

HCRG Care Services Ltd

# Farnham Hospital and Centre for Health

## Inspection report

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

### Ratings

#### Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

# Summary of findings

## Overall summary

We rated this location as good because:

- Staff had training in key skills, understood how to protect patients from abuse, and managed safety and controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. There was appropriate medicines management process in place. The service managed safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Staff provided good care and treatment, checked that patients had access to enough food and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people and made it easy for people to give feedback. People could access the service when they needed it, although some services were reporting high waiting times.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However;

- Managers and team leaders did not ensure that clinical supervision was always recorded in line with policy. It was not clear how the teams identified and recorded personal areas for development through the supervision programme.
- Managers did not always record in staff appraisals the strengths of the appraisee and the areas they needed to improve on, in line with the provider's overall strategy.
- The service was reporting a high waiting list for podiatry of up to 84 weeks. Staff reported this was as result of podiatry services being suspended during Covid-19 pandemic and national shortage of podiatrists. We were concerned that people who needed the service may not always get timely interventions.
- Rapid response/ intermediate care teams did not ensure that patients were contacted within the 24- 48 hours response time set by commissioners.
- The service was reporting a vacancy rate of 12.2% across all staff group. Staff reported that the teams were quite stretched which had been impacted by sickness and people going on leave. However, staff reported the workload was generally manageable.

# Summary of findings

## Our judgements about each of the main services

Service	Rating	Summary of each main service
Community health services for adults	Good 	

# Summary of findings

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# Summary of this inspection

## Background to Farnham Hospital and Centre for Health

HCRG Care Group provides community adults services across Surrey Heath and North East Hants and Farnham in partnership with the NHS and the local authorities. After more than 10 years as part of the Virgin Group, Virgin Care rebranded as HCRG Care Services Limited in 2021 and was acquired by Twenty20 Capital.

The service registered with the Care Quality Commission in 2012.

They are registered to provide the following regulated activities:

- Treatment of disease, disorder or injury
- Nursing care.

Community health services for adults. The community health services for adults operates across

Surrey Heath and North East Hants and Farnham. They provide care and treatment for patients in their own homes and in clinics.

The teams at Farnham Hospital and Centre for Health included:

- General outpatients service (subcontract with the NHS trust), Diagnostic and Treatment centre (DATC), podiatry clinic, GP Direct Access Physio, Speech and Language Therapy, in-patient therapy (subcontract with the NHS trust), and specialist nurses including continence and tissue viability nurses operated Mondays to Fridays between 8am to 5pm. The community nursing teams operated 24 hours a day seven days a week service, while the intermediate care teams operated a 12 hour shift between the hours of 8am to 8pm.

Other sites where the service operated from included:

- Camberley Health Centre on Frimley Road, Camberley hosted Surrey Heath Single Point of Access (SPA), community nursing, intermediate care and diabetes team. We were informed at the time of our inspection that the services were moving out of this site. The services operated from 8am to 8pm.
- The district nursing office at Ash Vale Health Centre that hosted the Surrey Heath community nursing teams at Wharf Road Aldershot. The service operated from 8am to 8pm.
- Frimley Green Health Centre on Beech Road, Frimley that hosted Surrey Heath community nursing teams, the intermediate care teams and community nursing weekend services. The service operated 7 days a week 8am to 8pm.
- Lightwater Health Surgery on All Saints Road, Lightwater, that hosted the seven day community nursing teams.
- Fleet community hospital in Fleet, that hosted the tissue viability and diabetes nursing teams and the service operated between 9am to 5pm.
- The service had podiatry clinics which were held at Aldershot Centre for Health and Yateley Medical Centre that operated on different days of the week between 9am to 5pm. The intermediate care in-reach service at Frimley Park Hospital, Camberley was available Monday to Friday.

The service had a registered manager in post. This service was last inspected and rated good overall under the previous provider Virgin Care Services Limited. The inspection report was a single report that covered all core services by the provider at the time. On this inspection we inspected and rated the community health service for adults under our current inspection methodology.

# Summary of this inspection

## How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about the service. We announced this comprehensive inspection 48-hours prior to the inspection visit. Due to the service providing services throughout Surrey in South East England, we announced the inspection so that the service could arrange interviews.

During the inspection, the team:

- Visited outpatient clinics where care and treatment were provided
- Attended two home visits with staff
- Spoke with 28 members of staff including managers, service leads, community nursing teams, specialist nursing teams, therapists, allied health professionals and health care assistants. These were carried out via onsite interviews as well as virtual staff focus groups for staff we could not speak to onsite
- Spoke with 14 patients and their relatives
- Reviewed 10 patient care and treatment records
- Observed a handover meeting
- Looked at a range of policies, procedures and other documents related to the running of the service.

You can find information about how we carry out our inspections on our website:

<https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection>.

## Outstanding practice

We found the following areas of outstanding practice:

- The diabetes team recently completed an awareness campaign for diabetes - Diabetes Roadshow, funded by the provider. The aim of the campaign was to meet and engage with people and professionals including General Practitioners (GPs) and nurses, and also provide education and awareness to staff around the management of diabetes. The education and training covered areas such as using new drugs in the early management of diabetes for people with type two diabetes. Staff reported that studies have shown that early detection of diabetes and treatment in the first year led to better prognosis over a 10 year period. The teams were able to reach 26 GP practices and 300 different professionals.

