton site, but one ward recently closed, meaning that the staff from that ward have been able to move over to Hersham ward.

The service had low staff turnover rates. The average turnover rate in the three months prior to the inspection was 2.38%.

The service had high sickness rates; however this was likely due to the prevalence of COVID-19 within the community. The average sickness rate in the three months prior to the inspection was 6.35%.

The service used bank and agency staff to cover vacancies on the wards. Managers requested staff who were familiar with the wards. Managers monitored the use of agency staff via their electronic incident reporting system.

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.

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.

Community health inpatient services

The service had enough medical staff to keep patients safe. A consultant geriatrician covered both wards and each ward also had a doctor.

The medical staff matched the planned number.

The service had low vacancy rates for medical staff.

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.

Out of hours medical cover was provided by a third-party organisation. Staff told us their calls were triaged when they rang the number and they then waited for a call back. If urgent medical care was required or if patients had a NEWS score above a certain level staff would call 999.

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. At the time of the inspection staff were using paper files, but there were plans to move over to an electronic system in August 2022.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely in locked cabinets.

Medicines

The service used systems and processes to safely prescribe and administer medicines. However, staff did not manage controlled drugs in line with the provider's medicines management policy.

Staff followed systems and processes to prescribe and administer medicines safely. Nurses administering medicines used a 'drug round in progress – do not disturb' tabard to indicate to others they should not be disturbed. The drug trolleys were tidy and organised. Staff completed daily checks of the fridge temperatures on the wards to ensure that medicines were stored at the correct temperature. Staff did monthly checks of medicine expiry dates and we did not find any out of date medicines during our inspection.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up-to-date. Staff kept comprehensive medicines records, including documenting the reason for any omissions. Staff documented any allergies or sensitivities on medicines charts.

Staff did not always manage controlled drugs in line with the provider's medicines management policy. On both wards staff were using two controlled drugs books as the initial ones were nearly full, however the policy states that only one book should be used and that all controlled drug balances should be transferred to a new register. The standard

operating procedure for controlled drugs was due for review by March 2021 but this had not yet been done. Following the inspection the provider told us that the process to review the standard operating procedure was ongoing and therefore they had extended the expiry date of the procedure to December 2022. They told us that ward managers and matrons were emailed to notify them of this and that a memo should be in the standard operating procedure folders. However, we did not see a copy of this memo during our inspection.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The acute hospital had recently moved to electronic medicines charts, however Alexandra and Hersham wards required a paper copy of the charts. A joint working group was set up prior to the acute hospital moving to the electronic system in May 2022 and it was agreed that the acute hospital would provide handwritten copies of charts on transfer to the community wards.

Staff learned from safety alerts and incidents to improve practice.

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. All staff we spoke with knew what incidents to report and that they should report them using the online incident reporting system.

Staff raised concerns and reported incidents and near misses in line with provider policy.

The service had no never events on any wards.

Staff reported serious incidents clearly and in line with provider 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.

Staff received feedback from investigation of incidents.

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. For example, following an incident relating to the management of a patient with diabetes, staff had implemented a blood glucose monitoring chart. They had also developed a visual escalation flowchart for healthcare assistants to refer to. Staff completed audits prior to and following the implementation of these measures, and improvement was seen once the measures were put in place.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Managers debriefed and supported staff after any serious incident.

Community health inpatient services

Is the service effective?

Good

We rated effective as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service had various steering groups in place to ensure that staff kept up to date with guidelines and best practice, for example a falls steering group.

Staff completed a range of comprehensive assessments for patients. This included a body map, Waterlow scale, bed rail decision tool, Barthel index, elderly mobility scale, Tinetti gait and balance assessment tool, continence assessment and mini-cog (cognitive assessment tool).

Nutrition and hydration

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

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

Staff fully and accurately completed patients' fluid and nutrition charts where needed.Staff utilised colour coded systems for water jugs and food trays. Patients with blue jugs were on normal fluids; patients with yellow jugs had a restriction and patients with red jugs required extra help. Where patients' food intake was being closely monitored staff gave them a red tray so that housekeeping staff knew not to remove it until a staff member had documented what the patient had eaten.

A nutrition board was displayed on the wards which contained information about good nutrition and hydration care. This included useful information about dysphagia, which is a condition where a patient has difficulty in swallowing food or liquid.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST).

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. A dietitian from the local acute hospital visited the wards weekly and staff could make urgent referrals to a speech and language therapist who was based at Woking community hospital.

Community health inpatient services

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 utilised the Abbey pain scale to assess the needs of patients who were unable to articulate these themselves.

Patients received pain relief soon after requesting it. Patients told us that staff responded quickly to their needs.

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 service participated in relevant national clinical audits. Managers and staff used the results to improve patients' outcomes.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time.

Managers used information from the audits to improve care and treatment. Staff completed catheter audits and NEWS2 audits every four weeks. The ward doctor on Alexandra ward also completed audits of hypoglycaemic care.

Managers shared and made sure staff understood information from the audits.

Improvement was checked and monitored.

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.

Managers supported staff to develop through yearly, constructive appraisals of their work. Eighty-nine percent of staff on Hersham and Alexandra wards had received an appraisal within the last year.

The provider's policy stated that staff should receive eight hours of supervision per year, however no record was kept of this and so managers were unable to evidence whether this was achieved. Staff told us that they received varying amounts of supervision with some staff receiving supervision monthly, some quarterly and others every six months. Newer staff members told us that they met with their managers weekly for the first few months.

The clinical educators supported the learning and development needs of staff. The consultant geriatrician held fortnightly teaching sessions for staff. These were delivered online and recorded so that staff unable to attend could watch them back later. Recent topics had included nutrition, frailty, medication, pressure ulcers and the Mental Capacity Act.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff meetings took place monthly and minutes were disseminated afterwards.

Managers gave staff the time and opportunity to develop their skills and knowledge. Managers told us they would never expect staff to work outside their competencies, and that they were confident to refuse referrals for any patients they did not feel staff were competent to care for. For example, they had declined some referrals for people who required continuous positive airway pressure (CPAP) machines as staff did not feel confident with using these. However, managers had arranged for staff to receive training in using these machines from an external provider. Staff told us that they did not receive any specific training in changing stoma bags, but that they were shown how to do this by other staff who knew how to do it. Managers told us that they had requested stoma training via the learning and development department. A stoma nurse from the acute hospital also visited patients with stomas. When we reviewed minutes from the community hospitals operations group meeting we saw that the stoma nurse had requested a link nurse however staff were unable to tell us what action had been taken in relation to this and the action was not documented in any subsequent meeting minutes.

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 access continuing professional development opportunities.

Managers made sure staff received any specialist training for their role. For example, the occupational therapists and physiotherapists had recently been supported to attend amputee training.

Managers identified poor staff performance promptly and supported staff to improve. Managers told us that they received support from the Human Resources department in addressing any performance issues.

Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff held a daily board round meeting to discuss all the patients on the ward. These were led by the ward sister and attended by the ward doctor, discharge co-ordinator, occupational therapist, physiotherapist and social worker. The doctor, therapies staff and nursing staff were also all based on the ward, which aided communication and enabled good multidisciplinary team working.

Health promotion

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

The service had relevant information promoting healthy lifestyles and support on wards. Information relating to healthy eating was displayed in the lounges.

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

Community health inpatient services

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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. Patients told us that staff always asked their permission before taking any physical observations.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. We saw that where patients did not have capacity their family had been involved in making decisions about their care.

Staff made sure patients consented to treatment based on all the information available.

Staff clearly recorded consent in the patients' records. Staff kept copies of signed consent to care and treatment forms and consent to share information forms within patient records.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. A member of the safeguarding team and the consultant geriatrician had recently done a lunchtime training session for staff, which was in addition to the provider's mandatory training.

Managers monitored the use of Deprivation of Liberty Safeguards (DoLs) and made sure staff knew how to complete them. A member of the safeguarding team regularly checked patient records to ensure that DoLs paperwork and MCA documentation was completed appropriately.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored 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?

Good

We rated caring 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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients said staff treated them well and with kindness. Patients told us that staff seemed genuinely interested in them and made them feel like a person, not a number. Patients told us that staff were very supportive and gave them lots of encouragement and praise to help them to meet their goals.

Staff followed policy to keep patient care and treatment confidential.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients and relatives told us that staff took time to get to know them, the things they liked and disliked. For example, a relative told us that staff made an effort to do their relative's hair the way they liked it, which helped them feel more like themselves.

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We observed staff being mindful of managing the distress of patients and relatives. For example, we observed a receptionist making a phone call to a relative and starting the conversation by reassuring them there was nothing to worry about.

Understanding and involvement of patients and those close to them

Staff supported 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 met with patients shortly after admission to discuss their expectations and goals from their admission. Families were also invited to contribute towards care discussion and discharge planning. The discharge co-ordinators made themselves available on the ward during visiting hours so that families could speak to them.

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

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients and families were asked to complete feedback on discharge. Some patients had also taken part in focus groups as part of a quality improvement project. They had fed back that the TVs didn't always work, or they didn't have remotes and so staff were going to order more portable electronic devices for them to use instead. They had also fed back that they expected the rehabilitation provision to be more intensive, so staff had created a leaflet for patients to be given on discharge from the acute hospital to help manage their expectations of what the service offers. Patients and relatives could also fill in comments cards and place these in boxes in the reception areas.

Staff supported patients to make informed decisions about their care. Patients told us that staff were very good at explaining things in a way they understood, and that they felt involved in their care.

Community health inpatient services

Patients gave positive feedback about the service. They told us that staff were very responsive to their needs, that they felt safe, and that they had confidence that staff were proactively managing their health needs. Patients and relatives fed back that they felt the visiting times on the ward (2pm to 5pm) were restrictive. We discussed this with managers who told us that visiting hours had been reduced due to COVID-19, but that there were plans to increase them. They also told us that individual requests to visit outside of the scheduled visiting hours would be considered.

Is the service responsive?

Good

We rated responsive 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.

Staff knew about and understood the standards for mixed sex accommodation. All bays in both wards were designated as male or female only and the toilets closest to the bays were allocated accordingly.

Facilities and premises were appropriate for the services being delivered.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access diagnostic tests such as x-rays and ultrasounds within the same building.

The service relieved pressure on other services and departments, for example if a patient was seen on site for an outpatients appointment and an admission was indicated, where appropriate they could be admitted straight to one of the community wards rather than needing to go to the acute hospital for assessment.

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.

Wards were designed to meet the needs of patients living with dementia. The wards had contrasting handrails along the corridors and large pictorial signs on the toilet doors to help people know where to find the toilets. There were also large calendar clocks displayed, however the wrong date was shown when we visited Hersham ward.

Staff understood and applied the policy on meeting 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 staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Community health inpatient services

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.

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers made sure patients could access services when needed.

Managers and staff worked to make sure patients did not stay longer than they needed to. The average length of stay was 21 days on Hersham ward and 14 days on Alexandra ward. A social worker attended the daily board ward round meetings and gave updates on progress for any required care packages.

The service moved patients only when there was a clear medical reason or in their best interest. For example, there were some instances where patients had been moved back to the acute hospital when their physical health had deteriorated.

Managers and staff started planning each patient's discharge as early as possible. There was a clear focus on discharge on the wards. Both wards had a dedicated discharge co-ordinator who closely monitored progress and actions required to enable each patients' discharge.

Staff supported patients when they were referred or transferred between services.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers told us they would speak to staff if they needed to raise a complaint, but they had not been given any information about how to do this.

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

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Managers told us that the main theme in complaints was discharge, but that complaints had reduced since the discharge co-ordinator had been in post.

Staff knew how to acknowledge complaints and 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.

Staff could give examples of how they used patient feedback to improve daily practice. For example, by developing a leaflet for staff at the acute hospital to give to patients prior to their admission to the community hospital, in order to help manage their expectations about treatment.

Community health inpatient services

Is the service well-led?

Good

We rated well-led 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.

Leaders had the relevant skills and abilities to effectively run the service. They all had a good understanding of the key issues faced by the service and the actions that were in progress to mitigate any risks.

Staff told us that the matrons, senior matron, senior manager inpatient services and therapies manager were all very supportive and approachable. They told us they were all a visible presence on the wards and that they made time to listen to staff. Staff told us that managers were contactable via telephone if they were not on site. Staff told us that members of the executive team rarely visited the wards.

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 strategic ambitions of the service were excellence, transformation, collaboration, people and co-ownership. Staff set targets related to these ambitions when they had their annual appraisal.

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 that there was a positive culture on the wards and that they felt able to be open and honest with managers.

Staff were encouraged to pursue career development opportunities, for example, a number of healthcare assistants on the wards had been supported to complete the nursing associate programme.

There were no cases of bullying or harassment within the teams and staff told us they would not hesitate to raise any concerns as needed. In the staff survey carried out in 2021, 83% of respondents said they would feel secure raising concerns about unsafe clinical practice.

Community health inpatient services

Governance

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

The organisation had a corporate governance framework in place. The organisation's board had established six committees to support its delivery. These were a quality and safety committee, an audit and risk committee, a finance digital, and innovation committee, a putting people first committee, a remuneration committee and a nominations committee. At a service level, staff held monthly community hospitals operations group meetings which were attended by senior staff. The senior manager inpatient services attended these meetings as well as the Quality and Safety Committee which enabled any relevant issues to be escalated as needed.

Staff we spoke with were clear about their roles and responsibilities, and what was expected of them.

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 service had a risk register to document any potential risks and the mitigation plans. Each risk was assigned to an individual staff member. We saw evidence that this was regularly reviewed and updated.

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 could access key information such as policies on the intranet.

