

# Bath and North East Somerset, Swindon and Wiltshire Community Health Services Quality Account 2026-27

HCRG Care Services Limited, trading as HCRG Care Group  
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## Part one

## Executive summary

A Quality Account is an annual report which providers of NHS healthcare services must publish about the quality of services they provide. This quality account covers the services provided by HCRG Care Group on behalf of Bath and North East Somerset Swindon and Wiltshire Integrated Care Board in Bath and North East Somerset Swindon and Wiltshire.

HCRG Care Group may also provide other services in Bath and North East Somerset Swindon and Wiltshire, but these may not be included in this document if they are not commissioned by Bath and North East Somerset Swindon and Wiltshire Integrated Care Board or are not eligible to be included within a Quality Account.

This document aims to demonstrate our commitment to providing the best quality services to local people and is an opportunity for us to take stock of what we have achieved and our plans for the coming year.

We have used the information presented here to analyse our performance and to set priorities for the coming year. To ensure those priorities reflect the needs of the people who use our services, views have been gathered from people who use them and community representatives, as well as commissioners and frontline colleagues.

If you would like a hard copy of this document, a copy in another language, to provide feedback on this document, or to talk to someone about your experience of using our services, please contact the service directly. Details can be found at [https://bswcommunityservices.co.uk/contact us](https://bswcommunityservices.co.uk/contact-us)

## Regional Director's introduction

I am extremely proud of the achievements and progress we have made in BSW Community Health Services over the last year.

In particular, I am proud of the following achievements:

- The safe mobilisation and transfer of community services from 9 different providers into HCRG Care Group as part of the new Integrated Community Based Contract.
- Delivering the first year of our major transformation programme to support the delivery of community health services that are accessible, delivered closer to home and neighbourhoods, and empower individuals to manage their own health.
- Our continued delivery of community health services in BSW that are effective, efficient, and high quality.
- Our collaborative work with partners - statutory and third sector organisations - to proactively manage and support , adults, children, young people and families with increasing levels of health and wellbeing concerns.

Over the coming 12 months, we will continue to build on these achievements and take the lessons learned over the past year to ensure we can continue to change lives by transforming health and care in BSW.

We will also continue to work closely with our partners, the Care Quality Commission (CQC) and the communities we work in, to demonstrate our high standards of quality.

In putting together this publication, we have sought feedback from staff and people who use our services and I would like to take this opportunity to thank them for their input into the process.

I can confirm that, to the best of my knowledge, the data and information in parts two and three of this report reflect both the successes and the areas that we have identified for improvement over the next 12 months.

A handwritten signature in blue ink that reads 'V. Scrase'.

Val Scrase

Regional Director – Bath and North East Somerset Swindon and Wiltshire Community Health  
HCRG Care Services Limited

## Part Two

### About HCRG Care Group

**We change lives by transforming health and care.**

We're the UK's largest specialist community services provider. Since 2006 we've been changing lives through health and care transformation – a transformation that we deliver quickly and at scale.

We act as a system leader on behalf of local authorities, ICBs and NHS England, co-designing and co-delivering care pathways with local partners.

The result is an innovative health system that is driving prevention, improving productivity and reducing cost.

## Our colleague survey results

We are committed to understanding the experiences of our colleagues and ensuring that feedback directly informs improvement. In 2025, we strengthened our approach to colleague engagement by transitioning to an annual externally delivered survey model through Best Companies. This marks the first year of using this enhanced methodology and establishes a clear baseline for future comparison.

The b-Heard survey is based on a robust and validated framework that assesses the eight key factors that contribute to a high-performing workplace:

- My Team
- Leadership
- My Manager
- Personal Growth
- My Company
- Wellbeing
- Fair Deal
- Giving Something Back

This approach provides deeper, more structured insight and enables benchmarking against comparable organisations across the health and care sector.

In July 2025, 48% of colleagues across England participated in the survey. The results provide a valuable baseline measure of colleague engagement under the new methodology and highlight areas of strength as well as opportunities for improvement.

Early analysis indicates a strong relationship between organisational pride and colleague advocacy. The statement “I love working for this organisation” demonstrated a strong positive correlation ( $r=0.761$ ) with colleagues’ likelihood to recommend the organisation as a place to work. This suggests that organisational pride is a key driver of advocacy and will remain an important focus area as we embed and build on this survey model.

In addition to the annual survey, we run a supplementary pulse survey incorporating the NHS People Pulse questions. This ensures alignment with national workforce measures and allows for wider benchmarking.

Action plans are being developed at organisational and local levels in response to the findings. As we move into subsequent survey cycles, we will be able to track trends over time and evaluate the impact of improvement actions more fully.

## How our colleagues can speak up

Our Freedom to Speak Up policy sets out how our colleagues can raise concerns at a number of levels either anonymously or by being identified.

It is very important to us that our colleagues can speak up about any concerns they have at work because it helps us to keep improving our services and the working environment for our colleagues. While colleagues might feel worried about raising a concern, our policy and our senior leadership team and board are all committed to an open and honest culture. Our policy reflects the recommendations of the review by Sir Robert Francis into whistleblowing in the NHS, and we have fully adopted the policy produced by NHS England and NHS Improvement alongside all other NHS organisations.

We regularly promote this policy to colleagues, encouraging anyone who has concerns to raise them.

Whenever a colleague raises a concern, they will always be listened to, and they will always be supported. Concerns about risk, malpractice, wrongdoing, bribery, fraud or sexual harassment/inappropriate behaviour that they think is causing harm can be raised under the FTSU Policy.

Through Freedom to Speak Up, colleagues can raise concerns:

- with their line manager, or another manager in their service.
- with a lead clinician or tutor.
- with any member of our senior leadership team.
- with our Freedom to Speak Up Guardians.
- through our anonymous online reporting system SpeakInConfidence;
- with one of three nominated members of the executive team outlined within the policy
- with our independent chairman.

Colleagues can also directly contact our senior leadership team and executive team at any time, whether they are raising a formal concern or an informal query.

## Statements from CQC

Some services we operate are required to register with the Care Quality Commission (CQC).

As part of this document, we confirm that HCRG Care Services Limited is registered with the CQC for the provision of the relevant regulated activities, and has no conditions attached to its registration. HCRG Care Services Limited's services have not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC conducted an inspection of Paulton Community Hospital in Autumn 2025.

### **“Safe** Rating Good

In our recently completed assessment of Paulton Memorial Hospital's community health inpatient services our overall rating of safe has changed from requires improvement to good.

### **Effective** Rating Good

In our recently completed assessment of Paulton Memorial Hospital's community health inpatient services our overall rating of effective has changed from requires improvement to good.

### **Caring** Rating Good

The rating for caring is good for Paulton Memorial Hospital's community health inpatient services.

### **Responsive** Rating Good

The rating for responsive is good for Paulton Memorial Hospital's community health inpatient services.

### **Well-led** Rating Good

The rating for well-led is good for Paulton Memorial Hospital's community health inpatient services.”

“We inspected community adult inpatients at Paulton Memorial Hospital on 9 October 2025. Our inspection was a comprehensive inspection of all key questions and was in response to concerns raised relating to staffing and continence care.

In our recently completed assessment of Paulton Memorial Hospital's community health inpatient services our overall rating of safe has changed from requires improvement to good.

HCRG Care Services Ltd provide services in the local community. Paulton Memorial Hospital offer 28 community inpatient step-up and step down beds to avoid admission to acute beds.

We found improvements since the last inspection in 2022 and is no longer in breach of regulation. The community inpatient service is now rated as good. Previously it was rated as requires improvement.

Colleagues now managed medication and emergency equipment safely.

Care plans now included patients' needs and preferences.

Colleagues compliance with mandatory training levels had also increased.

We observed care on the ward and spoke with 6 patients and 2 carers during our assessment.

Overall patients and carers were satisfied with the care they received and some described exemplary care and colleagues going the extra mile to meet their needs.”

Full copies of CQC reports are available on the CQC's website at [www.cqc.org.uk](http://www.cqc.org.uk) under HCRG Care Services Limited.

## Safeguarding statement

We are committed to safeguarding and promoting the welfare of adults, children and young people and to protect them from the risks of harm.

To achieve this, we have appointed dedicated National and Local Safeguarding Adults and Children's Leads and policies, guidance, training and practices which reflect statutory and national safeguarding requirements:

- Our National Safeguarding Assurance function works across localities and partnership boundaries to respond to national developments, legislative changes, national, local and organisational learning leading to continuous improvement and learning across the organisation, whilst our local teams work as part of multi-agency partnerships in their areas to support and influence safeguarding at strategic and operational levels.
- Our Clinical Governance and Safeguarding Committees provide board assurance that our services meet statutory requirements.
- Safeguarding Leads and named professionals are clear about their roles and responsibilities and have sufficient time and support to undertake them.
- Where appropriate, services have submitted a Section 11 Review report, Section 42 or section 47 report and/or Safeguarding Adult Self-Assessment audit tool, with all services completing our national safeguarding audit
- Action plans are monitored across the organisation at committee and board level.
- Safeguarding policies, processes and systems for children and vulnerable adults at risk are current, up to date and robust.
- Safeguarding training is undertaken in line with our safeguarding training strategy and in accordance with the three intercollegiate documents for safeguarding children, looked after children and adults.

## Duty of candour statement

We are committed to being open and transparent with the people who use our services and, while considering confidentiality, their representatives too.

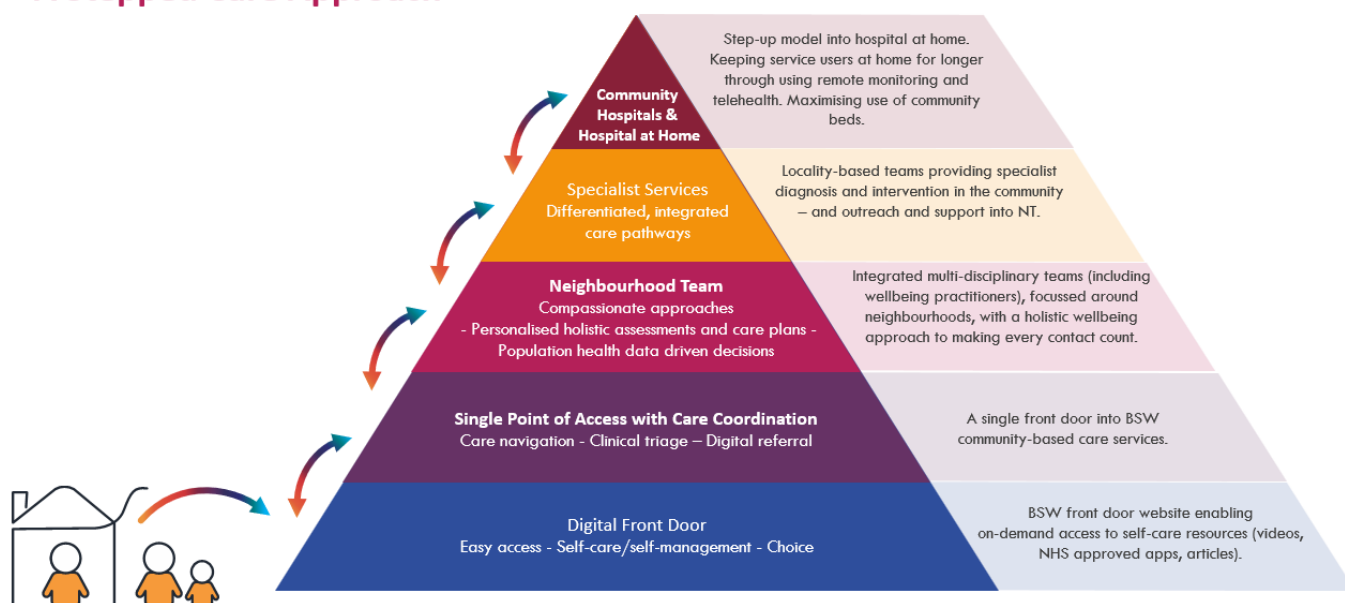
We encourage colleagues to be open and honest at all times but particularly when a notifiable safety incident has been recognised. Colleagues report incidents via our incident report system and follow our Duty of Candour policy. This ensures that an apology is made to service users within 10 days of the incident occurring, which is followed up in writing.

We investigate, establish the facts, and report externally as required. We also have due regard to the relevant safeguarding policy and input from suitably trained colleagues before any disclosures are made. Following the investigation, we send another letter to the person who used the service to advise them of the outcome, lessons learnt and how we'll share lessons and knowledge to reduce the likelihood of the same kind of issue happening again. We may also offer a meeting to listen to those affected by the incident and help understanding of our findings and resulting actions.