# Summary of this inspection

- The teams have developed a lot of resources including information leaflets for GP practices and patients on how to manage a hypoglycaemic (low blood sugar level) episode. The outcome of the campaign was that the teams now received more appropriate referrals from GPs, and the integrated care board (ICB) was now utilising the materials developed by the service.
- The diabetes teams delivered teaching for an accredited course to nurses and GPs who want to specialise in diabetes, and they received an accredited certificate at the end of the course. They were also promoting flash glucose monitoring which research showed was more effective at identifying patients with hypoglycaemia than more traditional methods.
- The teams did a hypo awareness week as data showed there had been an increase in diabetes since covid-19 pandemic. Hypo awareness week was a national initiative which was a teaching programme for HCRG staff across the country both face to face and virtual. The ICB participated in this project and the teams won a national award for this work. A district nurse gave feedback that they had gone into a patient's home who was having a hypo and thanks to the training they knew exactly what to do.
- The teams offered 'shadow the nurse' – an initiative by the diabetes team which gave other members of staff the opportunity to shadow a specialist nurse to learn more about diabetes. This programme followed a more formalised, structured curriculum. The programme was originally just for district nurses but had now opened up to all professionals. Other specialities were also using this model.
- Other initiatives by the teams included the 'Diabetes walks for health' – initiative done in conjunction with local council. This included a weekly guided group walk for those with diabetes. Every 6 weeks the teams gave a talk for specific topic. For example, diet and foot care. The local council took the lead on this with the diabetes nurses presenting the talks.
- The provider has implemented staff wellbeing support initiative called 'what are you proud of today?' book where staff could add comments about how they felt at work. Team managers reported they have been researching how they could improve on staff wellbeing and what made an effective workplace.

## Areas for improvement

Action a provider **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 service **SHOULD** take to improve:

- The service should take more proactive steps to reduce the waiting list for podiatry.
- The service should work to recruit to vacant positions and ensure all shifts are covered.
- The service should consider having a clear system for recording clinical supervision and leaders should ensure there is clear governance oversight of clinical supervision.
- The provider should ensure that appraisal records are completed fully and that they meet the needs of the staff member.
- The provider should ensure that all patients referred to the service are contacted within the set times agreed with the commissioners.

# Our findings

## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good



# Community health services for adults

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

## Is the service safe?

Good 

### Mandatory Training

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

Staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. The teams met their mandatory and statutory training targets which were consistently above 91%.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff were in process of completing the newly introduced Oliver McGowan training on Learning Disability and Autism which commenced in November 2022. We saw that 35% of staff had completed this training and staff who had not completed the training were given a deadline of April 2023 to complete it.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers received an email alert when staff book themselves for a training course.

### 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.**

The provider had clear safeguarding policies and procedures which were easily accessible to staff. There was a safeguarding flowchart on the intranet with guidance for staff about making a safeguarding referral. For example, the document detailed how staff would manage missed health appointments for adults and when there were safeguarding concerns. When a patient failed to attend a clinic appointment or when staff could not access or contact them, following an initial risk assessment and discussions with the team, an urgent safeguarding referral would be made, and concerns reported to the police to conduct a welfare check.

# Community health services for adults

All staff were required to complete their safeguarding training and we saw that the safeguarding training rate was 91% which was above the provider's target. The safeguarding trainings were detailed, and staff felt the safeguarding training was useful for their roles. Clinical staff who had regular contact with patients were required to complete level 3 safeguarding training for adults and children.

Staff knew how to make safeguarding referrals and who to contact if they had concerns. There were safeguarding champions across the teams. The provider was in the process of recruiting a full time safeguarding lead as the previous safeguarding lead had retired. There was an experienced safeguarding manager in an interim role who staff contacted when they needed to discuss or escalate any safeguarding concerns. Managers were trained to safeguarding level 3.

Safeguarding was discussed at handovers, team meetings and one-to-one sessions between staff and their managers. Safeguarding referrals were monitored by managers and discussed at clinical governance meetings. During handover, the manager updated the team on the outcome of a safeguarding referral for a patient who was at risk of hoarding.

Staff knew and understood how to protect people from harassment and discrimination. They could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. The intermediate care team reported they worked very closely with social services who were co-located in the same office.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. Staff kept equipment and their work area visibly clean.**

All clinic areas we visited were visibly clean and had suitable furnishings. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

The provider monitored performance around cleanliness and reports showed that most of the services generally performed well for cleanliness. Cleanliness audit including hand hygiene audit ranged between 85 to 100% across the teams and sites. The provider's audit had identified that the Rapid Response, Camberley Health Centre rooms where clinical practice took place were not carpeted and the floor coverings were not washable and impervious to moisture. There were no hand wash basins in the clinic rooms. The provider informed us that they have put in mitigations to reduce the risk of infection at this site by stopping all invasive procedures. All staff that worked at the site have been provided with hand sanitisers. The provider had also raised this with the estates team. The registered manager and the infection prevention and control (IPC) lead informed us that they were moving out of the Camberley site the week following our inspection and that the new environment has appropriate flooring and the clinic rooms had appropriate hand washing facilities.

Staff followed infection control principles including the use of personal protective equipment (PPE). The provider had clear and up to date IPC policies and procedures which was monitored by the IPC lead. The IPC lead worked nationally and provided support to the service one day a week for any concerns around IPC, training and compliance concerns.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

# Community health services for adults

## Environment and equipment

**The design and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well. When providing care in patients' homes staff took precautions and actions to protect themselves and patients.**

The design of the environment followed national guidance. The environment was generally clean and tidy. The equipment storage rooms were locked and keypad accessible. All items including dressings, stock boxes and syringe pumps were neatly stored in a systematic way and clearly labelled. All disposable and single use items were within date.