Managers told us that business intelligence colleagues were working on several dashboards, such as a safer staffing dashboard, for them to be able to see key, up to date information at a quick glance.

The service submitted notifications to external bodies, such as the CQC, as required. Staff had submitted one notification to CQC in the six months prior to the inspection.

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 service worked closely with colleagues from the local acute hospital as well as with wider system partners.

The Chief Executive sent out newsletters to staff to share good news/good practice and any other relevant updates.

The organisation had last completed a staff survey in 2021.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation.

Community health inpatient services

Managers told us that they were working to develop a training package for basic nursing care, to help improve consistency amongst the nursing staff.

Managers told us they had future plans to recruit a practice development nurse to focus on inducting new starters, training, competencies, and delivering teaching for staff.

Managers had identified that people were sometimes having to wait a long time to get through to the wards on the telephone. They therefore carried out a pilot where the nurse in charge carried a mobile phone, which saw the percentage of abandoned calls reduce from 25% to 12%.

Community urgent care service

Good

Is the service safe?

Good

This was the first time we have inspected and rated this service as part of CSH.

We rated it as good.

Mandatory training

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

All staff received and kept up to date with their mandatory training. Most staff delivering care and treatments were Emergency Nurse Practitioners (ENPs) or Emergency Practitioners (EPs), such as doctors or paramedics so had completed specialist training to fulfil their role. Assistant nurse practitioners were up to date with their mandatory training and had also completed specialist training to support them to do their role. In addition, reception staff were up to date with mandatory training.

Medical staff who worked in the walk-in centres received and 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, learning disabilities, autism, and dementia.

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

At the time of the inspection 82% of staff (across both centres) had completed their mandatory 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 ENPs and EPs had all completed Level three safeguarding training. The clinical leads at the walk-in centres offered staff safeguarding supervision.

All 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.

Community urgent care service

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The team at both sites had useful links with the local safeguarding teams and staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children.

Cleanliness, infection control and hygiene

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

All areas were extremely 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.

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.

Once patients had provided their details to the receptionist at the walk-in centres, they waited in the wating area. Waiting areas were large, pleasantly decorated and well ventilated and had televisions for patients to watch while they waited. Patients were not left alone in consulting rooms so could always attract staff attention but if they were placed in a consulting room (if they needed to lie down or needed to be away from others) they were provided with a call bell to call for staff if needed.

The design of the environment followed national guidance and was well designed with plenty of space to accommodate patients' needs. Staff had been involved in designing the environments. Consulting rooms were clean, bright, and spacious. All rooms were set up in the same way so that any staff members could easily access equipment needed to examine, care for, and treat patients

Staff carried out daily safety checks of specialist equipment, such as emergency equipment. All equipment was clean, stored appropriately and very well maintained and there was enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

Whilst the building and outside areas of the walk-in centre at Woking was excellent and very well- maintained, the car park (used by both staff and patients) was quite a way from the walk-in centre and out of hours, and in the evening, it could feel very isolated and was quite dark, especially in winter, which resulted in staff and patients/carers feeling quite vulnerable. CCTV was in place in the car park.

Community urgent care service

Assessing and responding to patient risk

Reception staff made a brief assessment of patient risk as the checked into the reception and would immediately identify any risk issues or concerns to clinical staff who would then take appropriate action. They removed or minimised risks and updated the assessments as needed. Staff identified and quickly acted upon patients at risk of deterioration.

If patients came into the walk-in centres that needed emergency care and treatment staff acted quickly to provide that care and to ensure they were redirected or taken to the Emergency Department (ED) or elsewhere, such as to the mental health teams so they could receive the care and treatment they needed.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. All clinical staff were Immediate Life Support (ILS) trained, including Paediatric Life Support (PLS). Each centre had a 'green button' in each room so staff could summon help quickly if patients deteriorated and they needed emergency or lifesaving care.

Staff completed a National Early Warning (NEWS) score on all patients that they deemed needed to be transferred to ED. This involved measuring patients' basic physical observations including heart rate and blood pressure.

If required, staff called for an ambulance using key words to ensure the ambulance call handler understood that this was an emergency and they needed to dispatch an ambulance to take a patient to ED immediately. Ambulances responded quickly to emergency calls but other than this the walk-in centres were treated and prioritised like any other caller.

Staff completed risk assessments for each patient on arrival, using a recognised tool, and reviewed this regularly, including after any incident should anything occur.

Staff knew about and dealt with any specific risk issues, including anyone presenting with a clinical emergency, having had a fall, with a deteriorating physical health condition or a mental health issue.

The service had access to mental health liaison and specialist mental health support. However, staff told us that this needed to be quicker and more responsive. Young people who have self-harmed do come into the walk-in centres seeking help and the team have access to the paediatric team who staff described as providing an excellent service when needed.

Staff shared key information to keep patients safe when handing over their care to others. Patients' notes were sent directly to each patients GPs following attendance/discharge. Staff could refer directly to the virtual fracture clinic, knee clinic, Ear, Nose and Throat (ENT) and eye clinics, X-ray and the local ED and share information as needed.

Shift changes and handovers included all necessary key information to keep patients safe.

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. At times there was a high use of agency staff, some of whom did not have the right skills and experience which put pressure on the more permanent staff.

Community urgent care service

The walk-in centres provided a nurse led service, although other professionals, such as doctors and paramedics, also fulfilled the emergency practitioner role. Assistant practitioners also worked in the walk-in centres.

The service had enough staff to keep patients safe. However, there were high staff vacancy rates, particularly at Ashford (46% vacancy rate). This meant that agency staff were often required to fill shifts. Although managers made every attempt to secure staff who were familiar with the service or had the right level of skill and experience, this was not always possible. Therefore, shifts did not always have the right level of skills and experience, which put more pressure on more permanent staff.

If there was not enough staff to provide care for all those patients presenting at the walk-in centres they do not physically close their doors during the scheduled hours of operations so patients can present but they are re-directed to alternative services.

Both walk in centres had four ENP/EPs per shift and this could be increased at busier times. In addition, there were an assistant nurse practitioner and a receptionist.

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

The department manager could adjust staffing levels daily according to the needs of patients.

The service had low turnover rates with an average of 1% recorded for April - June 2022.

The service had reducing sickness rates with an average of 5% recorded for April - June 2022 compared to 7% for January – March 2022.

Medical staffing

Although the WICs provided a nurse led service some of the agency staff were doctors. They carried out the same role as the ENP/EPs within the centres.

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.

At the time of the inspection there was a temporary national 'outage' of the electronic patient record system used at the WICs which meant that staff had to keep paper records of all patient notes. This was a temporary issue and paper records collated and provided the same level of information as the electronic records but were slower to complete and not as easily transferred to other services, when needed, as the electronic records.

However, the service worked well with the temporary paper record systems and patient notes were comprehensive and all staff could access them easily.

When patients transferred to other services or were discharged delays in transferring records were kept to a minimum.

Records were stored securely.

