

HCRG Care Services Ltd

Keynsham Health Centre

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

Outstanding 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Outstanding 

Are services well-led?

Outstanding 

Summary of findings

Overall summary

During this inspection we visited two community adults' locations within the Bath and North East Somerset (BaNES) area. Our findings reflect the findings across the community adults' services. Any variances to the service provided is reflected within the individual reports. This report relates only to the Keynsham Health Centre and the services provided there.

Keynsham Health Centre is one of five bases within the BaNES area that provides community health and care services for adults by looking after their physical and mental health and wellbeing.

We rated this location as outstanding because:


- Services were tailored to meet the needs of individuals and were delivered in a way to ensure flexibility, choice and continuity of care. Individual needs and preferences were central to the planning and delivery of tailored services. Patients could access services in a way and at a time that suited them.
- The involvement of other organizations' and the local community was integral to how services were planned and ensured that services met people's needs. There was good interaction between the local GPs and the services provided.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Comprehensive strategies in place ensured the delivery and development of the desired culture. Leaders had a shared purpose, strove to deliver and motivate staff to succeed.
- While the service had staff vacancies, they used regular bank and agency staff to maintain care for patients that kept them safe.
- Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records.
- The service used systems and processes to administer and record medicines safely. The service recorded safety incidents well and learned lessons from them. Staff collected safety information and used it to improve the service.
- Team leaders monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. This included patients with complex needs.
- 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 patients we spoke with were happy with their care and described the service as "excellent" and "caring."
- The service provided care to meet the needs of local people, took account of patients' individual needs, and ensured people were able to give feedback. People could access the service when they needed it and received the right care in a timely way. It worked well with external agencies and organisations to plan care.
- Leaders were knowledgeable about quality issues and had the experience and capability to ensure that the strategy could be delivered. Leaders encouraged cooperative, supportive relationships among staff so that they felt respected, valued and supported.
- Governance and performance management arrangements were proactively reviewed and reflected best practice. There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

Summary of findings

- Leaders actively reviewed complaints and how they were managed and responded to, and improvements were made as a result across the service.

Summary of findings

Our judgements about each of the main services

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

Summary of findings

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Summary of this inspection

Background to Keynsham Health Centre

Virgin Care was rebranded as HCRG Care Services Ltd. and acquired by Twenty20 Capital in December 2021.

HCRG Care Services Ltd. provides community health and care services for adults by looking after their physical, mental health and wellbeing. HCRG Care Services Ltd. works in partnership with the NHS and local authorities to transform and deliver intermediate care, primary care, pathway and diagnostic services for everyone in the area through their community services.

The adult community services are delivered in a person's home or in a nearby local care setting. Bath and North East Somerset (BaNES) Council, the NHS and BaNES Clinical Commission Group (CCG) work alongside HCRG Care Services Ltd. to provide services locally. The district nurses are based within Keynsham Health Centre.

Keynsham Health Centre is one of five bases within the BaNES area and provide the following specialist nursing services including heart failure, intravenous therapy, lymphoedema, and leg ulcer and community nursing services, therapy, reablement outpatients' services.

The service is regulated for the following activities:

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

We spoke with:

- Nine staff including district nurses and specialist nurses
- Three service leads
- Six patients and two carers/relatives
- Head of Operations
- Reviewed five care records
- Attended an IV therapy clinic, a lymphoedema clinic, a respiratory clinic and a heart failure clinic
- Reviewed electronic performance data for the various services.

What people who use the service say

We spoke with three patients attending an outpatient clinic and they were extremely complimentary of their treatment. They stated that the nurses were "excellent" and made attending the clinic more of a social interaction than medical treatment, while still getting the "job done."

Patients told us they were happy with the service they received and said they treated their visits to the clinics as a "good social opportunity to chat and meet new people, rather than just a specified treatment process."

One patient spoke very highly of the nurses holding the clinic they attended and said their care had been excellent throughout. They also told us that staff had helped them "understand their illness so much and eased anxieties around it" while another said staff had "kept them informed" and offered an "excellent service." They said they were more than 100% satisfied with the service received."

Summary of this inspection

We spoke with three patients and two carers by telephone. They said staff were “kind, respectful and polite at all times.”

Everyone we spoke with said they had confidence in the staffs’ ability. Staff provided a “first class service.”