Staff regularly took stock of supplies to ensure they did not run out. The service had an online ordering service which the band four nurses could utilise to order items, and the administrative staff could order items via NHS direct. Staff informed us that delivery was always prompt.

Staff carried out daily safety checks of specialist equipment. Some services such as the physiotherapists used disposable privacy curtains to protect privacy and the curtains were replaced regularly. There was a hand wash basin in the clinic room and the clinician wore appropriate PPE and replaced them as required to limit cross-contamination. Staff disposed of clinical waste safely.

The service had suitable facilities to meet the needs of patients. There were ample rooms where staff could meet with their patients including a dedicated room for electrocardiogram (ECG) at Farnham Hospital site. An ECG machine *records the electrical signal from the heart to check for different heart conditions*.

The service had enough suitable equipment to help them care for patients safely. Specialist nurses and clinical leads had laptops and nurses had tablets and mobile phones which were recently upgraded. While some staff felt the Information Technology (IT) systems were generally okay, and that they could get support from the IT department when they had concerns, some staff felt that sometimes IT issues took a long time to be resolved as they worked remotely.

Managers informed us that they could facilitate access to the patient record system for new and agency staff to reduce any delays in care, while their IT credentials are being set up

Staff could utilise the office desktop computers at the Farnham hospital site on a first-come, first-served basis. However, some staff reported there was not always enough computers to do their work. Managers informed us that the service had received 60 new desktop computers to replace some of the old computers.

## 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 completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff ensured that they recorded baseline observations for each patient on first assessment and obtained consent to treatment. All patients were red, amber and green (RAG) rated on referral to ensure they are allocated to the appropriate teams who would respond to their presenting needs.

# Community health services for adults

The community nursing teams, and tissue viability nurses took photographs of any areas requiring treatment such as wounds during initial assessment or consultation and monitored this to ensure that the patient's condition was not deteriorating.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning Score 2 (NEWS2) which improved the detection and response to clinical deterioration in adult patients. The community matrons had devised a pathway to incorporate NEWS2 to triage referrals.

Staff knew about and dealt with any specific risk issues. Staff carried out SSKIN (S – surface. S – skin inspection. K – keep moving. I – incontinence. N – nutrition and hydration) and Waterlow risk assessment which were embedded in the pressure ulcer detection and prevention pathway. Staff completed Malnutrition Universal Screening Tool (MUST) assessment for patients who might be at risk of malnutrition, malnourished or obese.

The service had a dedicated diagnostic and treatment centre/ falls assessment unit which consisted of a multidisciplinary team including occupational therapists, physiotherapists, speech and language therapists, nurses and was led by a medical doctor. All patients who were referred to the service were robustly assessed, and appropriate referrals made.

The service had 24-hour access to mental health liaison and specialist mental health support, if staff were concerned about a patient's mental health. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff worked closely with the mental health teams to carry out joined up home visits.

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. The service had a handover book where they recorded key information and actions needed for staff coming on shift. We observed during handover that staff discussed whether a patient who they could not contact, or access could be at risk and actions they needed to take. Managers ensured that allocated visits that were not completed for the day were followed up.

## Staffing

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

Team leaders regularly reviewed staffing levels and skill mix, and prepared staff rotas months in advance to ensure all shifts were filled. The minimum staffing levels were agreed by the service and commissioners.

Managers used bank and agency staff to fill shifts which could not be covered by a regular member of staff. However, the service was reporting a number of unfilled shifts across the teams which managers reported were usually as a result of short notice sickness, annual leave or established vacancies. The intermediate care teams and the community nursing teams were reporting the highest numbers of unfilled shifts between November 2022 and December 2023.

The service was reporting a vacancy rate of 12.2% across the teams with the intermediate care and community nursing and Farnham specialist nursing teams reporting the highest numbers of vacancies and this correlated with the numbers of unfilled shifts.

# Community health services for adults

Managers reported that although there were staffing vacancies across the teams, they had put mitigations in place to minimise risks. For example, the teams were using more regular agency and bank staff who knew the patients well and had worked for the service a long time, they were undertaking telephone triaging and only substantive staff were doing the triaging of referrals.

The service had a pool of bank healthcare assistants who were available to cover a shift at short notice.

Managers and staff reported that the turnover rate was very low. Most staff reported that they enjoyed working for the service and chose to stay. A number of staff had been with the service for a long time. Staff reported that although the workload was high, and staffing was stretched, they always pulled together as a team to get the work done and ensured people received the best care and treatment. Managers and staff felt that the reasons why the service would report a turnover would be as a result of retirement or for personal reasons.

The provider collected feedback from all staff that left the service and analysed the information in order to improve recruitment and retention.

The sickness and absence rates were generally quite low across the teams in the last three months.

Due to staff being on maternity leave, the provider had commissioned an external speech and language therapist (SALT) company to cover which had been successful.

At the time of our inspection, the provider was actively recruiting for the vacant posts. The provider had successfully recruited one diabetes nurse to the diabetes team increasing the team size to four, and some teams were now fully staffed. The new staff members were undertaking a training and induction programme which included shadowing more experienced members of staff.

## Medical staffing

The medical cover supporting the delivery of the range of functions within the diagnostic and treatment centre/ falls assessment (DATC) unit was delivered by Frimley Health NHS Foundation Trust. This was done through a subcontracting agreement which was arranged through a provider-provider negotiation.