Medicines

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

Community urgent care service

Staff followed systems and processes to prescribe and administer medicines safely. The service had several non-medical prescribers who could prescribe medicines for patients as required. For those that were not there was a list of Patient Group Directions (PGD) which provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber.

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

Staff stored and managed all medicines and prescribing documents safely. Both walk-in centres stored medicines in the same way so that staff could easily work in each centre and know exactly where medicines were kept.

Staff followed national practice to check patients had the correct medicines when they were admitted, they moved between services or discharged after receiving care and treatment in the WICs

Staff learned from safety alerts and incidents to improve practice. For example, an incident involving the way codeine (a medicine used to treat moderate pain) was stored had occurred recently; the clinical lead at Woking investigated and changed the storage methodology so this was now stored in the same way as controlled drugs. Two staff now must sign for the drug and the stock is checked daily. This has prevented any further incidents occurring and is now the practice across both walk-in centres.

Incidents

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

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Managers shared learning with their staff about incidents.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Staff received feedback from investigation of incidents, both internal and external to the service. There were monthly governance meetings held where incidents and investigations where discussed and learning shared amongst the teams. There was an ethos of continually striving to improve and deliver high quality care for patients at both centres.

There was evidence that changes had been made because of incidents. There had been an incident at Ashford where a few FP10 (a prescription form that patients take to the pharmacy that helps eligible patients correctly claim free NHS prescriptions and avoid penalty charges) had gone missing, usually this would have been noticed at the regular monthly audit. However, the audit had not taken place for two months. It was found that an agency member of staff had destroyed a few of them as this was the practice at the GP surgery where they normally worked. To prevent this happening again all FP10 were now stored at the reception in a locked cupboard and all staff had to sign for them when they wanted to use them. This had been shared with staff at both Ashford and Woking and had been implemented to prevent further incidents.

Managers debriefed and supported staff after any serious incident.

Community urgent care service

Is the service effective?

Good

This was the first time we have inspected and rated this service as part of CSH.

We rated it as good.

Evidence-based care and treatment

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

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Pathways of care had been developed in line with national guidance for a wide range of care and treatment that patients presenting at the walk-in centres would require. Staff used these pathways to prescribe and deliver care and treatment. An extensive range of information about the care and treatment pathways had been developed and was available for patients.

In addition, staff used guidelines and pathways for referring patient on to other services. For example, when identifying sepsis and using the silver trauma pathways which used tools to help staff identify the level of trauma ensuring the best response and appropriate onward hospital referral for patients.

Staff protected the rights of patients subject to the Mental Health Act (1983) and followed the Code of Practice.

At handover meetings, staff routinely referred to the physical, psychological, and emotional needs of patients, their relatives, and carers to ensure individual needs were met.

Nutrition and hydration

Patients attending the walk-in centres only stayed for a brief period until their treatment had been completed. However, staff made sure patients had enough to eat and drink if they needed it. Staff identified those with specialist nutrition and hydration needs and ensured patients were referred to appropriate specialist teams, such as dieticians and speech and language therapists. Where required they could refer to the patients GP accordingly.

There were water coolers sited in the waiting rooms so patients could access drinks if required and both centres also had coffee/snack vending machines for patients to use.

Pain relief

Staff assessed and monitored patients pain 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.

Reception staff would identify patients presenting in pain to clinical staff who would quickly assess them and ensure they were given pain relief, as necessary. Patients were assessed using a pain score tool which was regularly reviewed by staff. All patients were triaged within 20 minutes of coming into the centres and would ensure anyone in pain were given pain relief even if they had to wait longer for care and treatment. Staff prioritised children, the elderly and people with a learning disability or autism. Pain relief was given in line with individual needs and best practice.

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 service conducted several local audits, including audits of the sepsis pathway to ensure it achieved good outcomes for patients. Managers and staff used the results to improve patients' outcomes and used information from the audits to improve care and treatment. Managers shared and made sure staff understood information from the audits.

For example, an audit of patients attending for post - surgery wound care found that many patients needed daily dressings. Action from this led to contact with the wound care team at the hospital and a bookable service made available on site.

Another audit identified several patients attending who were physically frail and more links were made with the frailty hub as a result.

All patients were triaged within 20 minutes of presenting at the walk-in centres and the majority (98%) were seen and discharged within four hours (the national target). Between April 2021 and July 2022 Woking had breached the four hours wait time 298 times and Ashford 572 times. During the same period Woking had seen 46,457 patients and Ashford had seen 47,292 patients.

Outcomes for patients were positive, consistent, and met expectations, such as national standards. For example, with appropriate antibiotic prescribing and stewardship.

The eight patients we spoke with were all incredibly positive about the service they received, and the outcomes achieved by the staff. Patients described an excellent service with caring and competent staff who met their needs

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.

Previously, the walk-in centres were staffed by band seven emergency nurse practitioners but more recently the service had found it difficult to recruit staff at this level (there is a local and national shortage of emergency practitioners at band seven). The service has recruited band 6 staff who will be on a developmental pathway to become ENPs. The provider had partnered with Kingston University who provided the academic programme to support their development. The service also provided placements for student nurses and trainee paramedics with the intention that they would move into substantive roles in the walk-in centres once they became appropriately qualified and registered. Staff were

experienced, qualified, and had the right skills and knowledge to meet the needs of patients. However, some agency staff did not have the skills or experience required for the role. Managers ensured all inexperienced staff received a full induction into the services and completed competency checklists as they developed their skills, expertise, and worked effectively in the centres.

The service had invested in staff attendance at study days. Several staff were due to attend a two-day conference in September on minor injury and illness to ensure they kept up to date with best practice. In addition, staff attended webinars which supported them to keep up to date. Staff told us that there were good opportunities for learning and development.

Staff felt supported by managers and leaders of the service. Staff received regular one to one sessions and group supervision. The clinical leads would also undertake informal supervision and reflective practice sessions with staff.

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. 84 % of staff had received appraisals and leaders said all appraisals were due to be completed by the end of September.

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

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

Multidisciplinary working

All, staff in the walk-in centres worked together as a team to benefit patients. They supported each other to provide safe care.

Staff held regular and productive multidisciplinary meetings to discuss effective care and treatment for patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. Managers and staff described the excellent working arrangements they had with other services. They met with managers and staff from the local EDs and shared information regularly regarding patients coming into each of the services. This helped identify when the walk-in centres needed to start redirecting patients to alternative provision so that EDs could be prepared

Staff were able to refer patients for mental health assessments if required. However, staff told us that the response was not always timely.

The service worked well with local GPs.

Seven-day services

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

Both walk-in centres were open from 8am to 8pm, seven days per week including Christmas Day, Boxing Day, and New Year's Day.

Health Promotion

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

Community urgent care service

The service had relevant information promoting healthy lifestyles. Staff assessed each patient's health when seeing them at the service and provided support for any individual needs to live a healthier lifestyle. Staff would refer patients to other services that could help them with their lifestyle choices or could support them to remain health, support them to regain their health or promote a healthy lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

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

Staff 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; consent was always sort on booking into the service. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions.