## About Bath and North East Somerset Swindon and Wiltshire Community Health

In October 2024 HCRG Care Group was commissioned to be the Lead provider for all Community Health Service throughout Bath and North East Somerset, Swindon and Wiltshire (BSW) from April 2025. This was to deliver a completely different model of health care based upon need, delivered where people are and using digital technology to enable easy access to advice and support. The stepped care model promotes access to self help and advice and self-referral into services which are needs led.

### A Stepped Care Approach



#### Digital Front Door

Our digital front door is our website which is available to all via personal or public access. This contains a valuable source of information about the community services within BSW and enables people to access this information at their convenience. The website has a growing number of advice and self help resources to support people in understanding their health and how to seek support with links to specialist organisations and NHS resources. There is also access to self-referral forms for specific support and care as well as the telephone number for our Single Point of Access (SPA) where callers can speak to someone about their needs and be directed to the appropriate service to help them.

#### Single Point of Access and Care Co-ordination Centre

The Single Point of Access is one telephone number and one email address into all BSW Community Health services. Callers speak to a care navigator who is able to direct them to the right service to meet their needs where they are triaged according to their condition. Referrals are received here mostly by

electronic mail, but also by telephone and are processed centrally so the people receive the right service according to their needs.

### Neighbourhood Teams

Neighbourhood teams work in the community to provide care and support to people where they live or within their local vicinity. These teams are multi-professional with community matrons, community nurses, therapists, support workers and others to meet the health needs of people at or close to home and also work collaboratively with General Practitioners (GP) and community, charity and voluntary groups to support health needs.

### Specialist Services

Specialist Services are there to support specific health needs related to either a condition or a need for targeted support to assess and manage symptoms.

We run outpatient clinics for audiology, bladder and bowel, speech and language, physiotherapy, podiatry and stroke and neurology. In addition, there are specialist clinics for diabetes care, falls, heart health, Intravenous therapy, Lymphoedema, orthopaedic problems, pain, Parkinson's Disease, Respiratory disease support.

Our specialist teams are highly experienced in their field and maintain regional and national links to ensure that they keep up to date with advances in their subject. They also support colleagues by passing on their expertise through ad hoc training and providing expert advice when requested. The Wheelchair service supports wheelchair users by supporting the maintenance and renewal or replacement of chairs where required. This includes the provision for specialist bespoke equipment for people with particular needs. The aim is to enable people to remain as independent as they can for as long as they can.

### Community Hospitals

HCRG care group runs 6 community hospitals where there are 8 in patient wards to support people who do not need acute hospital care, but need rehabilitation or other further clinical support before they can return home, or to a new home. The workforce in our community hospitals is multi-disciplinary and caters for the medical, nursing and therapy needs of people to support them into a planned return home, which may require the co-ordination of additional community support at home.

### Hospital at home

The hospital at home service cares for people who need short term enhanced support which would normally be delivered in an acute hospital, but by using technology to monitor them when the professionals are not there most adults can be cared for safely in the comfort of the familiar surroundings of their own home (which may be a care home). The team is made up of specialist doctors, nurses, paramedics, therapists and clinical support workers who work with people and their families and carers with concentrated health care provision for up to 2 weeks to assist their recovery during a period of illness.

### Minor Injuries Units

There are 3 Minor Injuries Units across BSW that provide advice and support and signposting to people with minor illness or injury. Each one of these is based in one of the community hospitals, although the one in Trowbridge will be moving to be based in the new Integrated Care Centre early in April this year.

### Learning Disability Autism and Neurodiversity (LDAN)

This service supports adults with learning disabilities, autism or Attention Deficit Hyperactivity Disorder (ADHD) and offers assessment and help to understand your diagnosis and the practicalities of daily living. They also give guidance to people and their families and/or carers about the additional services that people may benefit from to support physical, emotional and mental health; enhance communication and foster independence. The service also provides therapeutic input and works with General Practitioners and other professionals to make support people to get the help that they need.

## Children's Services

Children's services deliver care across Bath and North East Somerset, Swindon and Wiltshire. The Children's services are organised into:

- Universal services
- Specialist services

**Universal services** are those which are offered to all children and consist of:

- Health Visiting, which supports parents with infants, toddlers and pre-school children from 10 days post birth up to age 5.
- School Aged Health services, which supports all children, their parents and schools with the health needs of children of school age, including those who are not in formal education.
- The Family Nurse Partnership, which is a licensed programme of enhanced support for young first-time mothers, starting before a child is born and continuing up to the age of 2 years.

HCRG Care Group provides Universal Services in Bath and North East Somerset and Wiltshire areas only and these are commissioned by the Local Authorities in those areas.

**Specialist services** exist to support children and families with enhanced needs. Some of the specialist services in this quality account are delivered directly by HCRG Care Group and the rest are currently delivered by other providers at present under subcontracts covered by the Lead Provider agreement.

Specialist Services consist of:

- The Bladder and Bowel Service, which supports children and families with toileting needs such as promotion of continence or the management of incontinence, when continence cannot be achieved.
- The Children's Community Nursing Service, which supports children and families in the community where there is a nursing need. This may be following an acute illness or surgery or where the child has a life threatening or life limiting condition with complex care needs.
- The Children's Continuing Care Team, which works closely with the Children's Community Nursing Team and provides specialised care for children and young people to support families to have a break from 24-hour care of their child.
- The Children in Care team, which provides support to children and young people who are under the care of the local authority, as well as advice and support to their carers. It supports the local authority to fulfil its statutory duty of care, by undertaking health assessments of need and working with young people and their carers on a plan of care to meet their health needs.
- Community paediatricians provide medical diagnoses and the management of neurodevelopmental disorders in children and young people. They work closely with paediatricians in acute care and also support medical assessments for safeguarding and adoption purposes.
- The Integrated Therapies Team consists of physiotherapists, occupational therapists and therapy assistants who work together to support children with musculoskeletal conditions which may be

congenital, neurological or developmental, and coordination needs. They work in homes, schools and special schools to support children and young people to develop to their full potential and achieve maximum functional independence.

- The Learning Disabilities Service supports children and their families who have a diagnosis (or a working diagnosis) of a learning disability. It works to improve long term outcomes by working in partnership with parents, schools and the multi-agency team to enable children with learning disabilities to achieve their full potential.
- The Neurodiversity Pathway team provides a needs led approach to the assessment of children and young people who are referred with indications of possible autism, ADHD or both. The multi-disciplinary team of paediatricians, nurses, speech and language therapists and support workers support children, young people and their families to understand how their needs can be met and whether they need a formal diagnosis, which can have a life-long impact. Assessments are undertaken within the nationally agreed frameworks and children, young people and their families are signposted to support agencies for their ongoing needs after assessment regardless of whether or not they have a formal diagnosis. For children and young people with ADHD who require ongoing medication to help them through their education, this is commenced by the paediatricians, supervised and supported through titration until the optimum dose is achieved and stabilised, when the majority will be managed under a shared care agreement with the GP.
- The Paediatric Audiology Team provides audiological assessment, diagnosis and practical advice to ensure that children who are deaf or have hearing difficulties are able to develop and achieve academically, emotionally and socially to reach their full potential. The service also monitors children with otitis media and refers on for medical/surgical intervention or hearing aid provision as appropriate to their needs.

During the year the Paediatric audiology team were successfully accredited under the Improving Quality in Physiological Services scheme by the United Kingdom Accreditation Service. This is a great achievement for a community audiology service and demonstrates that the service is delivering their service in line with nationally recognised high standards.

## Partnership and Engagement Team

As part of the transition to the new care model in BSW, HCRG Care Group is committed to working with people who live, work, study or pass through the area to understand what their health care needs are and what barriers they face in accessing traditional health care. Our small team reaches out to community groups, charities and voluntary organisations to listen to them and learn from them and the individuals within them, about how working together and what they need to facilitate this, can enhance access to care and support from BSW community services for all within the area.

## Safeguarding Team

The Regional Safeguarding Team supports both adult and children's services, by providing specialist support, advice and safeguarding supervision. They work very closely with partners and attend multi-agency meetings; provide safeguarding assessments, including mental capacity, and reports to enable the organisation to fulfil its statutory safeguarding duties. The team also gather and share learning from national reports and Child Safeguarding Practice Reviews.

## Priorities in 2025-26

In April 2025, HCRG Care Group commenced the new contract with Bath and North East Somerset Swindon and Wiltshire Integrated Care Board to be the Lead Provider of Health services in the Bath and North East Somerset, Swindon and Wiltshire (BSW) community. The new contract offers great opportunities to refresh the services across the community; harmonise the offer across BSW; streamline access and work with the community to co-design the transformation of service delivery. The new model aligns with the government's NHS 10 year plan to:

- Focus on the prevention of future ill health
- Embrace digital technology to support easy access and remote support and monitoring
- Deliver more care in the community nearer to where people live.

The full transformation of services into the stepped care model is staged and prioritised over the first few years of the contract to ensure that it is carefully planned and delivered in a logical way, building up into a sustainable long term model to meet the needs of the population now and into the future.

The Priorities for 2025 – 2026 were:

### Priority 1: Safe transfer of community services from 9 different providers into HCRG Care Group

Following award of the new Community Health Services contract, HCRG Care Group worked with the existing care providers with the aim of providing a seamless transfer of services. There was a structured programme of due diligence with key milestones identified and colleagues responsible for their delivery.

A comprehensive programme was put into place to ensure that colleagues from previous provider organisations:

- Were formally welcomed into the organisation by Senior Leaders
- Were provided with the tools that they needed in advance of the transfer to enable them to work immediately on Day 1 post transfer including setting up their IT kit and work telephones
- Ahead of the transfer day there was also an online portal set up for colleagues transferring in to orientate them to the organisation, introduce key people and a section of FAQs which were populated from questions that had previously been posted onto the site.
- Received a handbook detailing important “how to”s and where to get help from support services
- Clinical policies and processes from previous providers that had been shared as part of due diligence were assessed ahead of transfer to check that they were safe and in line with national guidance and organisational expectations, so that they could continue to be used from day 1, so that clinical colleagues did not have to learn and understand a raft of new clinical policies immediately, but could continue to use the ones they were familiar with for clinical care, until these were harmonised across BSW
- A 100 day mobilisation plan was agreed which would go live immediately after transfer to identify and resolve any issues and to ensure that services were safe and working well. This would also enable the organisation to understand any immediate areas which needed attention that needed to be factored into the transformation plan

Following the transfer on 1<sup>st</sup> April 2025

- Floor walkers were engaged to provide hands on support to colleagues in their work places for the first few weeks where they were struggling to access the organisation's systems and also for setting up kit for those who had not been able to receive these beforehand
- Senior leaders from both BSW and the wider organisation visited every base during the first few days to introduce themselves and identify any issues that needed immediate resolution and to facilitate this.
- A formal induction programme was rolled out for all managers and team leaders to introduce the contract, vision and transformation programme plans and these events also functioned as networking opportunities to meet colleagues across the expanded area. An induction dashboard was created which was up and running on Day 1 which included a series of micro-learning opportunities for individuals to get all of the information that they needed.
- A new colleague survey was undertaken to understand how the transfer had been for them and to allow them to formally raise any ongoing issues
- The 100 day mobilisation plan was enacted and key milestones completed.
- During the summer and early autumn, a new leadership structure was put into place across BSW to meet the needs of the new delivery model
- The transformation team and operational leads identified project leads for the first tranche of projects to be undertaken
- New service CQC registered locations were assessed against the organisation's Individual Service Review tool within the first year of transfer
- A Leadership programme has been planned which will be delivered into next year.

## Priority 2 Transformation of services into the new commissioned delivery model

During the past year the focus of transformation has been on determining the key enablers to support community services into delivering the stepped care model (outlined above) successfully and sustainably and to get these into place. The key projects were identified and project groups set up supported by the transformation team who provided the project management support. The projects were undertaken using the 4 D approach:

- **Discover**— identify the current status of provision and identify the issues and connections which exist between services and partners
- **Define** – identify what needs to be in place and what the priorities are
- **Develop** –prepare a detailed plan in partnership with colleagues, partners and the community, which covers all of the practical issues and identifies key support required
- **Deliver** – implement the plan and monitor the impact of the change

The transformation was governed by a Transformation Group which including senior leaders from within BSW and the organisation's National Leadership Team. Regular updates were provided, risks and issues discussed and decisions were agreed by this group.

The new single BSW footprint for community services contained a multitude of different ways of working, using different systems and with different delivery offers based upon historical commissioning. In order to achieve the vision, it was important to get the support structures in place first as this would enable the rest of the plan to be put into place with a solid foundation.