The medical doctor was available from 9am to 5pm daily providing medical support to the teams. There was consultant support available for additional support provided by the Frimley Health Foundation Trust if required. 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.

Staff who worked in other teams such as the district nursing teams and intermediate care teams that provided 24 hour support to patients could access the consultant on call during evenings and weekends.

## Records

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

# Community health services for adults

The service used an electronic patient record system and staff reported that this worked well. Patients also had a copy of their personal management plan in their own homes. Some services such as the diagnostic and treatment centre recorded patients' assessment on paper which were then transcribed onto the electronic patient record system so that no information was lost.

Patient notes were comprehensive, and all staff could access them easily. All 10 patient records we reviewed were detailed, thorough, person-centred and in date. Staff told us that there were usually no delays in updating patient records. The nurses had mobile tablets which enabled them to complete their notes on the go. They also had access to the GP notes which they found very useful.

Records were stored securely. Staff had individual log in credentials to access patient records.

When patients transferred to a new team, there were no delays in staff accessing their records. However, some staff reported that the IT systems and support could be better and there were not always enough desk top computers for staff working on site. Staff were aware that new desk top computers had been delivered.

## Medicines

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

Staff followed systems and processes to prescribe and administer medicines safely. Staff ensured that medication and prescription charts were completed and signed by the patient's GP.

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

Staff stored and managed all medicines and prescribing documents safely. Staff completed medicines records accurately and kept them up to date. Patients who were seen at home had a medication booklet in their homes. The district nurses had specific details as to where this was stored to ensure it did not go missing.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. The service had a robust process around medicines reconciliation which was overseen by the lead pharmacist.

The service carried out regular medicines audits to identify areas that needed improvement and where there were concerns, the service had clear action plans on how they will address them. For example, the medicines audit had identified from the prescription charts that there had been three occasions of missed doses for patients. The service learned from this and put an action plan in place including providing extra support to staff.

Staff learned from safety alerts and incidents to improve practice. For example, although the service did not use a particular brand of chesty cough and cough powder for oral solution which had been recalled, the service took action to inform patients who may have purchased the medicine about the safety alert.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

## Incidents

# Community health services for adults

**The provider had a robust process for reporting, managing, investigating and learning from incidents. The service managed patient safety incidents well.**

The provider used an electronic system for reporting incidents, and staff received training on how to report incidents. Staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with provider policy. The provider's policy required staff to report all patient safety incidents within 24 hours.

The service kept an incident log which contained information such as who reported the incident, the level of severity, initial actions taken, and any lessons learned. All reported incidents were assigned to investigating managers who were usually service leads.

Managers investigated incidents thoroughly and shared lessons learned with the whole team and the wider service. Managers involved patients and their families in these investigations.

Staff and patients received feedback from investigation of incidents, both internal and external to the service. Staff who reported an incident received feedback and were updated on the outcome. 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, staff had reported that an emergency medicine was found to be out of date during weekly checks. Staff were now required to order stocks one month in advance of medicines running out or expiring.

Staff reported serious incidents clearly and in line with provider policy. Managers debriefed and supported staff after any serious incident. All reported incidents in the last three months were either reported as no harm, low harm or moderate harm which did not meet the criteria for root cause analysis (RCA) investigation.

Staff understood the duty of candour. They informed us it was about being open and transparent, apologising and giving patients and their families a full explanation if and when things went wrong, and providing suitable support.

Managers ensured that actions from patient safety alerts were implemented and monitored. For example, staff had reported that there were problems with a particular batch of blood collection set's spring-activated needle withdrawal system. The needle withdrew with excessive force and caused blood to splash onto the user's skin. The team has tested further examples and found they operated in the same way. Staff reported that the device could potentially cause a blood splash to the user's eyes when withdrawing a used needle. The service has escalated this to procurement, and they have taken steps to review the items on stock, supplied alternatives and quarantined the product.

The service had no never events in the last 12 months.

## Is the service effective?

### Evidence-based care and treatment

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

# Community health services for adults

Staff carried out detailed risk assessments for patients and developed a management and treatment plan following an assessment, and these were clearly documented.

Care plans were personalised and there was evidence of patient involvement. All assessments and care plans were incorporated in the visiting day report. One patient record we reviewed clearly showed wound management assessment with care plans, review date and consent to photograph the wound. There was documented evidence that concerns about the wound were escalated to the tissue viability nurses (TVNs).

Patients who were at the end of their life had a care plan in place with the patient's wishes documented. Staff ensured that Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were duly completed. Patients at the end of their life also had anticipatory drugs prescribed.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service used a red, amber and green (RAG) rating system to prioritise needs. For example, for patients who have been risk rated red, the teams would usually respond within 24 to 48 hours. The diagnostic and treatment centre/ falls assessment clinic incorporated a social history as part of the initial assessment.

Staff protected the rights of patients subject to the Mental Health Act 1983 and followed the Code of Practice. If staff had concerns about a patient's mental health, they could refer directly to the community mental health teams or the patient's GP. Where required, staff undertook joint visits with the mental health teams.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

## 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.**

Patients informed us that staff regularly asked them if they were eating and drinking well. Patients felt staff would assist them to make a drink or prepare a meal without hesitation.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. For example, most patient records we reviewed showed that staff undertook assessments for patients who could be at risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). Where there were concerns about a patient's eating, drinking or swallowing, they made appropriate referrals to specialist teams such as dietitians, speech and language therapists and staff also informed the patient's GP.