Outstanding practice







We found the following outstanding practice:

- The district nursing teams had developed a community phlebotomy service to support GPs and patient care requirements.
- The service had a community wellbeing hub which was co-located alongside the care coordination centre. The hub provided a “one-stop-shop” wellbeing service for adults and their families. The hub worked with other organisations to quickly respond to changing service pressures such as hospital admission avoidance. They had recruited a team of volunteers to support the delivery of emergency food parcels and two course meals.
- The Intravenous therapy team had supported the local GP by developing an education video on how to fit a peripherally inserted central catheter (PICC) line. A PICC line is a thin, soft, long catheter (tube) that is inserted into a vein. Feedback from the GP said they were confident that practice nurses would be able to proceed with the treatment therefore reducing waiting times.
- District nursing teams supported by the tissue viability nurses were provided support to GP practices with their leg ulcer clinics to support patients accessing the service.






Our findings

Overview of ratings

Our ratings for this location are:

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

Community health services for adults

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

Are Community health services for adults safe?

Good 

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

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

Safeguarding

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

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

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

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



Community health services for adults

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

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

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

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

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

Cleanliness, infection control and hygiene

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

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

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

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

Environment and equipment

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

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

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

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

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

Assessing and responding to patient risk

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



Community health services for adults

Staff triaged patients upon receiving referrals and prioritised patients according to the level of risk. The learning disability team met weekly and reviewed all referrals which were prioritised on a risk and needs basis. The learning disability team met weekly and reviewed all referrals which were prioritised on a risk and needs basis.

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

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

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

Staff ensured patients attending clinics were fully informed of the reasons for their attendance alongside any proposed treatment. We saw staff in the heart failure and lymphedema clinics discussing treatment and care plans with patients and giving them the opportunity to address any concerns. Lymphedema refers to tissue swelling caused by an accumulation of protein-rich fluid that is usually drained through the body's lymphatic system.

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

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

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

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

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

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

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



Community health services for adults

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

Staffing

While there were staffing shortages, the service ensured they had enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.

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

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

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

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

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

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

Records

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

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

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

Records were stored securely.



Community health services for adults

Medicines

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

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

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

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

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

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

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

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

Incidents

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

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

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



Community health services for adults

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

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

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

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

Are Community health services for adults effective?

Good



We rated it as good.

Evidence-based care and treatment

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

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

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

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

Nutrition and hydration

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

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



Community health services for adults

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

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

Pain relief

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

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

Patient outcomes

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

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

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

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

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

Competent staff

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

Managers ensured staff, including bank or agency staff, had the right skills, qualifications, and experience to meet the needs of the patients in their care. Staff received any specialist training required for their role. Staff had the opportunity



Community health services for adults

to discuss training needs with their manager and were supported to develop their skills and knowledge. Staff told us of additional training they had either undertaken or were in the process of completing. These included; physical assessment and clinical reasoning (PACR) training, non-medical prescribing (NMP) and the special professional qualification (SPQ) for district nurses.

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

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

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

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

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

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

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

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

Multidisciplinary working

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

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

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

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



Community health services for adults

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

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

Health promotion

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

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

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

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

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

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

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

Are Community health services for adults caring?

Good



We rated it as good.

Compassionate care

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



Community health services for adults

Staff were discreet and responsive when caring for patients. We observed staff discreetly asking patients personal questions in a way which made them feel valued as individuals. Patients said staff were “excellent” and treated them with “compassion and kindness” while respecting their privacy and dignity and taking account of their individual needs.

Patients we spoke with were extremely complementary of their treatment and said they treated their visit as a “good social opportunity to chat and meet new people.” Another said staff had “kept them informed” and offered an “excellent service.” They said they were “more than 100% satisfied with the service received.”

Staff took time to interact with patients and those close to them in a respectful and considerate way. During clinical treatments we observed staff demonstrated a caring and responsive approach by being kind, courteous and considerate of the patient’s individual needs. Staff explained how they would sensitively manage difficult and challenging conversations.

We observed staff within the intravenous therapy, blood transfusion and heart failure clinics paying great attention to their work. Staff ensured patients were informed of everything they were doing throughout their procedures.

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

Staff kept patient’s care and treatment confidential. They followed robust confidentiality procedures that were evident within healthcare records.

Emotional support

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

Staff gave patients and their families help, emotional support and advice when they needed it. Patients and those close to them were actively supported to be a part in their relative’s care. Staff were fully committed to working in partnership with the families. One patient said that staff had helped them “understand their illness so much” and had “eased their anxieties around it.”