The priority projects identified were:

Digital transformation

Single point of access and digital front door

Integrated neighbourhood teams

Workforce transformation  
Partnership development and community engagement  
Community estates strategy  
Service identity and brand development  
Outcomes and benefits realisation

## Digital transformation

During the year there has been work undertaken to get all colleagues onto the same clinical system across BSW community services. This has required working with partners to disaggregate records and other digital systems on to the HCRG Care Group platforms and telephony systems. In our Swindon wards an Electronic prescribing of medicines system (EPMA) was also implemented at the same time as colleagues were transferred onto the SystmOne health care system. The digital team have also been working on a robotic processing automation tool to be deployed next year to support the Single Point of Access and care coordination centre.

## Single Point of Access

The project group working on the Single Point of Access (SPA) transformation has set up all of the equipment and put the digital systems in place ready for the SPA to go live. This includes a standardised telephony system across the BSW footprint which links to a digital platform for receiving and supporting the triaging and processing of referrals into the clinical record. There is a monitoring system in place to enable team leads to have an overview of call volumes and waiting times, to enable resource to be redeployed to support timely responses. Processes have been designed and agreed and training packages have been prepared to support colleagues into the use of the system and the standard operating procedures. New rotas have been drawn up to support the expanded opening time of the SPA during the day and the overnight out of hours cover. Colleague engagement and consultation has taken place and additional support planned for go live. Business continuity arrangements are also in place.

The digital front door (DFD) has been set up which has a wealth of information about the community services across BSW. There are self help guides, videos and links to other sources of support and it is set up to enable people to search by their need and be guided to information about the service or services, most appropriate to meet their needs.

The digital front door also enables people to self-refer into services electronically using the link on the webpage. All of the digital initiatives have been overseen by the Clinical Safety Team to ensure that they meet the clinical safety requirements of NHS care.

## Integrated Neighbourhood teams

Within the Integrated Neighbourhood Team project HCRG Care Group ran two 'test and learn' projects which were focused on examining how an Integrated Neighbourhood Team could deliver a new model of Neighbourhood delivery.

The Objectives of the first test and learn project based in BaNES were to:

- Improve the function of Integrated Neighbourhood Team (INT) Multi-Disciplinary Team meetings by promoting the inclusion of specialist services, those from the voluntary sector, local authorities and acute hospital teams, and to
- Understand the effectiveness of a proactive approach alongside discussions surrounding complex situations

The aim was to provide a proactive approach to identify and focus on the needs of people who are frail, whilst also targeting particular GP networks or specialities. Selection criteria used population health management tools and interacted with Voluntary Services representatives to support conversations and bring in people who do not meet usual referral criteria. This was referred to as Multi-Disciplinary Team (MDT) Forward thinking. A questionnaire was sent to GPs for input and feedback about current MDTs and BSW Community health future plans.

As a result of the information gathered, the MDT template was adapted to include specialist services in order to enhance data reporting. The project tested linking in and working together with Locality Care Coordinators (LCC) in HCRG Care Group and Care Coordinators, based within Chew Primary Care Network in order to assist with a more proactive approach.

The first of the new MDTs took place in November 2025 to introduce and outline new plans, as a result of learning from this new approach. A wide range of community partners were involved including:

- Community Matrons
- Care coordinator/ LCC
- GP
- Social prescriber
- Community frailty specialist
- Community services representative
- Adult social care representative
- Voluntary services representative

As a result, partners agreed to work collaboratively to support the implementation of the new model to maximise support to people in the community. Positive engagement from community matrons and GPs was evident and community colleagues appear to be encouraged by the improvements.

Further work is underway to embed this learning with GPs and the Integrated Care Board (ICB) Medical Director. The learning from this project will be included in our wider approach across Swindon and Wiltshire by Integrated Neighbourhood Teams in year 2.

The objectives of the second test and learn project were:

- Self-completion of 'About you' questionnaire being a desirable and practical option for people
- Information being able to flow in and out of the clinical system via templates and questionnaires and to be coded appropriately for reporting
- The 'About you' questionnaire must contain the correct amount and content of information needed to commence a 'needs-led' care plan for patients
- The 'About you' questionnaire needed to integrate with the Single Point of Access, Integrated Neighbourhood Teams and care teams' records by ensuring that people are only asked to 'tell their story once'.

### **What BSW Community Health focused on**

A self-completion questionnaire to ensure that a person's voice is heard at the start of being supported with the integrated neighbourhood team (INT). Time spent in the initial consultation

needs to be meaningful and there was a need to ensure that information shared, supported future interaction with all services within BSW Community Health. The pilot group was multidisciplinary and involved colleagues from the voluntary sector.

#### **Implemented changes:**

- Colleagues used feedback on the assessment from an Age UK carers voice group
- Ways of sharing the patient questionnaire were tested and this provided learning in order to agree how to use and share this data on clinical systems
- The approach and processes were updated to meet the needs of people who would be using the service
- Care teams can use the assessment for enabling clients to tell their story only once; improve care with a more personalised approach, thereby reducing the risk of admission to hospital and the information is useful for communications about care between people and their families
- The feedback was invaluable and supported the plans for the new model of delivery
- The assessment was finalised and successfully integrated into clinical records systems with Read codes added to support reporting

There was good engagement with those involved in the new assessment approach. Patient and Carer feedback is still under review, however there is widespread agreement between colleagues across the system that the goals of the pilot and those of the assessment are good for future patient care.

#### **Workforce transformation**

It is imperative to have knowledgeable, skilled, compassionate and proficient colleagues in place to deliver care in the community. It is equally important during a period of change to have colleagues equipped to adapt to new models and ways of working, with the understanding and engagement with the vision. In year one the workforce transformation focussed firstly on welcoming new colleagues into the organisation and helping them settle into using new tools, or using them differently. The next phase was to identify and implement a new leadership structure to support the realignment of adult services into:

- Urgent Care, which encompasses inpatients, MIUs and hospital at home services
- Integrated Neighbourhood teams which in the first year was mainly community nursing and reablement
- Specialist Services – therapies, podiatry, Musculo-skeletal services (MSK) and Orthopaedic Interface Services (OIS) neurology and stroke, audiology, specialist nursing services and wheelchair services
- Learning Disability, Autism and Neurodiversity (LDAN) services

Children's services structures remained broadly the same as before, as these align to the Local Authority as well as ICBC contracts.

This structure is a BSW wide leadership to fully manage the complete BSW footprint and all of the services within it.

During the year there were some changes to other workforce structures such as the Quality Team including Pharmacy and Safeguarding to enable them to have a BSW wide support function; and the

business support teams to prepare them for the implementation of the BSW wide Single Point of Access and central support function.

Following the implementation of the leadership structure, the Senior Leadership Team undertook a series of listening events by having a designated “surgery” time in hubs across the area, where people could come and raise issues in private with a member of the team. On these days leaders also actively sought out colleagues on site to chat informally to them to understand how they were feeling and understand any concerns or frustrations as well as to learn about achievements and what they were proud about. This was a very useful exercise and enabled the team to get a feel for issues and themes as well as being able to myth bust and identify solutions and escalate some of their concerns. Following this the team addressed some of the themes and solutions agreed through BSW communications as well with individuals who ha

## Partnership development and community engagement

Since April 2025, HCRG Care Group has delivered one of the most comprehensive engagement programmes undertaken across Community Health in Bath and North East Somerset (BaNES), Swindon and Wiltshire (BSW). This programme has directly shaped the design of the Integrated Neighbourhood Teams (INTs), Single Point of Access (SPA) and Digital Front Door (DFD), ensuring these developments are grounded in the lived experience of the people and partners who use, deliver and support Community Health services.

### The reach (June 2025 – March 2026):

- **455** survey responses
- **156** engagement activities across BSW
- Collaboration with **88+** VCFSE partners
- Direct engagement with **1,200+** people — including **20+ seldom-heard communities**
- **58+** workshops and **46+** meetings with local groups and networks

## What was heard – core themes

### Access & Clarity

People remain unsure what Community Health services include and how to access them. There is confusion between SPA/DFD, GP, 111 and A&E routes.

### Inclusion & Equity

Digital exclusion, low literacy and variable confidence create barriers to access. People want simple language, clear options and strong non-digital routes.

### Integration & Continuity

People often repeat their story multiple times due to fragmented pathways and inconsistent information-sharing. Professionals report similar challenges.

### Trust & Transparency

Uncertainty about referrals, a lack of updates and unclear waiting times reduce trust and increase anxiety.

### Professional & Partner Needs

Partners emphasise the importance of maintaining professional-to-professional contact, flexible referral routes and consistent standards across INTs.

### What was changed – highlights

- Rewrote referral language into **plain English**, clearly distinguishing diagnostic queries from general support needs.
- Added a clear “**menu of options**” to the DFD to explain what the SPA/DFD is and when people should use it.
- Embedded **multi-channel access** (phone, email, postal, self-referral) and accessibility features (translation, read-aloud, large-font design).
- Designed a self-referral process that can be completed in **under five minutes**, with communication preferences and reasonable adjustments captured upfront.
- Strengthened our **no wrong door** approach, ensuring people without GP registration or a fixed address can still access Community Health services.
- Built **expectation-setting and reassurance messages** into referral journeys, including visibility of future referral status.

### Community estates strategy

With the transfer of services into HCRG Care Group, the organisation acquired some community buildings to add to the estate where patient care is delivered. These buildings were of various ages and in differing states of repair, accessibility and comfort for people using them. Some services came across without any buildings and have been located within the existing estate. Some buildings are not designed for modern health care provision and it is a challenge to keep these clean and safe for care delivery. There were some premises in use by the local teams already in the estate prior to April 2025 that had been identified as unsuitable and where teams needed to be relocated to premises that were better suited for health care delivery.

During 2025 -2026 HCRG Care Group estates and health and safety teams worked with landlords to undertake an in depth review of the estate, including location relative to population and other community properties, accessibility, state of repair, fitness for purpose and other factors, to understand the existing estate and its potential suitability to deliver the new stepped care model. Significant progress has been made in establishing the estate quality and compliance baseline. Condition assessments have identified priority maintenance requirements with early engagement underway with landlords, including NHS Property Services and local authority partners to address these.

A Community Estates Strategy has been developed to bring this expanded footprint into a coherent, modern and sustainable estate that supports integrated models of care, including Integrated Neighbourhood Teams (INTs), Neighbourhood Hubs, Children’s Health Hubs, and a greater focus on

prevention, early intervention and digital access. Opportunities have been identified to co-locate services to reduce duplication and strengthen integrated delivery.

The strategy is aligned to the BANES, Swindon and Wiltshire ICB Infrastructure Strategy and the NHS Long Term Plan, ensuring investment decisions support long-term system priorities. The foundations for a more digitally enabled estate have been established.

The strategy will be implemented during year 2 with the aim of providing the users of BSW community health services with premises that meet the needs of safe and accessible care within a pleasant environment, as well as flexible areas for community colleagues to work in. The rollout of digital room booking and utilisation tracking tools has commenced, improving visibility and supporting more efficient use of space.

### **Service identity and brand development**

After April 2025 one of the first priorities was to establish links into the wider community to understand their particular needs and to start to work with community groups and individuals to ascertain their views about the shape of the new model. It quickly became clear that people did not understand what was meant by community health services and neither did they have any concept of the breadth of health services which were available within their community.

People understood that GPs, dentists community nurses and ophthalmologists worked in the community and some identified community pharmacists, but many thought that you had to go to “the hospital” for some of the services that are routinely provided in people’s homes or other community settings.

It was clear that there needed to be a strong identity for these services which was distinct from acute care, but still unmistakably health care. It needed to reflect local delivery and also align with HCRG Care Group branding. There was lots of engagement with the public, community groups, partners and commissioners and a shortlist of designs was developed which was shared with partners. The design chosen has been accepted by colleagues, partners and members of the public and is now in use on the website, written materials and on colleagues virtual meeting backgrounds when meeting with service users virtually or other agencies.



### **Outcomes and benefits realisation**

As an outcomes based contract this project had been identified early in the year as a key priority in its own right and is therefore outlined below as our third quality priority.

#### **Priority 3 Determining and implementing outcome measures**

Prior to the Improving Community Based Care (ICBC) contract, HCRG Care group had already identified and implemented some outcome measures within individual services which were being captured and reported on regularly. Compliance with outcome measures was also being audited by some services as part of the annual audit programme.

Outcomes based contracts are not reliant on the same methods of determining performance through measuring the number of interventions provided, but instead look at the impact of the interventions being delivered on the people who are receiving them. Traditional outcome measures look at the impact of

interventions on an individual person basis. E.g. if someone completes a programme of 6 physiotherapy sessions what has the impact been afterwards: can they walk further, more confidently or safely? If people had agreed their own desired outcome with their therapist at the start of the programme their goal may have been to return to playing sport; getting up from weeding, playing with grandchildren; or going to the shops on their own.