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. For example, patients on home parenteral nutrition (intravenous feeding at home).

## Pain relief



# Community health services for adults

**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 such as the numerical rating scale (NRS) and Abbey pain scale. They gave patients pain relief in line with individual needs and best practice. Staff assessed patients who had communication difficulties for pain using a nonverbal rating scale.

Staff ensured that patients received pain relief soon after requesting it.

Staff ensured that patients on complex pain management received appropriate and timely intervention. For example, a patient at the end of their life had reported that the syringe driver had not been effective in managing their pain. The clinical team felt that moving the patient to a hospice was the best way for them to manage the patient's pain and they had arranged for the syringe driver to be collected once the move was complete.

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.**

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.

The schedule of audits included but was not limited to confidentiality audit, safeguarding audit, medicines audit, infection prevention and control audit and National Institute for Health and Care excellence (NICE) audits. The providers audit programme was useful to identify areas where improvements were needed and improve outcomes for patients. For example, the teams have recently completed a diabetes awareness campaign which aimed to improve patient outcomes for patients living with type two diabetes which was consistent with NICE guidance. The NICE guidance on the management of type two diabetes focused on patient education, dietary advice, managing cardiovascular risks, managing blood glucose levels, and identifying and managing long-term complications.

Outcomes for patients were positive, consistent and met expectations, such as national standards. For example, the service regularly carried out audits of patient health records to identify whether patients' needs were consistently met. The mental capacity audit undertaken by the rapid response team showed that staff ensured that patients consented to treatment and where applicable, best interest decisions were clearly documented.

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

Patients reported that they generally received good care and treatment from the service. One patient reported that the support they received at home from the occupational therapists and physiotherapists who assisted them with their exercises was very effective. We saw another example where there was a treatment care plan to incorporate mobilisation for a patient following surgery; This was agreed with patient and family for a 6 week reablement programme.

## Competent staff

# Community health services for adults

**The service made sure staff were competent for their roles. Managers appraised staff's work performance. However, staff clinical supervision was not always recorded in line with the provider's policy.**

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. The qualified staff told us they kept up to date with their clinical practice through continuous professional development (CPD), and with support from the clinical educators.

The diabetes nurse leads attended a specialist conference at least once a year hosted by Diabetes UK or European Diabetes, and articles from the conferences were shared with the teams.

The teams provided support to other services and health care providers across the integrated care systems (ICS) through education and training. The SALT teams were preparing a dysphagia training for nursing homes, GPs and other independent health care providers.

Managers gave all new staff a full induction tailored to their role before they started work. Staff told us that they found the induction very useful, and it had prepared them for their roles.

Managers supported staff to develop through yearly, constructive appraisals of their work. However, we saw that the appraisal records were not always completed thoroughly. For example, for some staff there were no records of what their strengths, goals or areas of improvement needed were.

All staff we spoke to including medical staff felt they received regular clinical supervision including group supervisions and one to one time with their managers. Staff reported that they did peer supervisions where they attended home visits in pairs to observe practice and feedback. However, we observed that clinical supervisions were not consistently recorded in line with the provider's policy.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. For example, the diabetes leads were supporting new members of staff with specialist training.

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

## Multidisciplinary working

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

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service held a weekly integrated care meeting which was usually attended by the dementia care team, mental health teams, adult social care, family action, social prescriber and GPs which was held remotely. There were clear agenda for these meetings and patients who were open to these services were discussed, action plans were developed, and patients assigned to the appropriate specialisms. The service also held a frailty meeting which was attended by a consultant for the elderly, dementia nurses, physiotherapist, GPs, clinical leads and pharmacy teams.

# Community health services for adults

Staff worked across health care disciplines and with other agencies when required to care for patients. For example, staff worked closely with the ambulance service to identify patients who could be supported at home and avoid hospital admissions.

Staff referred patients for mental health assessments when they showed signs of mental ill health, for example, depression.

Patients had their care pathway reviewed by relevant consultants. For example, the service had a coproduced treatment pathway with the dementia nurses for housebound patients. The intermediate care teams also worked closely with the enhanced recovery service (ERS) which was run by another organisation. The ERS provided the two hour urgent community response to patients who required it.

The community nursing teams had a joint monthly governance meeting with the local trust. The teams did a deep dive into the services each month to review waiting lists and patient care and how it could be improved.

Staff reported they sometimes worked with the local hospice, community nursing teams and or consultants to do joint home visits.

## Health promotion

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

The service had relevant information promoting healthy lifestyles such as healthy eating and smoking cessation.

Staff assessed each patient's health during their appointments and provided support for any individual needs to live a healthier lifestyle. For example, we observed a physiotherapist giving out a booklet to a patient advising them of the recommended exercises after a session. The staff member also demonstrated how to perform these exercises and supported the patient to practice them.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff informed us that capacity assessments were incorporated into care plans.

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, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available. 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. They understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act 1983 and Mental Capacity Act 2005 and they knew who to contact for advice.

# Community health services for adults

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. Information about the Mental Capacity Act was available on the intranet.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

## Is the service caring?

Good 

### Compassionate care

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

Feedback we received from all 12 patients and carers we spoke with was generally positive. Patients felt staff were compassionate and kind. They reported that staff were discreet and responsive when caring for them.