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

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

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

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

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



Community health services for adults

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

Understanding and involvement of patients and those close to them

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

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

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

Everyone was made very welcome on arrival to the clinics. Staff ensured patients and those close to them understood the treatment being undertaken. Staff communicated with patients in a way they could understand. The learning disability team used creative materials to develop communication packages for people who use the services to address social, psychological and emotional wellbeing.

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

Staff supported patients to make advance decisions about their care.

Are Community health services for adults responsive?



We rated it as outstanding.

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

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

Managers planned and organised services, so they met the changing needs of the local population. Locality staffing arrangements were implemented to meet identified themes and trends within local communities. For example, the district nursing teams had developed a community phlebotomy service to support GPs and patient care requirements.



Community health services for adults

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

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

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

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

The Intravenous therapy team had developed a video of how to fit a peripherally inserted central catheter (PICC) line. A PICC line is a thin, soft, long catheter (tube) that is inserted into a vein. The video was produced as an educational tool in supporting the local GP to carry out this procedure who were in the process of rolling it out to their staff. Feedback from the GP stated that they were confident that this video would enable practice nurses to proceed with treatment quicker and reduce waiting times. The therapy team informed us they were currently awaiting approval from their internal education and training department before rolling it out across the organisation.

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

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

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

An urgent community emergency response team project had been set up to deliver a two-hour response, centred around avoiding hospital admission and enabling people to live independently for longer. This allowed patients to get faster access to a range of health professionals such as 24-hour district nursing, physiotherapy, occupational therapy and medicine prescribing and reviews which relieved the pressure on emergency services. Figures seen showed the response rate being 85% within the two hours.



Community health services for adults

Meeting people's individual needs

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

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

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

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

The Intravenous (IV) therapy team were very proud of their achievements and said they had been able to establish a service that patients were happy to attend and felt relaxed and comfortable to do so. They had arranged the treatment area in such a way that managed the privacy and dignity of patients which included placing chairs into individual cubicles that had the potential to be opened should patients wish to chat with each other.

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

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

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

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

Access and flow

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



Community health services for adults

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

The organisation's digital performance programme was able to provide daily updates regarding waiting times. Data showed the service was meeting its waiting times. For example, the falls and audiology services showed 100% of patients being seen within six weeks. Staff within the musculoskeletal team said they saw all urgent patients within two weeks.

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

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

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

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

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

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

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

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



Community health services for adults

Learning from complaints and concerns

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

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

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

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

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

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

Are Community health services for adults well-led?



We rated it as outstanding.

Leadership

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

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

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



Community health services for adults

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

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

There were clearly defined roles and responsibilities within the leadership teams. All managers knew what was expected of them which was supported by the senior leadership team including the head of operations. Managers were available for advice and support for staff working on weekends.

Managers told us they were able to attend a mentorship and coaching programme to support better communication. Staff told us they were able to access training to complement their role. They said their manager supported them to develop their skills and take on more senior roles.

Vision and Strategy

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

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

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

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

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

Culture

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

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

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



Community health services for adults

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

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

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

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

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

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

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

Governance

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

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

The service had a clear systematic governance process to continually improve the quality of services provided to patients. These arrangements were clear and operated effectively. Staff understood their roles and accountabilities.

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

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



Community health services for adults

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

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

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

Management of risk, issues and performance

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

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

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

The operational registers were merged in January 2022 into one BaNES register. The register contained risks such as; staffing levels, inability to complete training and information technology (IT) issues. This was regularly reviewed during the monthly quality and safety meetings, with actions in place to mitigate risks. New risks were reviewed by the senior management team prior to being submitted to the board and commissioners.

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

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

Information Management

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

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

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



Community health services for adults

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

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

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

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

Engagement

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

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

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

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

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

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

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

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

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

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



Community health services for adults

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

Responses seen from patients were positive with many staff described as “excellent” and provided “good care.”

Learning, continuous improvement and innovation

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

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

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

Staff were given the time and opportunity to learn.

The Intravenous therapy team had developed a video to share with local GPs on how to fit a peripherally inserted central catheter (PICC) line. This was waiting for approval from the organisation’s internal education and training department before rolling it out.

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

District nursing teams supported by the tissue viability nurses were provided support to GP practices with their leg ulcer clinics to support patients accessing the service.