The outcome measures which were required by BSW Community services were not solely about individual people's outcomes, but were about outcomes across a whole community across BSW.

In conjunction with commissioners and with insight gained from population health data, a set of six core outcomes have been agreed, which are underpinned by 43 contributing outcomes.

The 6 overarching outcomes are:

|                                        |                                      |                                                   |                                         |                                                 |                                         |
|----------------------------------------|--------------------------------------|---------------------------------------------------|-----------------------------------------|-------------------------------------------------|-----------------------------------------|
| <b>1</b><br>Improve Health & Wellbeing | <b>2</b><br>Increase Life Expectancy | <b>3</b><br>Reduce Impact of Long-Term Conditions | <b>4</b><br>Improve Access & Experience | <b>5</b><br>Improve Sustainability of Workforce | <b>6</b><br>Optimise Impact of Enablers |
|----------------------------------------|--------------------------------------|---------------------------------------------------|-----------------------------------------|-------------------------------------------------|-----------------------------------------|

There has been a lot of progress during the year with work towards setting out the outcome measures and understanding what needs to be in place to achieve them.

## OVERARCHING OUTCOME 1 – Improve Health & Wellbeing of our Population

Improving the health and wellbeing of the Bath and North East Somerset, Swindon and Wiltshire (BSW) population is the most fundamental of the six overarching outcomes. It encompasses everything from identifying frailty early in life and supporting people to manage their long-term conditions; to improving the mental and physical health of children and young people; screening people for lifestyle risk factors; and ensuring that people nearing the end of their lives are identified and supported with the personalised care they need. It is the outcome that most directly reflects the contract's prevention-first ambition.

Year one outcomes focused on establishing the foundations from which real population health improvement can be built. That involved gathering the baseline data on our population that will allow the organisation to measure future progress against. It will also allow the BSW community health to co-design who in the population requires support and the most appropriate way to achieve this, using determinants of health and lifestyle behaviours. HCRG Care Group was therefore able to undertake risk stratification to help target where there is not only the greatest need but also where there can be the greatest impact.

Transformation planning and design has focused on the types, number and design of deliver of the new neighbourhood teams; consultation and planning for the Single Point of Access to allow patients to refer directly to BSW community health and using our new Digital Front Door; how to share patient information more widely in the system most effectively for the delivery of care; and delivering targeted interventions which will address the health of children. Finally, it focuses on delivering frailty screening, utilising population health data, at scale.

Across the measures that sit under this outcome, year one delivery has been concentrated in three areas:

- establishing consistent frailty identification and personalised care planning for older people and those with complex needs
- planning the delivery and design of some early years and children and young people investments that will improve life chances for children,

- beginning the prevention and lifestyle behaviour work that will, over time, reduce the burden of avoidable illness across the BSW population.

### Contributing outcomes

|                                                        |                                             |                                            |                                        |                                              |                                         |                                      |
|--------------------------------------------------------|---------------------------------------------|--------------------------------------------|----------------------------------------|----------------------------------------------|-----------------------------------------|--------------------------------------|
| Reduce impact of negative wider determinants of health | Increase life expectancy / Reduce Mortality | Increase prevention and early intervention | Improve early diagnosis / case finding | Improve quality of life and mental wellbeing | Improve school readiness and attainment | Reduce adverse childhood experiences |
|--------------------------------------------------------|---------------------------------------------|--------------------------------------------|----------------------------------------|----------------------------------------------|-----------------------------------------|--------------------------------------|

**Ambition: Develop a ‘connecting care for children’ offer, to reduce fragmentation across the system and improve care-coordination for babies, children and young people aged 0-25 with multiple needs.**

**Measure: Provide improved access to specialist paediatric advice and reduce GP appointments for 0-18 year olds.**

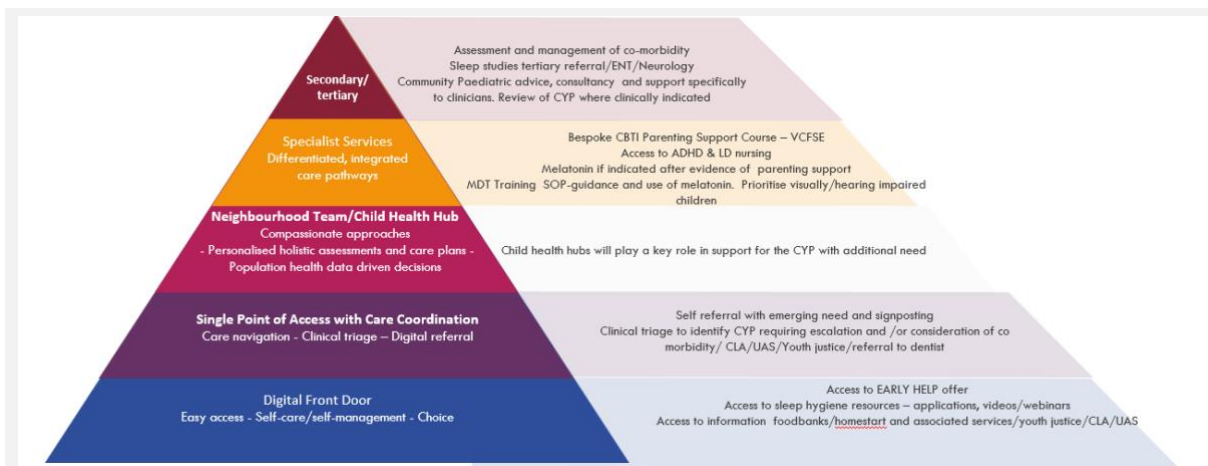
A Sleep pathway test and learn pilot was undertaken where the team set about developing an integrated care pathway for Children and Young People (CYP) with a neuro-disability and an integrated care pathway for Sleep.

The Pathway for sleep was redesigned after findings found that there was:

- An inconsistent assessment and intervention approach from professionals and services
- Limited awareness or understanding of sleep issues experienced by children and their families in the community
- A fragmented service delivery with unclear ownership or accountability with multiple providers of sleep support
- An increasing expectation amongst some parent/carers of use of melatonin due to social media coverage
- An over-reliance on passive resources e.g. leaflets and use of apps, instead of active and tailored support
- A lack of robust knowledge regarding the existing resources to inform care
- Sideways entry into the system, resulting in missed opportunities for structured triage

**As a result, an ‘The Always Statement’ was agreed** which is – “We will always ensure timely, equitable, and support for all children across BSW, with access to early help, clear referral pathways, joined-up multi-disciplinary working, and proactive prevention strategies using a graduated approach.”

As a result, the Children and Young People’s Sleep – Stepped Care Model is pictured here



Implementation of this new model will be rolled out from April 2026 and will involve:

- Developing a robust understanding of available resource to CYP and their families
- Working with partners to understand the Early Help Offer
- Developing additional resources available to patients on referral including key videos relating to how and when melatonin is considered
- Clinical triage protocols to identify and expediate co-morbidity
- Working with Children and Young Peoples services across HCRG Care Group to develop a core offer of resources
- Working with system partners to develop and implement a Cognitive Behavioural Therapy for Insomnia (CBTI) based course and exploring opportunities with the voluntary sector and charitable organisations
- Developing a BSW Standard Operating Procedure for use of melatonin and agree KPIs outcome measures to monitor effectiveness and measure decrease in prescribing
- Identifying training needs and options required to support colleagues/partners to deliver basic sleep hygiene advice

**A number of opportunities and benefits will result from this pathway including:**

- Reduction in referrals to both acute hospitals and community paediatric providers prior to trial of basic sleep hygiene strategies
- Reduction in the cost of prescribing by using a 'stepped care' approach
- Engagement with Voluntary, Community, Faith, Social Enterprise (VCFSE) to deliver standardised specialist sleep programmes as part of the stepped care offer
- Scope a specialist sleep provider to support Children and Young People and their families with most complex needs requiring highly specialist care and intervention.

**Ambition: Voice of children, young people, their parents, carers, families and communities to be heard and at the heart of everything, with care and treatment co-produced and personalised to them and their needs**

## Measure – Children and Young people are fully engaged in the development of the services that support them.

This project focused on a new Clinical Pathway Information for Unaccompanied Asylum Seeker Children (UASC) model of care.

In January 2026, the number of Unaccompanied Asylum Seeker Children across BSW was 123.

### What we know, and the associated health risks:

The young people have travelled through multiple countries and are do not have knowledge around this.

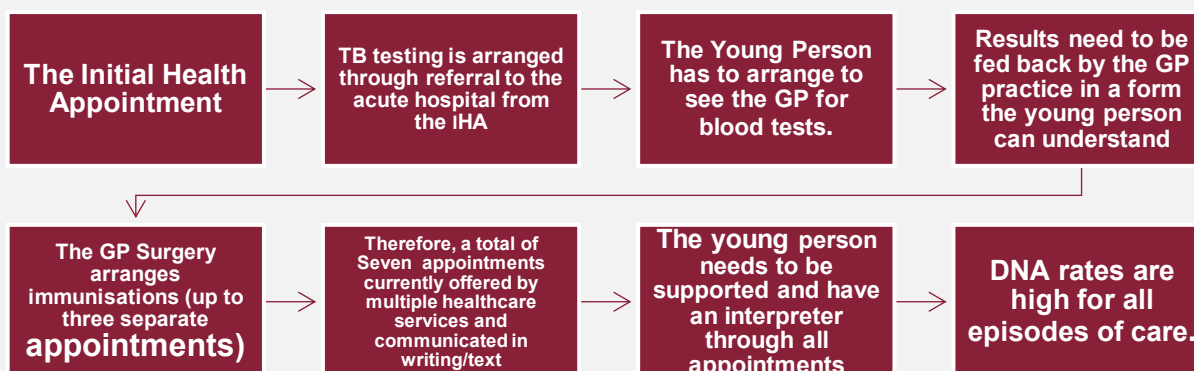
They have often travelled in cramped conditions, in close proximity to others, whose health status is unknown

They are children and have often travelled for years, so cannot remember their own health history

They often cannot contact their parents (if the parents are still alive). They rarely have knowledge regarding imms status

They may have experienced extreme trauma that they are, as yet, unable to verbalise  
English is not their first language.

The current experience of the Screening journey includes:



Feedback we received from Unaccompanied Asylum Seeker Children (UASC) included;

- **Having a One stop shop** – Suggestion of having a “One-stop shop” where UASC are able to be seen in a timely way, in a clinical setting, and get a full health check that includes bloods and vaccinations
- **Young people were very positive about this** and explained how they had several appointments spread across 4 months. If this could all be delivered in one appointment they would be pleased as they find traveling around and understanding our ‘systems’ very difficult

- **Other Care Leavers in the group** thought this would be a good idea for them too when they first come into care. It could save a lot of time and stress, especially one young person who shared that they had clinical settings anxiety

## Benefits for the young person



Further benefits of this model and the results of the project were: **H**

- That highly specialist clinical care is focussed on reducing health inequalities for highly vulnerable young people and improves access to specialist resources
- It offers right clinical, right time, right place with a focus on Making Every Contact Count and a 'trauma informed' approach
- Reduces the number of appointments for the Young Person from 7 to 3 with added benefits of reduction in requirement for an interpreter to attend those sessions and improved completion of the assessments and vaccination programme
- Addresses public health priorities; specifically, the uptake of immunisations and screening. TB is currently on the rise in this cohort and completion of full immunisation schedule is rare
- It responds to feedback from young people who often find attending health appointments extremely traumatic

There is a significant amount of excitement from clinical colleagues and local authorities who have agreed to participate in 2026/27.

**Ambition: Urgent care pathways including admission avoidance or supported discharges including Hospital at Home will expand to provide at home diagnostic interventions and community diagnostic centres and specialist support ensuring alternatives to conveyance**

## Hospital at Home:

The Hospital at Home initiative was a priority for HCRG Care Group, in order to maximise capacity across the system, providing acute care in the place our patient calls home. The concept has been rolled out and has continued to be developed across BSW in the last few years.