Staff interacted with patients and those close to them in a respectful and considerate way. They addressed patients by their preferred name. We observed that staff were very kind and knowledgeable when caring for a patient, treated them with dignity and respect at all times and explained what they were doing. One patient reported how a member of staff had cared for them over Christmas. The patient was unwell and unable to get out of bed. The carer had tried to contact the GP, but they had not yet responded but staff acted swiftly and contacted the ambulance service to take the patient to hospital where they could receive the required care.

The majority of patients felt staff took time to care for them, listened attentively and ensured that their holistic needs were met. Patients felt visits were never rushed and staff reported they had enough time to spend with their patients. While one patient complimented the district nurses who visited them regularly, they also reported that some staff had not always met their needs.

Staff followed policy to keep patient care and treatment confidential. Staff discussed patients' care and treatment privately among colleagues and with the patient.

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

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients reported that staff planned visits and appointments for when they were most convenient for the patient.

### Emotional support

# Community health services for adults

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

Most patients we spoke with felt staff gave them emotional support when they needed it. One patient reported that staff informed them of who was attending their next home visit, as this reassured them. However, one patient felt that staff did not always provide them with emotional support, and they will be raising this as a concern to the provider via their carer and that they would like this to be included in their care plans.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. Staff ensured that patients who became distressed in an open area such as the reception room were taken to a private room or prioritised. Patients informed us that staff always respected their privacy and one patient reported that staff ensured their injections were given discreetly in their bedrooms.

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

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. For example, a patient who was the primary carer for their partner reported that they had become acutely unwell and was becoming anxious about how they would look after their partner. Staff ensured that they got the help they needed and also ensured that there was someone to look after their partner.

## **Understanding and involvement of patients and those close to them**

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

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary. One patient reported they had regular conversations with staff and they could ring them if they had any concerns.

Patients and carers felt staff empowered them to take responsibility for their care. One carer who had a similar condition as the patient informed us that staff provided extra support to them, ensured they understood their condition and received appropriate training and supported them to manage their condition.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Patients informed us that staff provided them with leaflets of how to contact the service and how to make a complaint on the first visit.

Staff supported patients to make advanced decisions about their care.

Staff supported patients to make informed decisions about their care.

Patients gave positive feedback about the service.

## Is the service responsive?

# Community health services for adults

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 to meet the changing needs of the local population. The community nursing teams operated 24 hours a day, seven days a week. The intermediate care teams operated 12 hours a day and there was an out of hours service. The night cover was provided in conjunction with the teams from the local trust.

The service had a clear operational model for each service line which fed into governance. For example, the community nursing service met regularly with other services to provide joined up care for patients. The teams offered a short-term intensive treatment regime to enable people to regain their independence. The service worked with the acute trusts and other healthcare providers such as the ambulance service to care for people in their own homes in order to avoid hospital admissions.

Most facilities and premises were appropriate for the services being delivered. The diagnostic and treatment centre and falls assessment unit had a dedicated electrocardiogram (ECG) machine which was available five days a week. The service had a range of rooms that could be used for treatment including a physiotherapy assessment unit.

Staff could access emergency mental health support 24 hours a day seven days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. For patients with a heart condition, which could be a predisposing factor to falls, the teams had a diary to record daily activities and patients were placed on the palpitations pathway to monitor any concerns.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted.

The service relieved pressure on other departments when they could treat patients in a day. Although the two-hour urgent service was managed by the local trust, HCRG Care Group also provided a same day service to patients via the community nursing and intermediate care teams. One patient reported they were so pleased that the nurses came out to see them at 8pm and provided them with the care and support they needed. To enhance the community service provision, the teams provided a hospital at home service.

The service provided support to Frimley integrated care systems (ICS) during a critical incident between 29 December to January 2023. For example, patients who were started on insulin in hospital were not there long enough to get education around insulin, so these came to the team instead. The teams usually had around two patients referred a week for support with insulin, but the number of referrals had gone up in the last few weeks. The service had received 11 of these referrals the week we inspected the service which was about five times more than usual.

## Meeting people's individual needs

# Community health services for adults

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

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care that met their needs. Staff worked closely with mental health teams and dementia link nurses to formulate detailed care plans.

Services and clinics were easily accessible to people with mobility needs. Patient's individual needs were recorded in their electronic care records. Records were person centred and holistic and included patients' wishes when appropriate. For example, we saw for patients at the end of their lives, staff ensured their wishes for place of death were clearly documented.

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. The service provided leaflets to patients where English was not their first language. The service had access to interpreters and signers when required.

The speech and language therapy teams provided an International Dysphagia Diet Standardisation Initiative (IDDSI) explanation leaflet to care homes for patients with dysphagia (difficulty swallowing). They also produced easy to follow summaries for care home staff to follow, in addition to the full dysphagia reports.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff could access a third party organisation for any interpretation or translation needs.

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 in a timely way.**

All referrals to the service came through a referral email address with a dedicated mobile number. The day and night teams each had a dedicated email address for referrals. Calls to the referral mobile phone were transferred to the out of hours number at the end of each working day.

Referrals to the service came from a variety of sources including GPs, the ambulance service, the acute trust and other professionals. People could also self-refer, and discharged patients could re-refer when required.

Calls were handled by administrative and clinical staff who inputted the referrals into the system. The clinical triaging of referrals was done by senior clinicians. Clinicians could obtain information from GP records.

The teams had a clear referral process flowchart and a clear admission criterion for who they would offer a service. For example, the intermediate care team (ICT) referral process described clearly how decisions would be made to ensure which service best met the patient's needs. However, the ICT did not have a standardised referral form and clinical triaging was based on the clinician's individual expertise. We saw that some teams such as the diagnostic and treatment centre/ falls assessment clinic had a standardised referral form.