Staff clearly recorded consent in the patients' records.

Staff received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards 2009. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

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.

Is the service caring?

Good

This was the first time we have inspected and rated this service as part of CSH.

We rated it as good because:

Compassionate care

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

Staff were discreet and responsive when caring for patients. Patients told us staff were sensitive to their needs and made every effort to provide reassurance. Patients said staff showed empathy and had a caring and responsive attitude even when they busy

Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients said staff listened, treated them well and showed kindness. Several patients said staff went out of their way to provide care to respectfully meet individual needs

Community urgent care service

Staff followed policy to keep patient care and treatment confidential. Patients said staff at reception offered privacy when sharing personal information and showed sensitivity when asking questions.

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. Receptionists were discreet when checking people into the centres and made every effort to keep details private. If patients wished to speak to staff in private, they would facilitate this by taking them into a private room.

We observed staff assessing and treating a patient with mental health needs with care and compassion.

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

Emotional support

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

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Patients said staff provided support and reassurance about their condition and understood patients' frustrations about being unable to access help from GPs.

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

Staff assessed patients' needs sensitively and where needed allocated quiet waiting cubicles for patients with a learning difficulty, autism, mental health issues or children and older people.

Staff undertook training on breaking unwelcome 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. Staff offered relevant advice and signposting to patients in a caring manner.

Patients said staff explained why they were unable to treat their problem at the walk-in centres but were not dismissive and ensured patient would get help elsewhere. Patients said staff listened to them and gave them time to explain their concerns fully even though it was obvious how busy the centre was.

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.

Patients said they were given verbal and written information about their care and treatment. One staff member used a computer image for a patient to show what was and was not normal and the patient found this helpful

Staff talked to patients in a way they could understand, using communication aids where necessary.

Community urgent care service

Patients said staff checked they understood information given and what to do next.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Both walk in centre received many compliments; in the last year they received over 40 formal letters of compliment and many more informal compliments in cards and notes and gifts from grateful patients.

Staff supported patients to make informed decisions about their care.

Patients said staff regularly updated them about the waiting times within the centres and were patient when dealing with repeated enquiries.

Is the service responsive?

Good

This was the first time we have inspected and rated this service as part of CSH.

We rated it as good because;

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 needs of the local population. They understood the local population demographics and so took account of this. For example, Ashford was able to better identify and meet the needs of the Polish and Eastern European community. This included the use of interpreters, and some members of staff were also able to provide translation.

Facilities and premises were excellent and appropriate for the services being delivered.

Staff could access emergency mental health support as needed for patients with mental health problems, learning disabilities and dementia. However, responses from the mental health teams could be slow.

The service was an integrated part of the wider health care system. It worked well with local GPs, ED, and a variety of specialist teams to ensure local people got the urgent care they needed when they needed it.

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.

The environment in the walk-in centres had been designed to be dementia friendly and was easy to access for those who used wheelchairs. Both walk-in centres had hearing loops and were designed to support those who were partially sighted. Staff had been involved in the design of the centres.

Community urgent care service

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports when patients presented with these. Staff would prioritise patients with dementia, learning disabilities and autism and would ensure they did not have to sit for prolonged periods in the waiting area. If they needed a less stimulating, quiet environment they would take them to a consulting room or quiet area to wait or if patients needed to lie down, they would accommodate this.

Patients told us that they felt staff took them seriously, listened to them and providing excellent care.

In addition, staff prioritised children and ensured that children did not have to wait longer than an hour.

Staff understood and applied the policy on meeting 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 and the service had access to interpreters and signers as needed. In addition, they had links with advocacy services.

Managers made sure staff, and patients, loved ones and carers could get help from advocacy services, interpreters or signers when needed. Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

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

All patients were triaged within 20 minutes of presenting at the walk-in centres and the majority (98%) were seen and discharged within four hours (the national target). Between April 2021 and July 2022 Woking had breached the four hours wait time 298 times and Ashford 572 times. During the same period Woking had seen 46,457 patients and Ashford had seen 47,292 patients.

Managers and staff worked to make sure patients did not stay longer than they needed to.

The number of patients leaving the service before being seen for treatments was low. Patients told us they would wait even if a long time as they knew they would receive a good service.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards.

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 urgent care service

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Both walk in centre received many compliments; in the last year they received over 40 formal letters of compliment and many more informal compliments in cards and notes and gifts from grateful patients.

Patients we spoke with did not have any complaints about the care they received but were often frustrated at the length of time they waited to be treated.

Patients could access I Want Great Care forms at reception to provide feedback. Staff also used an iPad to record feedback and had a QR code data link for patients to feedback online.

Staff said they received one or two complaints per month. Patients' complaints were taken seriously and initially staff would arrange an informal discussion to try and resolve the issue and then begin the investigation process and share any learning with staff.

Staff told us the main complaint themes were around waiting times, staff attitude and patients having to give details in public at reception.

Leaders were addressing these concerns and the long waiting times were a direct reflection of a shortage of staff within the centres.

Staff also told us that patients sometimes expected antibiotic prescriptions which the ENPs found were not clinically appropriate for their condition. Patients sometimes complained to staff about this.

The service clearly displayed information about how to raise a concern in patient areas. We saw a You Said, We Did board displayed at the services sharing how leaders and staff had acted on patient complaints.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Leaders discussed complaints at monthly governance meetings with the patient experience team. Staff knew how to acknowledge complaints and 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. For example, staff changed the options for describing gender when patients were booked in to add an option for non-binary people.

Staff could give examples of how they used patient feedback to improve daily practice. A privacy booth was also put in place by staff to help avoid patients being overheard when sharing personal information at reception.

Is the service well-led?

Good

This was the first time we have inspected and rated this service as part of CSH.

We rated it as good because:

Community urgent care service

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.

Managers and clinical leaders of the service were highly competent and passionate about the service they delivered; they worked closely with staff on each site. All staff held them in high regard and told us how effective they were at managing the service

However, there was a lack of visibility within the service of the CSH senior leadership with staff feeling that senior leaders did not have a clear understanding of the pressures they faced or oversight of the service they delivered. The manager of the services told us that they believed that they were interested in the service and were supportive when the centres needed them. The Director of Nursing had arranged to work with the clinical lead at Woking over the weekend following the inspection.

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.

Managers, the clinical leads, and all staff understood and knew how to apply the vision and monitor progress. The vison for the walk-in centres focused on delivering high quality urgent care to all who presented at the service in a timely manner, including redirecting patient to more appropriate services and making sure that patients got the care they needed even if the centres could not provide that care.

Managers and clinical leads were focussed on quality improvement and clearly strived to learn and continually develop the service.

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 on both sites described the culture as positive saying they believed they worked as ‘one team, one big family.’ The clinical leads provided cover for each other and worked across both walk-in centres. The leads encouraged and facilitated positive working relationships across the centres and encouraged a ‘one team’ approach, with some staff working at both sites.