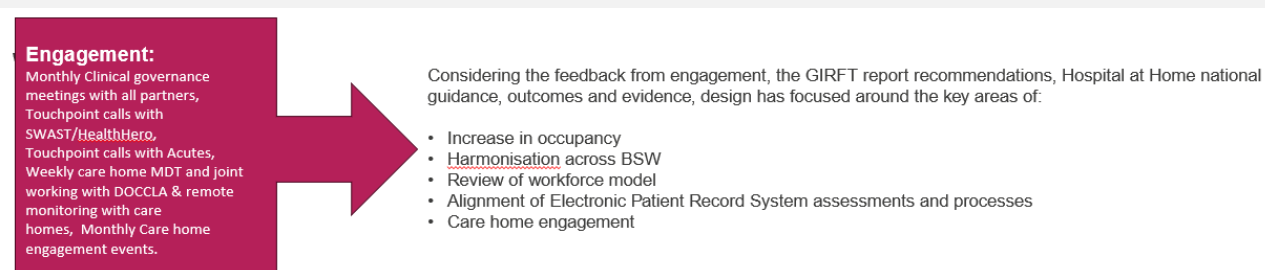
There is a defined capacity for each area, and in part due to the service's infancy, there has remained some difficulty in achieving full occupancy. There has been a lack of understanding and confidence in the service from partners across the system, reflected by suboptimal referral numbers.

Each of the localities in BaNES, Swindon and Wiltshire has delivered different workforce models which needed to be aligned to ensure an equitable offer to the community. Similarly, each service had differing levels of key skills and access to diagnostic support.

There was also no consistent social care offer across each area and some limited engagement with local authority social care leads in order to offer additional support to maintain care delivery in the patient's own home.

Additionally, we found that data captured, differed across each locality and did not lend itself to cross system working. Ensuring consistency in approach would support a more uniform offer across BSW.

We engaged with partners across the system and considered recommendations and learning from the Get it Right First Time Approach (GIRFT). See illustration below.



## As a result a new pathway was developed which led to a core approach:

- Reporting consistently and capturing data about patient care across all of our sites
- Offering a comprehensive geriatric and holistic assessment
- Personalised care planning approach
- Provided joined-up system working
- Providing both digital and non-digital access options

## Proactive, Person-Centred Care:

- Early identification of suitable Hospital at Home patients
- Holistic assessment with onward referrals where needed
- Preventative support and signposting
- Make Every Contact Count – based wellbeing interventions

## Identification:

- Same- day diagnostics and testing
- Rapid onward referrals into required services
- Digital onboarding through Doccla

## Assessment:

- Comprehensive Geriatric Assessment completed

- Individual care plan initiated

#### **Multi-Disciplinary Team (MDT):**

- Daily MDT and board rounds
- Specialist MDT input for complex patients
- Liaison with acute specialists as required

#### **Personalised Care:**

- Co-designed personalised care plans
- Preventative care planning following specialist/INT intervention
- Regular review and update of End of Life (EOL) Respect plans

#### **Care Homes:**

- Quarterly in-reach workshops for care homes
- Increased uptake of technology (such as Doccla) to support monitoring within high-risk homes
- Focus on reducing ED admissions

#### **Digital:**

- Rollout and onboarding of Doccla
- Digital support for discharge pathways
- Assessment of digital suitability and literacy

#### **Interdependencies:**

- Close working with specialist services, INTs and SPA
- Collaboration with acute hospitals
- GP Partnership working

In 2025 – 2026 the services:

- Worked with SPA transformation pathway to assess changes in pathway
- Worked with the clinical systems team to develop a BSW unit for Hospital at Home (H@H) in the summer of 2025
- Aligned services across BSW, with a new Swindon dedicated H@H team)
- Implemented a Standard Operating Procedures (SOP)
- Evidenced Acute Hospital admission avoidance in patient referrals
- Audited the Digital respect forms uploaded
- Increased the sharing information digitally across professionals
- All patients now have a NEWS2 score upon admission and discharge
- All patients now have a Clinical Frailty Scale (CFS) score (Frailty)
- Full Comprehensive Geriatric Assessment (CGA) is routinely completed for every patient with Frailty
- Rolled out use of the BEMS mobility score
- Improved resilience
- Increased and sustained 80% + occupancy across BSW

### Case Study:

**Ambition:** Improve prevention and early intervention by empowering citizens & strengthening local partnerships

**Measure:** All interventions engage with risk factors that cause or exacerbate long term conditions or complications from long term conditions, utilising the resources available in the NHS and in the wider community including voluntary community and social enterprise.

### Our approach - Improving Health and Experience Through Personalised Care and Community Partnership

A gentleman had been referred for a falls risk assessment after experiencing increasing difficulties with his balance and mobility outdoors. For him, getting out of the house wasn't just about exercise; it was his connection to the world. Once a week, he would catch the bus into town. Sitting in a café, watching the bustle of life, he described, "seeing people and being around people is important to me"

But the trips came with risk as his only walking aid was an unstable quad stick, and with uneven pavements, this had caused him to trip and fall.

#### 'About You' Care Planning: Reducing Falls and Promoting Safe, Independent Mobility

Through a needs-led assessment, it became clear that a more stable walking aid, specifically a four wheeled walker, would significantly improve his safety and confidence outside.

Although a communal walker was available in his housing complex, it couldn't be taken off the premises. And buying one of his own wasn't an option; the cost felt far out of reach, and he didn't know where to begin.

As we talked more, a fuller picture emerged and he had spent many years working for Great Western Railway and still held a deep love of transport, especially trains. He lived alone, had no family, and his closest friend was hundreds of miles away in Scotland. He had even tried a befriending service before, but the match hadn't been right. Despite everything, he remained determined to stay connected to the world around him.

#### Partnering With Voluntary and Charity Organisations for Better Outcomes

With his permission, his occupational therapy apprentice reached out to the Railway Benevolent Fund (RBF), which supports former railway employees. Together, the patient, the RBF, and the therapy apprentice explored options for a suitable four wheeled walker. A supplier was found who could deliver straight to him, and evidence was gathered to apply for a grant through the fund.

Just days later, wonderful news arrived as the RBF approved the funding.

He will receive his brand-new four wheeled walker. The equipment will give him a safer, more secure way to move around outdoors and continue the weekly trips that mean so much to him.

#### Building Independence and Connections

The RBF also reached out to him about social networking opportunities. Having new ways to connect with people can transform emotional wellbeing and support his sense of purpose - outcomes that are absolutely vital for health and happiness.

The HCRG Care Group occupational therapy apprentice said:

"My patient's journey shows what can happen when clinical care, compassion, and community support come together. With his new four wheeled walker and new opportunities, he is set to move forward, steadier on his feet and stronger in his social connections."

### OVERARCHING OUTCOME 2 – Increase Overall Life Expectancy Across our Population

People in BSW do not all have the same life expectancy. Those with learning disabilities, serious mental illness, or living in the most deprived communities die, on average, significantly earlier than the general

population not because of inevitable biological differences, but because of avoidable gaps in identification, treatment, coordination and support. Closing those gaps is an organisational priority. Year one work under this outcome has focused on the two most direct levers available: frailty identification and personalised care planning, which reduce the risk of catastrophic deterioration and unplanned acute admission for the most vulnerable older adults; and improving access to preventative health interventions particularly annual health checks for people with a learning disability, where the contrast between statutory ambition and actual delivery has historically been stark. The measures under this outcome are deliberately focused and are based on two key measures: evidence of Rockwood frailty screening for the over-60 population in contact with community teams, and the proportion of people with moderate or severe frailty who are captured on our BSW Integrated Care Record. Both are foundational and without them the system cannot proactively manage risk, coordinate care, or demonstrate that its investment in frailty is translating into better outcomes.

#### FRAILITY SCREEN

**50%**

Of the 60+ population in contact with community teams screened

#### CARE PLANS

**50%**

Of moderate/severe frailty with care plan on ICR

#### Learning Disability EXPECTANCY

**+10 yr**

Ultimate life expectancy ambition for people with LD

### Contributing outcome areas

Increase life expectancy / Reduce Mortality

Reduce gap between healthy and overall life expectancy

Reduce variation across demographics

Reduce early deaths from preventable causes

Reduce deconditioning in the last 1,000 days

**Requirement:** Redesign frailty pathways including a case finding and a coordinate frailty offer.

**Ambition:** 50% of people aged 60+ in contact with community teams are screened for frailty using the Rockwood Clinical Frailty Scale by end of year one, creating a reliable population-level baseline for proactive care

This has been delivered in year as the data outlines below. This data will be used to benchmark against when a wider and more targeted offer is rolled out via our neighbourhood health approach in 2026/27 (year 2).

| % of open referrals with frailty score             | Age group |     |
|----------------------------------------------------|-----------|-----|
|                                                    | 40-59     | 60+ |
| BaNES Adult Heart Failure Nursing                  | 33%       | 77% |
| BaNES Adult Podiatry                               | 8%        | 25% |
| BaNES Adult Reablement Service                     | 34%       | 46% |
| BaNES Adult Virtual Ward                           | -         | 43% |
| Wiltshire Community Intensive Rehab Team           | -         | 97% |
| Wiltshire Continence Service                       | 62%       | 66% |
| Wiltshire Hospital at Home Service                 | 50%       | 89% |
| Wiltshire Integrated Community Neurology Service   | 80%       | 83% |
| Wiltshire Stroke Early Supported Discharge Service | 38%       | 83% |

**Ambition:** 50% of people identified with moderate or severe frailty hold a personalised care plan on a cross-system clinical record, ensuring that their needs are visible to all clinicians they encounter and their care is actively coordinated.

What we did – in Swindon BSW Community Health tested a programme entitled “Steady on your Feet”. Visit [Welcome to Steady On Your Feet BaNES, Swindon and Wiltshire](#)

The results of our pilot showed that on the site we had;

16,175 Page Views

5,706 Unique Visitors

954 Self-Assessments

594 Action Plans created

#### As a result;

**84% of users know more about the major causes of falls**

**72% of users are more aware of local falls prevention services**

**80% of users are confident about reducing falls risks**

**71 % of users have not fallen since completing self-assessment**

**£8,907,149 Was the potential system-wide cost saving if 71 % of 594 users are prevented from experiencing a fall within 12 months**

*based on cost of £21,120 per fall (Kings Fund)*

#### Client feedback has been very positive to date with some patients reporting;

*“Making me think and take more care more slowly. For example we have two sets of steps on the way to the shops. I now make sure to hold on to the battered hand rail and step off the final step carefully.”*

*“It helps me just by being available, it boosts my wellbeing by knowing I have competent back-up.”*

*“No specific feedback. But thank you for advice!”*

*“I found the information provided about fall risks to be very helpful. I have taken several steps in my house to help me prevent a major fall accident. I am very happy to have found and reviewed you website.”*

*“Good advice given and makes me more aware”*

*“Useful information for me to work at, thank you.”*

### Overarching Outcome 3 – Reduce Impact of Long-Term Conditions and Morbidity

The majority of demand on community health services comes from people living with one or more long-term conditions including Diabetes, COPD, Heart failure, Musculo skeletal conditions, Dementia and Mental Illness. The question is not whether the system will care for people with Long Term Conditions, but how: reactively, at cost in hospital; or proactively, in the community, with personalised support that helps people manage their conditions, maintain their independence and avoid the deterioration that leads to unplanned acute hospital care.

Year one work was anchored in two areas. The first is the use of a shared care patient record to enhance care coordination to ensure people with Long Term Conditions, particularly those with complex or multiple conditions, are not falling through the gaps between services.

The second is the early deployment of digital advice and guidance tools which enable community and primary care clinicians to access and provide specialist input quickly to avoid unnecessary onward referrals that might delay patient care.

The measures under this outcome in year one focused on the reasonable adjustments and data collected on people’s care plans to provide a baseline of activity to evidence the difference to be made when BSW Community Health begins to provide a proactive service to specific population cohorts (including those with learning disabilities, autism and mental health needs. There is also an aim to use more feedback tools to evidence and measure shared decision-making with people and the use of digital tools to provide specialist advice and guidance.

Together these establish the quality infrastructure on which year 1 transformation in services sought to address those with long term conditions and reduced morbidity.

Y1 FOCUS

COLLABORATE  
TARGET

Advice and guidance

Long Term Condition  
TRAJECTORY

## Baseline

Establishing care plan quality standards

## 80%

Of patients providing feedback

## Y1 deploy

Specialist Advice & Guidance available from Integrated Neighbourhood Teams from Y1

## Y3–Y9

Measurable morbidity reduction horizon

**Requirement: Ensure that make reasonable adjustments are made for communities of known poorer health, mental health, learning disability, autism and neurodiversity**

What BSW community Health did - Identified a Baseline care plan approach for specific people, including those with complex or multiple needs including learning disabilities, autism and mental health conditions. This was established in year and will assist with evidencing the changes to be delivered as the services are transformed.

**Requirement: Implement redesigned end of life pathway including single point of contact and coordination, integrated primary care and community care nursing in the context of implementing the wider BSW end of life strategy**

This approach required HCRG Care Group to capture the number of patients who had been asked for feedback in the service they had received and to use this to consider how to improve our approach. These models of feedback are referred to as CollaboRATE and IntegRATE

**What BSW Health care did:**

**Requirement: Avoid appointments and tests by providing remote clinical advice, education and training for people and their Primary Care clinicians**

The use of a digital platform called Cinapsis which allows primary care and specialists to refer people and to discuss their needs, was fully deployed across BSW.