# Community health services for adults

Managers monitored waiting times to ensure they were in line with national standards. However, the podiatry service was reporting very high waiting times of up to 84 weeks due to a national shortage of podiatrists and consequential impact of the Covid-19 pandemic. The service had escalated this to the commissioners and reported it as an ongoing risk. The service had benchmarked itself against other trusts and healthcare providers in terms of staffing to workload and the data showed that the commissioned staffing levels were significantly low compared to other providers. Staff carried out a risk assessment and contacted patients to find out if their conditions had changed or risk increased using a red, amber and green (RAG) rating system. Patients who were rated red were seen urgently.

Managers monitored the numbers of cancelled and did not attend (DNA) appointments. Staff and patients reported that appointments were hardly ever cancelled. The provider reported two cancelled appointments within 24 hours in the last six months for the community rehab and rapid response teams. Managers made sure they were rearranged as soon as possible and within national targets and guidance.

Staff ensured that patients who cancelled their appointments were rebooked as soon as possible if the service was still required. Staff contacted patients who did not attend their appointment to explore why they did not attend and whether further support was required.

## Learning from complaints and concerns

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

The service had a complaints policy in place and staff understood the policy on complaints and knew how to handle them.

Patients, relatives and carers knew how to complain or raise concerns. Patients reported that staff provided them with information about the service on their first appointment or visit on how to contact the service if they needed to raise any concerns or make a complaint.

Staff recorded all complaints and informal concerns raised by patients, carers or relatives. The provider reported five complaints in the last three months; three of these were informal complaints. Most patients we spoke with said they have not needed to make a complaint because the teams have been fantastic. Although one patient fed back that the nurses sometimes came in the afternoon when they wanted a morning visit. Staff told us they would normally apologise if this occurred and tried to arrange visits for the patient's preferred time.

The service clearly displayed information about how to raise a concern in patient areas. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. Managers shared feedback from complaints with staff and learning was used to improve the service. For example, one patient had made a complaint because staff had informed them, they were to be discharged as they no longer met the service's treatment criteria. Managers discussed the concerns with the patient, offered apologies for the miscommunication by staff and offered reassessment by another clinician.

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



# Community health services for adults

Staff received a lot of compliments from patients and carers as shown in the complimentary notes, letters and cards. One patient card read that staff were always cheerful and kind.

## Is the service well-led?

Good 

### Leadership

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

Staff spoke positively of their managers, and they felt well supported if there were any issues. They spoke very highly of the service manager and felt they were highly approachable and took time to check on how they were. Staff felt that the leaders genuinely cared about their wellbeing and staff felt very well supported by their managers.

The senior leaders were qualified clinicians in their own field and understood the pressures and challenges of the service. Staff informed us that managers were always available to step in and provide support when required.

### 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 was to work collaboratively with partners in the integrated care system to deliver high quality, safe services which enhanced user experience and providing excellent clinical outcomes.

The organisation's 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.

In order to address the concerns around the high podiatry waiting list and shortage of podiatrists, the service was working towards developing their own staff. For example, one member of staff who was an assistant podiatrist was being supported to acquire a podiatry degree. The service was also working closely with the integrated care board (ICB) to address these issues.

Managers encouraged staff to adapt to changes in systems and technology, and they empowered staff to develop further. The speech and language therapists had recently adopted a new mobile application to enhance their productivity.

### 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.**

# Community health services for adults

Staff at all levels felt proud to work for the service. Staff reported that although the provider might not be the most competitive in terms of pay compared to other trusts, they felt the organisation cared about their welfare. Staff reported that managers respected them, supported them and made them feel valued.

The service promoted equality and diversity in daily work and provided opportunities for career development. All staff we interviewed both individually and in the focus groups we held felt respected, listened to and valued.

Staff at all levels reported that there was a good working relationship among the senior leaders, and we observed that the communication and dynamics among the senior leaders was very respectful, kind and polite. Staff felt their leaders worked well together, complimented one another and treated them as equals.

Staff reported that there was an open culture at the service, and they felt able to approach members of the senior leadership team if they had any concerns or wanted to provide feedback. Staff reported that despite the pressures of the day to day job and workload, the support they received from their senior leaders meant each day was a good day at work. They felt as a result they were able to continually provide a high quality service and that morale remained high.

Staff felt that HCRG Surrey was a good place to work, and they had not seen or witnessed any form of bullying and harassment. A good number of staff had worked for the organisation for years and they felt very proud to work for the service. The provider had a range of incentives and rewards were available to staff through the rewards gateway where staff could get rewards such as discounts at national supermarkets, and a free wellbeing service.

The service had a freedom to speak up guardian. Staff we spoke to knew who they were and how to contact them but had not needed to.

## Governance

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

The service had a good governance process with clear lines of reporting and systematic way of maintaining quality issues, performance and regulatory compliance via clinical leadership and board oversight. Performance, quality and patient safety issues were discussed on different forums including at team meetings, handover meetings, staff supervision and appraisals. For example, the service had a non-medical prescribing group which met regularly and reported to the chief pharmacist and issues discussed at clinical governance meetings.

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

Leaders held regular leadership meetings known as Business, Clinical Quality and Risk meeting (BCQR) and business unit (BU) meetings which demonstrated that the senior management team had oversight of the service's quality and performance measures such as complaints, staffing, safeguarding, incidents, medicines management and compliance with key performance indicators.