Staff described a culture of learning and improvement. Professional development and attendance at training was encouraged and funding was available to support this.

CHS provided an effective occupational health service which staff valued.

Nurses and paramedics who undertook bank shifts told us they were unhappy with the lower rate of pay for these and, whilst CSH had agreed to address this, action had not been taken at the time of inspection. In addition, the rates of pay for agency doctors was significantly higher than the other emergency practitioners even though they were undertaking the same role. These issues had left other ENP/EPs feeling undervalued and demoralised.

Community urgent care service

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.

Each walk-in centre held daily morning safety huddles to ensure all knew their roles and responsibilities for that shift. Further huddles would be held throughout the day as needed to address issues that arose. For example, if there were any serious risks with patients or if they were finding it challenging to meet the demand due high numbers of patients.

There were clear and robust systems and processes in place to ensure the appropriate referral or redirection of patients to other services. For example, if a patient needed to be transported by ambulance to the locals EDs or if the centres needed to close due to high demand.

There were effective governance processes in place to ensure key information about waiting times, complaints, audits, and major risk issues were escalated appropriately within the service and to senior leaders.

Leaders and teams at both walk-in centres 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 ensure finances did not compromise the quality of care they provided.

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.

At the time of the inspection the organisation was experiencing a national 'outage' of the patient record system and therefore both walk-in centres had to revert to keeping paper records. The paper records we reviewed were of high quality and information was still shared effectively within the organisation. However, staff now had to manually send information to GPs which created a delay.

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 walk-in centres engaged well with other services that provided care to patients. The service had close working relationships with GPs, local EDs and a variety of diagnostic and imaging services that supported patients.

Partner organisations within the local system told us that they felt the walk-in centres provided excellent care, were very patient focussed and played a key role in the delivery of urgent care services to patients.

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 urgent care service

Managers and clinical leads were focussed on quality improvement and strived to develop a culture of continuous learning and development. Staff undertook regular audits to improve performance. For example, one audit into diagnosing fractures from x-rays had focused on improving the accuracy of reporting. As a result of this the service had reduced the number of missed fractures/injuries to under 2%.

The teams had received various awards and nominations such as the clinical leads Star Award for CSH leadership and improvement.

Community health services for adults

Good

Is the service safe?

Good

Our rating of safe improved. 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 which was comprehensive and met the needs of patients and staff. Managers across teams monitored mandatory training and had access to a training matrix to identify when training was due.

The compliance rate for mandatory training was 89% across the community adults teams. The training included modules on safeguarding, infection control, equality and diversity, health and safety, basic life support and moving and handling. Specific topics relevant for the community nursing teams included pressure area care, falls prevention and medication management.

Staff completed an induction programme and were supernumerary for a period when starting work in the team. Qualified nurses completed observed practice by managers and competencies were signed off when required standards were met.

Regular agency staff were trained to the same level as permanent staff.

Safeguarding

Across teams staff understood how to protect patients from abuse and received training specific for their role on how to recognise and report abuse. Staff told us they could discuss concerns with colleagues, managers, and the organisation's safeguarding team. Managers told us they discussed safeguarding incidents in monthly community nursing operational meetings and then this cascaded down to the local teams through their team meetings. Team meeting agendas had safeguarding as a standing agenda item, so this meant that information was shared effectively to the teams.

We saw evidence of staff completing safeguarding referrals. Staff knew who to contact for specialist advice and worked closely with the providers dedicated safeguarding team.

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 (IPC) and hygiene

Staff kept equipment and their work area visibly clean. All clinic areas visited were clean and had suitable furnishings which were well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Staff also had access to personal protective equipment (PPE) and continued to wear face masks to reduce the risk of spreading COVID-19. We observed that staff cleaned equipment after use.

We observed nurses on visits to patients' homes and good infection control measures were in place. We saw nurses doing dressings and using aseptic techniques. Staff took precautions in peoples' own homes to protect themselves and patients. Patients had clinical waste disposal bins in their own homes and staff ensured these were used appropriately for disposal of soiled dressings. We saw examples of risk assessments for Personal Protective Equipment (PPE), and this was readily available for staff.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe, although some staff at clinics said it could get very warm.

Staff carried out daily safety checks of specialist equipment, which was clean, in date and fit for purpose. We looked at the equipment available for each team, including blood glucose machines, thermometers, pulse oximeter, blood pressure machines and weighing scales. Equipment held by staff was serviced and calibrated annually.

Staff said they could easily order equipment for patients in the community. Staff said there were sometimes delays with NHS supplies for example specialist dressings and they sometimes shared supplies across the three teams.

Assessing and responding to patient risk

We looked at fourteen patients' notes and saw evidence of holistic assessment and use of relevant risk monitoring tools. For example, tools to monitor food and fluid intake and pressure area care. Patients at risk were clearly identified and actions taken and shared with other providers to reduce risks. Staff at handover meetings clearly shared any new risks identified with the team and managers and took appropriate action including safeguarding.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included necessary key information to keep patients safe, including any social or psychological needs. We saw staff liaising with social care providers and relatives to provide the best care between nurse visits. Staff also educated people about how to escalate risks to appropriate services for themselves or those they cared for including out of hours support.

Staff administering insulin shared the patient's blood sugar reading at the team handover and any concerns were raised via the patients GP or diabetes nurse.

The service had recently rolled out a lone working app for staff to use in the community. However, we found that not all staff were made aware of this at the time of inspection. Managers assured us that this was being promoted across the teams and all staff would have access to it very shortly

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. However, the service relied heavily on regular agency and bank staff to fill shifts, particularly trained nurses. We saw staff being reallocated by managers to meet local need.

We attended two daily meetings where capacity, workload and staffing were discussed for each team. For example, in one area there were many patients requiring medicine via syringe drivers and staff with the relevant skills were redeployed to that area. We also saw planning for the next day including allocation of additional staff according to needs.

Community health services for adults

There were nursing and support staff vacancies across all the community nursing teams. The service was managing this with the support of contracted agency staff in teams which were consistently understaffed.

Team leaders accurately calculated and reviewed the number and grade of registered and non-registered nurses needed for each shift, and where staffing of registered nurses were low senior staff supported with patient visits.

At the time of our inspection 40 equivalent registered nursing posts were vacant across the community nursing teams. Leaders were managing the staffing challenges, and this featured on the organisation's risk register and quality improvement plan. There were recruitment plans in place with new starters across the organisation and a recruitment open day scheduled to take place in the weeks following our inspection.

Innovative ways to free up qualified nurses time included rolling out a new dedicated insulin administration team for patients. This would be staffed by Band 3 healthcare assistants (HCA) and coordinated by Band 6 nurses and would reduce time spent by qualified nurses on100 insulin injections needed to be given to patients per day, 7 days per week

Community nursing teams held caseloads within their geographical areas which aligned with primary care networks. Two of the community nurses team bases were within GP practice settings. This helped with continuity of care, although due to staffing issues patients were not always able to see the same nurse for every visit. Whilst patients often preferred to see the same nurse, staff told us this was valuable to their practice at times as it provided a 'fresh set of eyes' which benefitted the patient and encouraged clinical professional development. Patients said they enjoyed seeing different staff sometimes and all were friendly and caring.