## Overarching Outcome 4 – Improve Access and Experience



Access and experience is where the ambitions of the new community health model meets the experience that people receive in reality. It is the outcome that most directly answers the question: what is it actually like to receive community health services in BSW:

- Does a person have to tell their story more than once?
- Is there one requirement to refer via our Single Point of Access?
- Can they get an appointment in a way and at a time that suits them by phone, video or in person?
- When they have complex needs, is there one named person coordinating their care?
- When they reach the end of their lives, are they supported to die in the way and in the place they have chosen?

This was the most operationally complex of the six outcomes to deliver because it reaches across every part of our service from our Single Point of Access and digital referral service to those attending the 3 Minor Injury Units. It also included the work that our new Neighbourhood Teams will deliver and affects the quality of our care from digital access to those nearing the end of life and their families, as well as the buildings and spaces where care is delivered.

Year one has focused on providing good access and experience possible at scale: single core assessments, electronic referrals, care coordination for complex patients and demand management of populations with the highest-risk population cohorts.

Year one measures under this outcome include managing and evidencing that we are reducing Emergency department and Acute hospital attendances; the effective care coordination of complex patients; and providing a consistent offer to our patients nearing the end of their life. It also involves

providing digital access to people across BSW and our workforce (including increasing electronic referrals and providing virtual consultations to patients); and includes a focus on BSW buildings and how they support people by welcoming them with clear signposting and in supporting their needs. These measures reflect that inclusive access and the experience of people and their families or carers who use these services is ultimately, the measure of how well every other part of the system is working.

#### EOL

**90-95%**

Of people dying in preferred place of death

#### CARE COORDINATION

**95%**

Of complex patients will have a co-produced care plan on their record

#### E-REFERRALS

**95%**

Of referrals made electronically by end of Y1

### Contributing outcome areas

Improve equity and opportunity to access services

Reduce health inequalities across neighbourhoods

Ensure 'tell your story once'

Improve delivery of care closer to home

Increase streamlined pathways of care

Improve system-wide cross-sector integration

**Requirement: Implement a redesigned end of life pathway including single point of contact and coordination, integrated primary care and community care nursing.**

**Ambition: Those identified as on an end of life pathway have an advanced care plan in place that is available to all that may come in contact with that person.**

In year 1, the development of End of Life care has focussed on strengthening and embedding advanced care planning to ensure people's wishes and preferences are understood and respected. This has made a significant difference to care by supporting individuals to plan for what matters most to them at the end of their life.

A key area of focus has been increasing the use of the Integrated Care Record (ICR) to create a single shared record across all health services, including GP's, Health Hero and hospital teams. This supports better communication, improved coordination of care, and ensures all professionals involved have access to the same information and an understanding of the patient's needs.

Further work has centred on outcome measures within advance care planning, including understanding people's preferred place of death and ensuring appropriate support is in place to enable them to remain comfortable at home where possible. This includes access to 'just in case' medications, up-to-date drug charts, regular review of ICRs, and ensuring all professionals involved in care are informed and aligned.

Collaboration with partners has also increased across the three hospices that HCRG Care Group partner with in BSW: – Dorothy House, Prospect and Salisbury Hospices. It also includes the voluntary sector and wider community services to strengthen support for both patients and carers. This partnership approach aims to enable more people to remain at home, supported and comfortable, during the final stages of life.

**Ambition: To engage with our community and community groups to understand their needs and current difficulties in accessing health care**

#### What we did

Between April 2025 and March 2026, engagement activity reached a broad and diverse cross-section of communities, service users, carers, colleagues and partners across BSW:

- 1,200+ people engaged directly

- 455 survey responses
- 156 engagement activities across BSW
- 58+ co-design workshops and 46+ meetings with local groups and networks
- Collaboration with 88+ voluntary, community, faith and social enterprise (VCFSE) partners
- Engagement with 20+ seldom heard communities, including people experiencing homelessness, Gypsy, Roma, Traveller and Boater communities, refugees and asylum seekers, people with learning disabilities and neurodivergent needs, carers, veterans, rural communities, prison residents and young people

Engagement took place in trusted community settings, including community centres, hostels, carers' cafés, libraries, faith venues, livestock markets, supported housing, prisons, youth groups and GP practices, enabling more inclusive and meaningful participation.

### What we heard

Across communities and partners, several consistent themes emerged:

- **Access to Community Health services is confusing**, with uncertainty about what services offer and how to use different access routes
- **Digital exclusion remains a significant barrier**, particularly for older adults, people with low literacy, those without reliable access to devices or data, and people experiencing homelessness
- **People often have to repeat their story** due to fragmented pathways and poor information sharing
- **Silence after referral increases anxiety**, particularly when waiting times and next steps are unclear
- **Inclusion, communication needs and cultural sensitivity** must be recognised from the first point of contact
- **Carers and families**, especially those supporting people with long-term or complex needs, experience a high burden navigating services

These insights highlighted where existing models unintentionally create barriers and inequalities in access and experience.

### What we changed

The engagement programme directly shaped and enabled tangible changes to service design:

- **Clearer, plain English service information and referral language**
- **A “no wrong door” approach**, ensuring people can access Community Health services regardless of entry point, GP registration or fixed address
- **Multiple access routes**, including phone, digital, postal and assisted self-referral
- **A self-referral process designed to be completed in under five minutes**, with communication preferences and reasonable adjustments captured upfront
- **Accessibility features embedded by design**, including translation, read-aloud, large-font layouts and non-digital options

- **Improved expectation setting**, including reassurance messages and planned referral-status visibility
- **Stronger integration through Integrated Neighbourhood Teams**, supporting joined-up, person-centred care and reducing duplication

These changes will improve experience, support earlier intervention and reduce avoidable deterioration for people living with long-term conditions.

#### **An example of designing Community Health Around Families – Turning insight into Impact**

Working closely with parents, carers and young people, we focused on understanding whole-family impact, which directly informed the design of improved referral pathways, including the Digital Front Door and the needs-led neurodevelopmental pathway.

Families told us that accessing services can feel confusing, time-consuming and emotionally draining, particularly for those supporting children with additional or neurodivergent needs. We heard stories of fragmented routes into care, repeated requests for information, long waits, and the burden of coordinating care themselves. ***“Keeping track of appointments, paperwork and chasing emails is exhausting. Better coordination would change my whole week.”*** Parent /Carer

Parents and carers also highlighted the importance of clear communication, simple language, and support that recognises the needs of the whole family, not just individual children. ***“Each of my children was assessed separately, but no one looked at how this affects the family as a whole.”*** Parent of twins, both ND

Young people shared how appointments can be disruptive to their education and daily routines ***“Every time I access my vaccinations and therapy, I get taken out of my favourite class, and I don’t like going.”*** Young person, special school

#### **What we changed – highlights**

In response, we introduced a Single Point of Access (SPA) to provide one clear, trusted route into services, bringing referrals, advice and triage together. This is supported by a Digital Front Door, designed in plain English, to be quick to use and flexible around caring responsibilities.

A key principle of the new approach is a think-family, trauma-informed model that supports earlier help, better coordination, and improved signposting across services.

#### **Why this matters – improving outcomes**

This transformation shows what happens when lived experience drives change to improve access and experience and the Health & Wellbeing of our Population

By embedding lived experience into service design, families will benefit from:

- Reduced emotional and administrative burden
- Greater clarity, reassurance and trust
- Earlier, better coordinated support
- Services designed around whole families

BSW Community Health will continue to work alongside parents, carers and young people to listen, learn and improve as these changes are embedded.

#### **Overarching outcome 5 – Improve Sustainability of Workforce and Carers**

The transformation this contract demands is not possible without a workforce that is stable, skilled, motivated and growing. Some community health services have operated with tight margins of workforce resilience, high agency spend, variable vacancy rates and limited ability to deploy colleagues flexibly across organisational boundaries. Year one of the contract has addressed what is required to change this: not by adding more colleagues, but by changing the conditions in which people work.

Sustainability of workforce means reducing dependency on agency and 'off-framework' colleagues but it also required us to begin building a pipeline through apprenticeships, clinical placements and early careers that will meet future demand.

This has been focused on enabling colleagues to work across organisational boundaries through passporting, shared job planning and collaborative, integrated working that our neighbourhood team model will require.

Year one workforce priorities have required implementation of colleagues passporting, ensuring there is a flexible working policy in place, appointing an apprenticeship lead and signing-up to Step up to Health and Disability Confident schemes which support all colleagues' needs. These are not incremental improvements but are the commitments that signal a different relationship between the organisation delivering community services and the people who work in them.

## PASSPORTING

## PLACEMENTS

### Contributing outcome areas

Improve colleagues satisfaction and wellbeing

Increase co-designed models of care

Increase workforce efficiencies and clinical productivity

Increase sustainability and effective use of workforce

Strengthen partnerships across teams and organisations

**Ambition: Commitment to a compassionate and inclusive culture, underpinned by continuous improvement and learning, with provider(s) working and training differently to meet the needs of patients and new models of care**

**Measure:** Year 1 evidence of a sustainable learning and development infrastructure with access to development for all colleagues. Year 1 Partnership agreement with 3rd sector and evidence of access and co design of shared training and development. Year 1 onwards evidence of effective commissioning of education and dynamic upskilling programmes.

### Achievements:

**Colleagues passporting:** 100% compliance with the Core Skills Training Framework and BSW MoU for colleagues passporting from year one. Sign-up to NHS digital passporting confirmed. Evidence of cultural colleagues survey and related action plans. [Sustainable & Innovative Workforce]

**Requirement: Commitment to BSW, regional and national employee value proposition Organisation Diagnostic and culture:**

In year one the workforce team completed an Organisation Diagnostic, delivered a Cultural colleagues survey and created associated action plans were created and Equality, Diversity and Inclusion is being collected and reported. In addition, the organisation provided assurance and aligned with the NHS Impact (Improving Patient Care Together) framework from day one.

### Employee Learning and Development

A Sustainable Learning and Development (L&D) infrastructure in place with access to development for all colleagues. Partnership agreement with third sector. Evidence of co-design of shared training and development programmes. Effective commissioning of education and dynamic upskilling programmes.

### Clinical placements

The NHSE Educator Strategy was implemented in year and achieved 100% utilisation of clinical placement capacity and expansion in line with workforce plans. The Organisation received high levels of learner satisfaction feedback via National Education Trainings (NETs) and in turn saw a year-on-year increase in education capacity.

### Employee Value Partnership (EVP) and recruitment

The organisation signed up to Step up to Health and Disability Confident national schemes as an employer and became active partners in system-wide Employee Value Proposition with a BSW collaborative marketing campaign to attract colleagues from across health, social care and the third sector. An increase in year of recruitment from local communities was achieved.

### HCRG Learning Enterprise & Training

**Requirement: 25% of community workforce are trained in Make Every Contact Count by end of year 2 and then 5% increase year on year"**

'Make Every Contact Count (MECC)' training has been offered since before April 2025. The MECC approach enables health and care workers to engage people in conversations about improving their health by addressing risk factors such as alcohol, diet, physical activity, smoking and mental wellbeing. This training includes what is involved in this scheme and what it means to 'Make Every Contact Count', why it is important in addition to preparing colleagues from having the conversation with patients and their families about the scheme. This has been part of the pilot which started in October 2025.

|                                       | BSW colleagues completed |
|---------------------------------------|--------------------------|
| How to have a MECC conversation       | 43                       |
| What is MECC and why is it important? | 52                       |

**Requirement: Embed Population Health approaches /techniques/analysis through training community teams which relates to the The Learning Enterprise (TLE) Population Health training**

Population health is a key focus of the NHSE Ten Year plan and is a part of The BSW community Stepped Care model approach. A training programme was rolled out as an Introduction to Population Health Management in October 2025.

Swindon North Neighbourhood teams were the test group for this training and 6 individuals from the Swindon INT completed this in year.

**Requirement: Focus on working and training differently that meets the needs of people within BSW and new models of care**

The HCRG training offer is adapted based on user experience and business need. A consultation was delivered with workforce to ascertain training needs which will bring about changes in the training offered. Training is designed with the end user in mind, by subject matter experts and is piloted with the audience before final sign off. The training offer is revised every 2 years and on this basis is a Quality Assurance process is in place.

The ambition is for a year on year increase in colleagues capacity and capability of quality improvement with evidence of employing into practice and inclusive leadership behaviours and co-

production. Year on year increase in workforce EDI data OD diagnostic year 1 and subsequent implementation.