# Community health services for adults

The organisation undertook regular audits and was overseen by an audit committee which ensured that the internal audits operated effectively as established by management and this provided appropriate independent assurance to the Board. Managers learnt from actions identified in audits and shared outcomes with their teams.

Although all staff were able to access both individual and group supervision regularly, clinical supervisors did not always record when clinical supervision had taken place in line with the organisation's policy. The provider did not undertake an audit of clinical supervision to ensure it was being done consistently. However, staff were all happy with the amount of supervision they were receiving, and they were up to date with annual appraisals. They felt that issues relating to their work and patient safety were reported imminently and discussed as a team. Managers ensured staff were fit and proper and provided support for their wellbeing. The provider informed us that they were taking action to ensure that supervising managers consistently record and report when supervision had occurred, and which will be monitored via clinical governance.

## Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.**

The provider's risk management policy clearly outlined how risks would be identified, reported and escalated, and managed, including actions and learning from when incidents occur.

The service maintained a register of risk which was being monitored and reviewed at monthly clinical governance meetings and this fed into the provider's corporate risk register. For example, the service had escalated concerns around the impact of high podiatry waiting lists to the risk register. The service reported that the waiting list was due to the backlog from Covid-19 pandemic. To mitigate the risks, the service had put interim measures in place such as working with GPs and referrers to only refer high risk patients. They also introduced a RAG rating system to identify patients who were utmost priority, for example, those with wounds and or infection. The service had also recently recruited a locum podiatrist in order to see more patients and reduce risks.

## 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.**

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff collected and analysed data about outcomes and performance and engaged actively in local quality improvement activities. Incidents, safeguarding and complaints were reported via an incident management system which was monitored by managers.

The service had a portal where staff could report any information technology (IT) issues. However, staff reported that since the provider changed to HRCG Care Group, it had become difficult for them to access IT support.

# Community health services for adults

Staff received regular updates about the services, events or major incidents via emails, newsletters, text messages and the intranet. Patients were kept up to date about the services via emails, and information was available on the providers website.

The service consistently submitted information and notifications to external organisations such as the Care Quality Commission (CQC), Health and Safety Executive (HSE) and Integrated Care Board (ICB) as required.

## Engagement

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

The provider was engaging with staff via several platforms including staff surveys, “feel the difference programme” where staff could give feedback about the service. Managers and staff felt the provider treated them as partners in the planning and delivery of the services.

The provider’s annual staff survey and quarterly pulse survey were generally positive. The pulse survey results for the first quarter showed that 82% of staff would recommend HCRG Care Group as a good place to work. Although this figure had dropped to 60% on the second quarter, it rose to 74% in the third quarter. Managers had developed an action plan to address any concerns.

The service carried out monthly patient surveys through the Friend and Family Test (FFT) to check on how they were meeting patient’s needs and delivering good standards of care. The patient feedback for the last three months was good or very good. Patients felt staff treated them with respect, involved them in their care, provided enough privacy and explained their medication.

## Learning, continuous improvement and innovation

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

The diabetes team recently completed an awareness campaign for diabetes - Diabetes Roadshow, funded by the provider. The aim of the campaign was to meet and engage with people and professionals including GPs and nurses, and also provide education and awareness to staff around the management of diabetes. The education and training covered areas such as using new drugs in the early management of diabetes for people with type two diabetes. Staff reported that studies have shown that early detection of diabetes and treatment in the first year led to better prognosis over a 10 year period. The teams were able to reach 26 GP practices and 300 different professionals.

The teams have developed a lot of resources including information leaflets for GP practices and patients on how to manage a hypoglycaemic episode. The outcome of the campaign was that the teams now received more appropriate referrals from GPs, and the integrated care board (ICB) was now utilising the materials developed by the service.

The diabetes teams delivered teaching for an accredited course to nurses and GPs who want to specialise in diabetes, and they received an accredited certificate at the end of the course. They were also promoting flash glucose monitoring which research showed was more effective at identifying patients with hypoglycaemia than more traditional methods.

# Community health services for adults

The teams did a hypo awareness week as data showed there had been an increase in diagnosis of diabetes since Covid-19 pandemic. Hypo awareness week was a national initiative which was teaching programmed for HCRG staff across the country both face to face and virtual. The ICB participated in this project and the teams won a national award for this work. A district nurse gave feedback that they had gone into a patient's home who was having a hypo and thanks to the training they knew exactly what to do.

The teams offered 'shadow the nurse' – an initiative by the diabetes team which gave other members of staff the opportunity to shadow a specialist nurse to learn more about diabetes. This programme followed a more formalised, structured curriculum. The programme was originally just for district nurses but had now opened up to all professionals. Other specialities were also using this model.

Other initiatives by the teams included the 'Diabetes walks for health' – initiative done in conjunction with local council. On a Monday, a group of people with diabetes go for a walk with a trained guide. Every six weeks they gave a talk on a specific topic, for example, diet and foot care. The council took the lead on this with the diabetes nurses leading the talk.

The provider has implemented staff wellbeing support initiative called 'what are you proud of today?' book where staff could add comments about how they felt at work. Team managers reported they have been researching how they could improve on staff wellbeing and what made an effective workplace.

The teams were also delivering talks and training to care homes on improving nutrition and hydration in older people with dementia in care homes in line with a research study by a Professor of Nutrition published and endorsed by the Royal College of Nursing.