The service also employed a dedicated care home matron to work with patients and staff in local care homes. There were approximately 130 homes in the catchment area and previously they had required a lot of time from qualified nurses. The new matron's role involved providing advice training and support for care home staff to safely manage patients and reducing the need for community nursing visits. A dietitian also worked in the care homes providing specialist advice about eating and drinking for patients.

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. All staff had access to electronic records and their own secure laptop or tablet for recording patient data in the community. Staff could access updates from GPs (General Practitioner) and share information securely.

We saw during handover patients who were not at home when the nurse visited being followed up and office staff could access information that they had been admitted to acute hospitals.

Medicines

The service used systems and processes to safely prescribe, administer, and store medicines. Patient's GPs prescribed most medicines and stored in their own homes.

We saw evidence of completed insulin administration charts with the relevant blood sugar level also recorded.

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

Community health services for adults

Clinical staff described a positive medicine incident reporting culture within the organisation and in-house specialty training and competency checks completed.

Staff within the clinics were able to obtain prescriptions for patients as needed and would discuss any concerns with GPs and send photos of wounds for assessment.

Incidents

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

Staff knew what incidents to report and how to report them in line with the provider's policy.

Near misses were also recorded and investigated to avoid them happening again. An example of this was a patient with similar name to another having a blood test.

Pressure ulcers were the most common reported incidents across adult community services, and staff were clear about which of these needed to be reported.

Across services staff discussed recent incidents and what could be learnt from them at monthly team meetings, multidisciplinary meetings, and daily handover meetings. Team leaders investigated incidents thoroughly, looking for themes, and involved patients and their families in these investigations. Team leaders supported staff after any serious incident and staff accessed debriefs after significant incidents including expected deaths.

Is the service effective?

Good

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

Evidence-based care and treatment

Staff kept up to date with and followed relevant National Institute for Health and Care Excellence (NICE) guidelines to plan and deliver quality care according to best practice.

Staff had access to policies on the staff intranet and across teams staff knew where to find them. Leaders told us they checked to make sure staff followed guidance through individual and group supervision and team meetings.

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 regularly completed and recorded mental capacity act (MCA) assessments. Managers had also developed a patient choice agreement checklist which was completed by staff and patients when patients choose not to have the treatment option recommended by the professional. The patient, carer or advocate completed a series of questions and then signed to state they understand not choosing the recommended option may lead to harm. This form was shared with the team and reviewed regularly.

Community health services for adults

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. We saw examples of nurses working with carers to ensure patients had enough to eat including patients needing snacks at set times to help control their diabetes.

We saw evidence of multi universal screening tool (MUST) assessments being completed which are used to assess risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients, and we saw referrals that had been completed for patients who needed additional treatment.

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 at the complex wound clinic were observed asking patients about their pain and sharing tips on how to manage pain following a dressing change. We saw staff liaising with GPs and palliative care teams to manage pain in patients on end-of-life care**.**

Staff in specialist services assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way in line with individual needs and best practice.Some patients had access to syringe drivers for symptom control, specifically when patients were coming towards the end of life.

Patient outcomes

Staff monitored the effectiveness of care and treatment and managers used information from the audits to improve care and treatment.

The COVID-19 pandemic impacted the clinics availability to always see patients face to face. Technology was used to support video virtual appointments for triage of podiatry and wounds and advice, signposting or face to face appointments were then arranged. This technology reduced the need for some patients to travel to clinics and some appointments remain virtual following patient and staff feedback. Patients said they valued the flexibility of attending either virtual or face to face appointments.

Competent staff

The service made sure staff were competent for their roles and regularly provided updates and peer learning for all staff.

We saw a comprehensive preceptorship programme in place for newly qualified nurses joining the service.

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 appraisal rates were 80% and managers explained that all staff were due to have appraisals and personal development reviews completed by the end of September 2022.

Staff said they received both formal and informal supervision via their teams and clinical reflection formed part of team meetings. Staff felt this was adequate to meet their needs and knew they could always ask managers for additional support to discuss any concerns

All staff spoke positively about learning and development opportunities within the organisation. Staff told us that managers identified training needs and gave them the time and opportunity to develop their skills and knowledge in specialist areas. We met numerous staff carrying out their preceptorship, degree and masters level training and specific clinical training outside of the organisation that would help improve and advance their clinical skills. We saw staff being promoted from within the organisation and HCAs becoming nursing associates and qualified nurses undertaking specialist district nursing masters courses.

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

Managers identified poor staff performance promptly and supported staff to improve. Staff in all the teams told us they felt able to raise concerns or questions they had with their team leaders.

Multidisciplinary working

All those responsible for delivering care worked together as a team to benefit patients. They supported each other to provide safe care and communicated effectively with other agencies. We saw good examples of joint working with other professionals including mental health teams, carers, physiotherapists, occupational therapists, tissue viability nurses, dieticians and speech and language therapists.

We saw staff working with adult social care carers to ensure patients were moved in position by hoist before the nurses visit to carry out wound care. Staff also escalated any concerns about patients living conditions with relevant agencies including safeguarding.

Teams across adult community services referred patients on to other specialist teams as needed, sometimes carrying out joint visits to patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health. We saw evidence of referrals to mental health teams being completed in care records and observed staff discussing psychological wellbeing with patients during home visits.

Health promotion

Staff gave patients practical support and advice to lead healthier lives. We observed staff offering advice about reducing alcohol intake and falls prevention in the home.

Staff across the community nursing teams and specialist services worked with patients to maximise their independence in managing their own treatment. For example, community nursing staff assisted patients in their own homes to self-administer medicines when this was assessed as safe and appropriate.

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.

Mental Capacity Act and Deprivation of Liberty Safeguards training was covered within the mandatory safeguarding adults training.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, considering of their wishes, and recorded this in the patients' records.

Managers had also developed a patient choice agreement checklist which was completed by staff and patients when patients choose not to have the treatment option recommended by the professional. The patient, carer or advocate completed a series of questions and then signed to state they understand not choosing the recommended option may lead to harm. This form was shared with the team and reviewed regularly

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. We observed discussion around patients' mental capacity during community nursing face-to-face staff handover meetings.

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 and were passionate about delivering care to patients. Staff were discreet and responsive when caring for patients, respecting their privacy and dignity.

Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed clinic appointments and home visits where staff spoke kindly and respectfully to patients and those close to them.

We spoke with 23 patients and four carers during the inspection, and all felt happy with the care they had received.

Patients described staff as caring, kind and always doing their best to help them.

We saw staff explaining information clearly to patients and being patient when asked to repeat it.