**Requirement: Support for creating a high quality multi-disciplinary learning environment for students and trainees across multiple supply pathways**

A new Learning Management System Dashboard was launched which supports the creation of a high quality multimedia.

The current Apprenticeship offer will continue in BSW with Assessor practice supervisor, when taking on students. The commitment to support students will continue to be available.

**Overarching outcome 6 – Optimise Impact of Enablers**



The enablers outcome underpins the remaining 5. Digital infrastructure, estates, information flows and service harmonisation are elements of the community service model of approach. A clinician who cannot access diagnostic results at the point of care; a person who has to navigate different opening times in different localities; a team that cannot share information across organisational boundaries are not minor inconveniences but form structural barriers which prevent access and integration as well as waste capacity and undermine the care model.

In Year one HCRG Cre Group have focused on closing the digital ‘gap’ between ambition and current state. Building-wide Wi-Fi, shared desktop standards, achieving 95% electronic referral capability, providing all colleagues with the appropriate digital diagnostic tools, together with providing virtual consultations and real-time patient flow tracking are not luxury upgrades. These digital advances have enabled the delivery of a harmonised community health service in BSW.

Beyond digital, year one enablers have focused on planning the estate reception model and harmonising service standards across BSW to eliminate postcode lottery variation.

**WI-FI COVERAGE**

**95%**

Building-wide coverage across BSW estate

**DESKTOP STANDARD**

**95%**

Shared desktop coverage across all sites

**DIAGNOSTIC ACCESS**

**100%**

Professionals with digital access to results

**Contributing outcome areas**

Increase digital care planning / advice and guidance

Improve use of estates, IT and digital to enable care pathways

Release funding and flow differently through efficiencies

Reduce unwarranted variation in resources or access

Increase system-wide connectivity and cross-sector access

Improve estate utilisation and access for priority services

**Ambitions and Measures achieved:**

**Ambition: Digital diagnostic access**

**Measure:** 100% of clinical professionals have digital access to all relevant diagnostic results and images for patients under their care at the point of contact, underpinned by ICR rollout and (Doccla) remote monitoring infrastructure

### Ambition: Building-wide Wi-Fi

**Measure:** 95% Wi-Fi coverage achieved across the BSW estate by end of year one, providing a consistent, GovWifi-standard connectivity baseline for all providers sharing clinical space. [Digital Innovation]

### Ambition: Shared desktop standard

**Measure:** 95% coverage was exceeded as 100% of colleagues are provided with shared desktops as standard with dual monitors, USB-C docking, webcam capability across shared clinical areas, supporting agile and cross-organisational working.

### Ambition: Electronic referrals

**Measure:** 95% of referrals across all pathways can be made electronically, covering clinical and non-clinical routes

### Ambition: Virtual consultations

**Measure:** 95% of professionals have been equipped with the capability to provide remote or virtual clinical consultations across all three BSW localities.

### Ambition: Digital case management

**Measure:** cross-disciplinary and cross-agency digital case-management workflows have been achieved to allow for seamless patient care

### Ambition: Electronic discharge summaries

**Measure:** 100% of discharge summaries from BSW Community health are shared electronically, eliminating paper-based handovers and ensuring continuity of information across care settings

## Improve access & experience

|             |                                                                                                                     |
|-------------|---------------------------------------------------------------------------------------------------------------------|
| <b>S02c</b> | Time from RUH discharge to pathway 3 – <b>achieved an average of 6 days, Target is no more than 7 days.</b>         |
| <b>S03</b>  | Proportion of community beds where patient no longer meeting criteria to reside – <b>achieved target of &lt;15%</b> |
| <b>S10</b>  | <b>100%</b> inpatient SLT referrals seen within 13 weeks of referral                                                |
| <b>S12</b>  | 61.3% of outpatient attendances were face to face ( <b>&lt;75% Target met</b> )                                     |
| <b>S16</b>  | An average of <b>1896</b> Care Coordination referrals per month as per trajectory                                   |
| <b>S27</b>  | Average length of stay for patients discharged from community hospitals was <b>27.4 days (Target under 28 days)</b> |
| <b>S30</b>  | <b>65%</b> community hospital patients discharged before midday with a <b>target of 33%</b>                         |
| <b>S35</b>  | <b>100%</b> of End of life patients with preferred place of death recorded                                          |
| <b>S36</b>  | <b>Over 90%</b> End of life patients remaining in their preferred place of care                                     |
| <b>S37</b>  | Achieved End of life patients referred for CHC fast track – <b>no target</b>                                        |
| <b>S38</b>  | <b>100%</b> of End of life patients with 'What Matters To Me' conversations documented                              |

## Improve health & wellbeing of our population

|            |                                                                                                                     |
|------------|---------------------------------------------------------------------------------------------------------------------|
| <b>S31</b> | <b>94%</b> occupancy of community hospital beds with a <b>target of 85%</b>                                         |
| <b>S51</b> | <b>4%</b> unexpected MIU reattends within 7 days of discharge with <b>target of &lt;5%</b>                          |
| <b>S52</b> | <b>22.5 days</b> - Average length of stay in reablement service with <b>target of &lt;42 days</b>                   |
| <b>S54</b> | <b>87%</b> of people with decreased need on discharge from reablement with <b>target of &gt;80%</b>                 |
| <b>S66</b> | <b>1.4%</b> urgent community response referrals discharged to acute hospital with <b>target of &lt;5%</b>           |
| <b>S67</b> | <b>62%</b> urgent community response referrals receiving response in 120 mins or less with <b>target of &gt;70%</b> |
| <b>S68</b> | <b>89%</b> occupancy of the hospital at home service with a <b>target of 80%</b>                                    |

|            |                                                                                                                    |
|------------|--------------------------------------------------------------------------------------------------------------------|
| <b>S39</b> | <b>Over 85%</b> of End of life patients with advance care plan including goals                                     |
| <b>S40</b> | <b>Over 90%</b> of End of life patients with resuscitation recorded in TEP/ReSPECT with a <b>target of &gt;90%</b> |
| <b>S41</b> | <b>100%</b> of End of life patients with advance care plan in ICR with a <b>target of 100%</b>                     |
| <b>S42</b> | End of life patients with anticipatory medicines in place – <b>no target</b>                                       |
| <b>S43</b> | <b>Over 85%</b> End of life patients with family and carer experience captured with a <b>target of 85%</b>         |

## Priorities in 2026-27

### How we identified our priorities for 2026-27

HCRG Care Group's national priorities were identified by its board, having reflected upon the feedback provided by people who use services and other stakeholders throughout the year. A variety of methods were used, and the priorities set for us by commissioners in each local area were considered, alongside our delivery plans in each business unit.

Individual business units, including Bath and North East Somerset Swindon and Wiltshire were then able to set their own priorities.

For Bath and North East Somerset, Swindon and Wiltshire Community Health Services the aim is to build on the enablers which have been worked on in the first year of the contract and deliver on the next phase of the transformation journey.

#### Priority 1

Deliver a Single Point of Access and service user portal to support self-referral

The Single Point of Access (SPA) together with an online portal will be the front door into community health services across BSW. The dual approach will provide a digital and non-digital access for community care. There will be one single telephone number for people as well as one email address. Health Care Professionals will have a separate number for urgent referrals and GPs will be able to make referrals digitally by using the referral form on their existing Ardens system. Care navigators will support people to the right service for them to access the help that they need where they will be triaged according to priority of needs.

#### Priority 2

Rollout of Neighbourhood Teams with a new proactive care model using a Population Health Approach

Following the pilot projects during the year, next year is when the Integrated Neighbourhood Teams will consolidate the learning into their model of care delivery and support. Working collaboratively with partner organisations at local level, teams will focus on making every contact count with an emphasis on prevention and early intervention.

In year 2 the Integrated Neighbourhood Teams will increase the ability to provide specialist advice and guidance, to support the reduction in unnecessary onward referral to secondary care.

#### Priority 3

Harmonise care across BSW by developing new, clear clinical pathways

Across the community services within BSW there are different ways of getting help and support which are based on historical arrangements between partners. This has resulted in a disparity in the response to managing people's needs and the provision of service delivery based upon where they live with the area. The clinical pathways project will focus on a needs led approach to care which is informed by evidence based best practice guidance. Pathways will be developed in collaboration with people in the

community and other partners to determine the detail for each of the identified priority pathways.

#### Priority 4

Expand the Hospital at home provision, so that more people can receive care in their own homes instead of going into hospital.

By creating additional “beds” for people to be cared for at home, fewer people with short term illness or exacerbations of existing conditions will need to be admitted into hospital. This will enable them to recover in their own familiar environment which has been proven to reduce recovery times. It will support people with cognitive impairment who may be distressed in a hospital setting, as well as supporting hospital admission avoidance by increasing community care capacity.

It has been identified that some people have been referred inappropriately to the service, so a new referral process will be implemented from April 1<sup>st</sup> to enable referrers to speak directly to a clinician to improve communication and ensure that the people who are accepted are able to benefit from the service.

Further engagement with our acute hospital partners will be undertaken to improve timely access to investigations such as Chest X-ray and CT scans harmonised across BSW. Xray access will also be enhanced by the MIU transformations within BSW Community Health services.

Closer partnership working with Local authority partners to enable social care access as part of the support for caring for people in their own homes.

It has also been identified that the ability to step up people into community hospitals to support the reduction of carer burnout will enable people to stay in the community who might otherwise have been admitted to acute care.

There is an ambition to increase mental health support further within BSW for hospital at home, as this is currently only available in Wiltshire.

Other opportunities identified for the service is to harmonise the workforce model to strengthen medical oversight.

The potential to pilot an X-ray car.

Work with local authority colleagues on a reablement pathway for people after their hospital at home care is completed.

#### Priority 5

Implement the BSW Estates strategy to optimise clinical space.

The estates strategy which has been developed with partners during the first year will start to be implemented during 2026 – 2027. This will enable BSW Community Health to have premises fit for the delivery of 21<sup>st</sup> century care as well as improved spaces for colleagues to work in, that supports community based flexibility and the need for peripatetic working across BSW.

#### Priority 6

## Digital transformation

Digital innovation will be used to enable the delivery of more assistive technology to people in the community, including supporting remote monitoring. Colleagues will also benefit from more harmonised data reporting.

## Priority 7

Expand Community engagement by increasing the range of people and organisations that are involved in helping to shape the future direction of service delivery.

Engaging with people who use, or might use services, community organisations and disadvantaged groups is a key priority for BSW community health, as this is the compass for the design and development of services that align with the needs of the local population and the temporary or transient populations within BSW.

Strengthening partnerships with the Voluntary Community, Faith and Social Enterprise (VCFSE) groups will support BSW Community Health Services to understand the diverse needs within the population. This is key to ensuring that people can be supported with where they are in their health journey, in the way that addresses their health and care needs best.

BSW community Health Services will continue co-design, testing and live-feedback loops through the April 2026 launch and into business-as-usual. Specific priorities include:

- Deep-dives into accessibility of self-referral and the impact on health inequalities
- Ongoing engagement with seldom-heard communities
- Strengthening our feedback loops through transparent “You Said / We Did” updates
- Further partnership with VCFSE, Primary Care, Mental Health and system partners to ensure INTs and the SPA/DFD continue to evolve based on lived experience
- Development of Service User Advisory Board

This engagement programme is not a one-off exercise. It is the foundation for how HCRG Care Group will continue to design, improve and deliver Community Health services across BSW — in partnership with the people and communities we serve.

## Priority 8

Full harmonisation of clinical systems

The clinical systems team will lead on the project to harmonise clinical systems across BSW. At present although colleagues are now using the same system, it is set up differently across the patch. Aligning the system usage across BSW Community Health will support improved data capture, with consistent coding leading to improved validation and better information to enable robust

analysis of themes and trends. This will facilitate a more accurate assessment of local people's health needs and support data capture for outcomes evaluations and local reporting. It will also support benchmarking across BSW and the wider organisation.

## Priority 9

### Delivery of Training, Leadership and Culture project

The Community Health Services within BSW require a skilled workforce who are equipped to deliver the stepped care model. A programme of additional training aligned to the prerequisite competencies and the tools necessary to ensure that the new ways of working are embedded, will be delivered during the year. Strengthening clinical leadership and culture based upon the organisation's values and behaviours will be an integral part of the programme.

Early in year 2 the Managers' dashboard which was designed during year 1 will be launched. This will provide an additional 5 months of extra training sessions specifically targeted at Managers who will be leading the newly transformed, or transforming services.

BSW Community Health services have committed to having a compassionate and inclusive culture which is underpinned by continuous improvement and learning. This may require colleagues to work and adopt different principles in order to meet the needs of people and operate within the new care model.

Supporting mechanisms for this are:

- Identifying training issues to TLE in a timely way
- Learning from clinical and non-clinical Datix incidents to keep on promoting and driving learning from incidents or near misses is in place. This has triggered multiple training opportunities for different groups of colleagues.
- Learning from feedback and responding to learning needs for both Q&S and clinical training.
- Using existing and new subject matter expert for a to identify needs and having a cohesive approach to Learning and Education, sharing knowledge and expertise.
- A working group to be identified to understand and meet the competencies that BSW needs for niche services.

Measuring the impact and aligning them to the agreed outcomes will sit alongside all of these priority projects and this will enable ongoing monitoring of the achievements in line with the key milestones.

## Audits we've taken part in

Community services across Bath and North East Somerset, Swindon and Wiltshire participate in national audits:

- The National Respiratory Audit Programme (NRAP)
- The Sentinel Stroke National Audit Programme (SSNAP)

Data is submitted electronically into these national programmes to add to the national monitoring of care. The reports that the services receive are high level and relate to the previous year with most of the focus being on acute care. However, services continue to upload their information in order to support the national dataset and enhance understanding of these long-term conditions.

Community Services participated in the audits below during the year:

Medicines Safety Audit

IPC Audit

Safeguarding Audit

Health and Care Records Audit Inc. Confidentiality Audit

Peer Reviews

Environmental Audit

Health and Safety Audit

Internal Service Review (CQC benchmark).

Learning from audits is shared and discussed at our monthly governance meetings, as well as being shared more widely with colleagues across the organisation through specialist groups and the organisational clinical governance meetings.

## Research statement

The organisation continues to participate in a number of research, service evaluation and service development projects. HCRG Care Group in Bath and North East Somerset and Wiltshire is supported by the University of Bath's Schedule of Consultancy which provides a research management and governance service as part of the South West Research hub. The service supports applications for funding and ensures that projects can successfully navigate the Research Ethics Committee approval process, as well as providing practical advice and support to colleagues undertaking research as part of advanced academic study.

We support the participation in research to help improve the care for people who use NHS and local authority services.

### Current research activity

NSPCC Baby Steps Multi-site Evaluation Project

## Publications

- Kelly, B., Fletcher-Salt, T. and Williams, A. (2025) 'Confidence gap in community specialist diabetes nurses and general practice nurses in navigating diabetes technology', British Journal of Community Nursing, 30(12), pp. 574–582.  
<https://doi.org/10.12968/bjcn.2025.0108>
- Williams, A., Kelly, B., Fletcher-Salt, T., & Pemberton, J. (2025). Making sense of sensors: Evaluating CGM devices for safe and personalised insulin management. Journal of Diabetes Nursing, 29(3). Advance online publication.
- Kelly B, Fletcher-Salt T, Williams A (2025) Bridging the confidence gap: A national service evaluation of the impact of CGM and hybrid closed-loop technologies on UK nurses and midwives. Journal of Diabetes Nursing
- Fernando, K., Bell, H., Davies, S., Holmes, P., Kelly, B. and Seidu, S. (2025) 'A pragmatic approach to improving management and patient flow for painful diabetic neuropathy in UK primary care', Diabetes Therapy, [online] Available at: <https://doi.org/10.1007/s13300-025-01797-6>

Additionally, paediatric colleagues presented their work at national and international conferences during the year:

FOMO in Children and Young People

11th Congress of the European Academy of Paediatric Societies (EAPS), Lisbon 2025

Young People's Knowledge of Chaperones

11th Congress of the European Academy of Paediatric Societies (EAPS), Lisbon 2025

Elective Home Education

11th Congress of the European Academy of Paediatric Societies (EAPS), Lisbon 2025

Cats as Pets for Children with ASD

11th Congress of the European Academy of Paediatric Societies (EAPS), Lisbon 2025

Disease Mongering

RCPCH Conference, Birmingham 2026

History of Chaperones

RCPCH Conference, Birmingham 2026

Oral presentations at National/International Meetings

History Of Foundlings

RCPCH Conference, Birmingham 2026

Poster presentations:

Poster presentations at National/International Meetings

History of the Full Moon in Medicine  
RCPCH Conference, Glasgow 2025

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History of Balloons in Medicine  
RCPCH Conference, Glasgow 2025

[https://protect.checkpoint.com/v2/r06/\\_\\_\\_https://adc.bmj.com/content/110/Suppl\\_1/A269.2\\_\\_\\_ .ZXV3MjpoY3JnY2FyZWdyb3VwOmM6bzo4YjJmMWUyYzk2YjdiNmZhYWlwZmlwOGRhMzk0NGU0 Zjo3OjY1YWI6MTljMjBhYmMxNzc2ZjljODc0MjZlN2MwYmQ4Y2FiMTEzYTljMTUwMDIiN2ZjMzg4Z TjkNDdhMDkxYjNmMTY2Nzp0OIQ6Rg](https://protect.checkpoint.com/v2/r06/___https://adc.bmj.com/content/110/Suppl_1/A269.2___ .ZXV3MjpoY3JnY2FyZWdyb3VwOmM6bzo4YjJmMWUyYzk2YjdiNmZhYWlwZmlwOGRhMzk0NGU0 Zjo3OjY1YWI6MTljMjBhYmMxNzc2ZjljODc0MjZlN2MwYmQ4Y2FiMTEzYTljMTUwMDIiN2ZjMzg4Z TjkNDdhMDkxYjNmMTY2Nzp0OIQ6Rg)

## Learning from deaths

HCRG Care Group continues to work with partner agencies to learn from deaths and to adopt any relevant learning from serious case reviews and other local and national reports. The national Learning from Deaths Policy is available, and is followed locally.

The community hospital physicians continue to support the role of the Medical Examiner by referring deaths where there has been a question raised about the timing of death, even when the patient has been on a palliative or end of life pathway.

During the year our colleagues have shared and discussed the learning from:

The Fuller Inquiry phase 2 Report which was published in July 2025 into the care of people after death and as a result a Standard Operating Procedure was drafted to ensure the safe and respectful care of people who have died whilst they are in the care of BSW Community Health services.

In children's services, teams work closely with the safeguarding team, paediatricians and partner agencies in a joint agency review of all child deaths. Learning from the Child Death Overview Panel is shared at governance meetings as well as the learning from child deaths elsewhere in the country which are subject to a Child Safeguarding Protection Review investigation and report.

## Statement on the accuracy of our patient data

HCRG Care Group submitted information during the year to the Secondary Uses Service (SUS) for inclusion in the Hospital Episodic Statistics, which are included in the latest published data.

Community service outpatient data for SUS submissions is being validated to ensure ongoing submissions are confirmed as being successful.

## Community hospital PLACE reviews

Patient-led assessments of the care environment (PLACE) put the views of people who use HCRG Care Group services at the centre of the assessment process, helping to highlight how well a hospital is performing in certain areas. These areas include privacy and dignity, cleanliness, food and general building maintenance. The reviews focus on the care environment and do not cover the clinical care provision or colleagues behaviours.

PLACE reviews identified some issues with the environment due to the age of the buildings, but noted that the minor works identified previously had been completed at Paulton Hospital. There is more work to do on increasing dementia friendly environments, but also noted some good progress had been made.

## NHS colleagues survey key results

A summary of the prescribed data is included below:

KF26 (Percentage of colleagues experiencing harassment, bullying or abuse from colleagues in the last 12 months)

KF21 (Percentage believing that the organisation provides equal opportunities for career progression or promotion for the WRES)

## Overview of CQC inspections this year

| Registered provider        | Service name              | Full compliance                | Action plan and status |
|----------------------------|---------------------------|--------------------------------|------------------------|
| HCRG Care Services Limited | Paulton Memorial Hospital | Rated as Good in all 5 domains |                        |

## NHS Friends and Family Test

Like all NHS providers, we ask people who use our services to feed back to us on their experience using the NHS Friends and Family Test.

In 2025-26, it was not possible to record Family and Friends test responses for most of the year as the result of a cyber-attack which occurred in February 2025 and whose effects continued to cause challenges with some data capture for a large part of the year. As a result of this and the changes to service codes following the transfer of the new services only 12 responses were recorded in the last part of the year. 12 people rated our services in Bath and North East Somerset Swindon and Wiltshire and 100% per cent said they had a positive experience of our service. Encouraging a higher response rate will be a key focus into next year.

## Part three

### Prescribed information

|      |                                                                                                                                                                                                                                                                                  |     |
|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 12.  | a) The value and banding of the Summary Hospital-level Mortality Indicator (SMHI) for the trust for the reporting period; and<br>b) The percentage of patient deaths within palliative care coded at either diagnosis or speciality level for the trust for the reporting period | N/A |
| 13.  | The percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric in-patient care during the reporting period.                                                                                                       | N/A |
| 14.  | The percentage of Category A telephone calls (red one and red two calls) resulting in an emergency response by the trust at the scene of the emergency within eight minutes of receipt of the call during the reporting period                                                   | N/A |
| 14.1 | The percentage of Category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period                                                                                 | N/A |
| 15.  | The percentage of patients with pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period                                                                                        | N/A |
| 16.  | The percentage of patients with suspected stroke assessed face-to-face who received an appropriate care bundle from the trust during the reporting period                                                                                                                        | N/A |
| 17.  | The percentage of admissions to acute wards for which the Crisis Resolution Home Team acted as a gatekeeper during the reporting period                                                                                                                                          | N/A |
| 18.  | The trust's patient reported outcome measures for<br>(i) groin hernia surgery<br>(ii) varicose vein surgery<br>(iii) hip replacement surgery, and<br>(iv) knee replacement surgery<br>During the reporting period                                                                | N/A |
| 19.  | The percentage of patients aged -<br>(i) 0-15 and<br>(ii) 16 or over,<br>readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period                                    | N/A |
| 20.  | The trust's responsiveness to the personal needs of its patients during the reporting period                                                                                                                                                                                     | N/A |

|      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                     |
|------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| 21.  | The percentage of colleagues employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends                                                                                                                                                                                                                                                                                         | Colleagues survey                                                                   |
| 21.1 | <p>Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)</p> <p>Please note: there is a not a statutory requirement to include this indicator in the quality accounts reporting but provider organisations should consider doing so.</p> | N/A                                                                                 |
| 22.  | The trust's 'Patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.                                                                                                                                                                                                                                                                       | N/A                                                                                 |
| 23.  | The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.                                                                                                                                                                                                                                                                                                                                  | N/A                                                                                 |
| 24.  | The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.                                                                                                                                                                                                                                                                                                                       | N/A                                                                                 |
| 25.  | The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.                                                                                                                                                                                                                                               | 10,123 incidents were reported in year and 0.0389% resulted in severe harm or death |

## Commissioning for quality and innovation (CQUIN)

We work with our commissioners and other local providers to support the delivery of CQUIN targets.

In 2025/26 Bath and North East Somerset Swindon and Wiltshire Community Health Services were not required to undertake any CQUINs.

## Comments from commissioner

The Quality Account will be shared with commissioners and any comments added subsequent to publication.

## Appendices

### 1: Glossary of terms

|                                                       |                                                                                                                                                                                                                   |
|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Care Quality Commission                               | Also known as CQC<br>Independent regulator of health and social care in England.<br>Replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. |
| Clinical audit                                        | Quality improvement tool, comparing current care with evidence-based practice to identify areas with potential to be improved.                                                                                    |
| Integrated Care Boards                                | Organisations which seek and buy healthcare on behalf of local populations.                                                                                                                                       |
| Commissioning for quality and innovation              | Also known as CQUIN<br>System to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.                                |
| Community Services                                    | Health services provided in the community (not in an acute hospital)<br>Includes health visiting, school nursing, district nursing, special dental services and others                                            |
| CP-IS                                                 | Child Protection Information System<br>A computerised way of sharing data about child protection securely between organisations.                                                                                  |
| Did Not Attend                                        | Also known as DNA<br>An appointment which is not attended without prior warning, by people who use services                                                                                                       |
| Healthcare                                            | Care relating to physical or mental health                                                                                                                                                                        |
| Healthcare Quality Improvement Partnership            | Also known as HQIP<br>Organisation responsible for enhancing the effectiveness of clinical audits, and engaging clinicians in reflective practice                                                                 |
| National Institute for Health and Clinical Excellence | Independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health                                                                              |

|                                      |                                                                                                                                                                                          |
|--------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| NHS Outcomes Framework               | Document setting the outcomes and indicators used to hold providers of healthcare to account, providing financial planning and business rules to support the delivery of NHS priorities. |
| Patient-reported experience measures | Self-reporting by patients on their experience following treatment and satisfaction with treatment received                                                                              |
| Here to help/PALS                    | Informal complaint, concern and query service which gives advice and helps patients with problems relating to the access to healthcare services                                          |