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

Emotional support

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

Staff supported patient's relatives, particularly in understanding their complex health conditions. Staff emphasised that this support was important because many patients and relatives reported feeling isolated because of the COVID-19 pandemic. Staff told us they took extra time to listen to patients and support their emotional wellbeing despite feeling under pressure due to a lack of staffing, and this was reflected in the patient feedback.

Community health services for adults

Understanding and involvement of patients and those close to them

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs. Patients gave examples of staff being lifelines to the outside world and providing support to meet their needs. Patients said staff were positive and really helped them even when they had complex issues and needed extra support.

Staff supported and involved patients, families, and carers to understand their condition and make decisions about their care and treatment. Patients described staff teaching them to manage diabetes, including self- administration of insulin and promoting a healthy lifestyle. We saw staff advising carers and relatives about managing dressings in between nurse visits including when washing.

Staff talked with patients, families, and carers in a way they could understand.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service used a form called I want great care which was available to patients and carers in a range of formats. Overall patients gave positive feedback about the service. The feedback from people receiving care was that they felt listened to, respected, and had their views considered.

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. Staff worked closely with local primary care networks (PCN) in each area. Staff had good knowledge and working relationships with other local services and providers.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff referred patients to specialist services when further intervention was required.

Staff told us that GPs were referring patients with more complex needs and acute hospitals were under pressure to discharge patients so patients in the community needed more care.

Managers and staff told us that demand vs capacity of the team was constantly under review

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 described working at a local travellers site and how they overcame challenges to provide care in that environment. We observed staff considering individual needs and respecting patients' decisions in their own homes. We saw an incident where a patient was supported to make an unwise choice and the incident was reported appropriately by staff including a safeguarding referral.

The service had information leaflets available for patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed, although this system was not always used. When appropriate, staff used close family members and carers to support with discussions about care plans and clinical interventions.

All services visited were easily accessible to people with mobility needs.

Access and flow

People could access the service when they needed it and received the right care in a timely way. Staff allocated patient visits to the teams and a red, amber, green (RAG) rating system was used to prioritise patients according to clinical need. Some patients' visits were moved to later in the week if they were in the green category and required routine care. Staff told us this system worked well and most patients were understanding if their care needed to be delayed.

Staff told us that GPs were referring patients with more complex needs and acute hospitals were under pressure to discharge patients so patients in the community needed more care.

Managers and staff told us that demand vs capacity of the team was constantly under review.
At the time of inspection, the combined caseloads across all three community nursing teams were approximately 1400 patients. Caseloads per qualified full- time substantive nurse varied between teams but averaged at 93.

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. All 27 patients and carers we spoke with said that they were comfortable doing this and had positive feedback for the staff supporting them. They felt able to complain and that staff would address their concerns quickly.

Patients were encouraged to feedback on their care with an I want great care form. Questions included were they being treated with dignity and respect, involvement, information sharing and being treated with kindness and compassion. Basic optional equality monitoring information could also be recorded.

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 local team meetings which included a standing agenda item for incidents and complaints for managers and staff to discuss feedback and any learning.

Formal and informal complaints were discussed at a monthly community nurses' operational group.

Community health services for adults

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. Staff described accessible, visible, and approachable leaders who supported them to develop their skills and take on more senior roles. Feedback from staff was overwhelmingly positive about the support and guidance they received from the leadership team.

Leaders worked within the teams and were very aware of issues facing staff in the community doing their jobs.

Leaders had escalated concerns from staff about how delayed payment of mileage claims effected the cost of living. Senior managers acted and increased mileage threshold and streamlined claiming process. Leaders also worked with teams to ensure best use of travel and linking visits within a locality where possible.

Several staff we spoke with had been promoted within the organisation and had undertaken paid training and development opportunities.

Managers understood and managed the priorities and issues the service faced. Leaders had got involved during the recent staffing issues and supported the teams to continue to deliver care during the COVID-19 pandemic.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action. Leaders, managers, and staff were committed to turning plans into reality and were working together to provide the best possible service for patients.

Staff said they felt connected to the plans and wanted to live the organisations key values via their work.

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 worked closely with a local health alliance and shared sites with several other local providers including acute trusts and primary care networks. Contracts were being reviewed and commissioners were kept informed of the team's performance.

Culture

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

Staff said local leaders were clearly visible but said senior leaders were not as connected to frontline staff and their roles.

Community health services for adults

Staff we spoke with said they really enjoyed working as part of a supportive team. Some staff described reasonable adjustments made by managers in the workplace to enable them to return after sickness. Some staff described great support through life events and how teams were like family.

Staff felt listened to and would be happy to speak up. Staff were aware of freedom to speak up guardians and The Voice independent staff network.

The service promoted equality and diversity in daily work and provided opportunities for career development. Staff told us they felt proud of their roles and were encouraged to undertake further training to enhance skillset and career progression.

The service had an open culture where patients, their families and staff felt able to raise concerns without fear of consequences. Staff were focused on the needs of patients receiving care.

The organisation was taking steps to continuously recruit and offered incentives to work within the organisation.

Governance

Overall 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. All services had regular team meetings which were recorded.

A community nurses operational group meeting was held monthly. This received reports from each of the locality groups and was accountable to the quality and clinical governance group.

Standing items on the agenda included discussing current staffing levels, all datix incidents, safeguarding, complaints and identifying themes to learn from within the teams.

Leaders fed into the governance process and escalated concerns appropriately. Some staff appreciated that leaders all had a professional clinical background and could relate to their working lives.

Management of risk issues and performance

Leaders and teams used systems to manage performance effectively. The organisation had individual risk registers relevant to each service which outlined specific risks and a quality improvement plan designed to reduce their impact and improve services for patients. All members of the senior leadership team actively updated risk registers and managers told us this created a sense of collective responsibility.

The teams had a risk register and main items were staffing and capacity vs demand. Leaders were aware of these issues and had developed a range of mitigation actions to reduce these risks.

Information Management

Community health services for adults

Staff across all community adult services had access to systems that made sharing patient information possible. 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 could access IT dashboards for their service and relevant data was shared. For example, caseloads per team were analysed and staffing adjusted accordingly.

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 Voice independent staff network worked with staff to raise any issues to senior leaders via a democratic process.

The equality and diversity team had recently employed facilitators to run staff peer equality groups for staff with protected characteristics. At the time of inspection groups were running for black and minority ethnic communities, LGBTQ+ communities and disabled employees. Other equality groups were planned.

Leaders also worked with local voluntary sector providers, and we saw staff signposting patients and carers to other services**.**

Teams held regular local team meetings and staff confirmed that there was good engagement.

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. We saw staff were keen and engaged and staff told us they wanted to do their best for patients. We saw a culture of learning and development and staff's skills being used appropriately to teach others and promote good practice**.**

Innovation included the development of a dedicated insulin administration team and a dedicated community phlebotomy team. Both were developed to reduce time spent by qualified nurses performing these tasks.

The dedicated care home team has also worked to reduce pressure and demand on community nurses by providing advice and support to care home staff.