Gloucestershire Care Services NHS Trust

Quality Report

Edward Jenner Court,
1010 Pioneer Avenue,
Gloucester Business Park,
Brockworth
Gloucestershire
GL3 4AW
Tel:0300 421 8100
Website: www.glos-care.nhs.uk

Date of inspection visit: 23 – 26 June 2015, 4 and 6 July 2015 and 18 – 21 August 2015
Date of publication: 22/09/2015

Core services inspected	CQC registered location	CQC location ID
Sexual Health Community adults Community inpatients	Hope House Cirencester Hospital Dilke Memorial Hospital Lydney and District Hospital North Cotswolds Hospital Stroud General Hospital Tewkesbury community Hospital The Vale Hospital	R1JX1 R1J06 R1J10 R1J11 R1JX2 R1J13 R1J18 R1J07
End of life care Urgent care services Children and young people's services Dentists	North Cotswolds Hospital Cirencester Hospital Stroud Hospital Lydney and District Hospital Dilke Memorial Hospital Stroud General Hospital Vale Community Hospital Cirencester Hospital Southgate Morrings	R1JX2 R1J06 R1J13 R1J11 R1J10 R1J13 R1J07 R1J06 R1JX3
Dentists	The Dental Clinic – Redwood House The Dental Clinic – St Pauls Medical Centre The Dental Clinic – Springbank The Dental Clinic - Bourton on the Water	R1JAT R1JX7 R1J50 R1JX5 R1J56

Summary of findings

	The Dental Clinic - Lydney	
<Summary here>	<Location here>	<Location id here>

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

Summary of findings

Contents

Summary of findings

Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence. There has not been any variation to the ratings principles on this inspection.

Letter from the Chief Inspector of Hospitals

We inspected Gloucestershire Care Services NHS Trust as part of our programme of comprehensive inspections of all community healthproviders. We carried out an announced visit on 23 – 26 June and 18 - 21 August 2015. We carried out an unannounced visit on 4 and 6 July 2015.

Gloucestershire Care Services NHS Trust has a total of 19 registered locations, including seven hospital sites with a total of 196 beds, nine dental locations and community teams registered at the trust headquarters.

During the inspection we visited the following locations

- Hope House
- Cirencester Hospital
- Dilke Memorial Hospital
- Lydney and District Hospital
- North Cotswolds Hospital
- Stroud General Hospital
- Tewkesbury community Hospital
- The Vale Hospital
- Southgate Morrings
- The Dental Clinic – Redwood House
- The Dental Clinic – St Pauls Medical Centre
- The Dental Clinic – Springbank
- The Dental Clinic - Bourton on the Water
- The Dental Clinic - Lydney

We inspected the following core services:

- Community adults
- Community inpatients
- End of life care
- Urgent care services
- Children and young people's services
- Sexual Health
- Dentistry

We rated the trust as requires improvement overall. The trust was rated as requires improvement for safety, effectiveness, responsiveness and the well-led key questions. We rated caring across the trust to be good, and found it to be outstanding within the community inpatient service.

Our key findings were as follows:

Safe

- We judged safety in the urgent care service to be inadequate. This is because we were not assured that people were adequately protected from the risk of avoidable harm. We were concerned that some patients waited too long to be assessed by a registered nurse on arrival at Minor Injuries and Illness unites and that unregistered practitioners were undertaking this task without adequate training or supervision.
- There was a positive safety culture including a proactive approach to reporting incidents, particularly within the community hospitals, however within urgent care services the threshold for reporting an incident was too high.
- Resuscitation trollies and other equipment were not always appropriately checked.
- The trust could not be assured about the levels of mandatory training being completed by staff. There was a disparity between locally held and centrally held training data and there was little oversight or understanding of the scale of the problem by the trust. From the information available it appeared that targets for completion of mandatory training were not being met. Not all staff who were required to have undertaken safeguarding training at level 2 had achieved that.
- All wards within community hospitals were well staffed according to safer staffing requirements (requirements for the minimum levels of staff on an adult inpatient ward). However some services within the trust had insufficient staff to meet needs. Shortage of experienced nursing and therapy staff within the community adults service left teams overstretched.
- We could not be assured that Minor Injuries Units were consistently staffed by sufficient numbers of

Summary of findings

appropriately qualified, experienced and skilled staff. Staffing levels and skill mix had not been adjusted in response to increased and activity and a changing profile of presentations.

- We were concerned that some patients waited too long to be assessed by a registered nurse on arrival at Minor Injuries Units and that unregistered practitioners were undertaking this task without adequate training or supervision.
- Within the adult community service staff were not consistently following best practice in their approach to pressure ulcer wound assessment.
- In one community clinic, medical supplies were inappropriately stored above room temperature which meant that the effectiveness of the ingredients could not be guaranteed.
- Staff adhered to infection prevention and control practices. Staff were 'bare below the elbows' and observed good hand hygiene.
- There were processes in place to ensure the safeguarding of vulnerable adults and children, however processes were not subject to audit within Minor Injuries Units to ensure all concerns were captured and acted upon, and board oversight and assurance was limited.
- The layout of some Minor Injuries Units meant that waiting patients, including children, were not adequately observed.

Effective

- Staff in all areas provided care that was based on the best available evidence. However within the Urgent Care Service there was little audit to demonstrate best practice was followed.
- Multidisciplinary team working featured highly in all areas, with teams working in a coordinated way.
- In places within the community settings there were difficulties accessing information about patients on the electronic record keeping system because internet connectivity was not always available, particularly in rural areas.
- Social care staff and health care staff used different patient record systems which complicated the process of obtaining up to date information and important alerts at the point of referral.
- 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms did not contain clear explanations for the reason for the decision to withhold resuscitation and records of discussions with patients and their relatives, or of reasons why decisions to withhold resuscitation were not always documented.
- Patients with long-term conditions who might have been in the last year of life were not consistently recognised by staff throughout the trust.
- The trust was not able to fully assure us that people's needs were assessed and care and treatment delivered in accordance with current legislation because not all staff had received training in the Mental Capacity Act 2005.

Caring

- We found that there was a strong, visable patient-centred culture within all of the community hospitals and that patients, carers and relatives were active partners in care and worked in partnership with staff. It was clear that the anxieties of patients and their relatives were alleviated with the caring nature of all of the staff. Staff spoke with passion about their work and were proud of what they did.
- Throughout the trust care offered by staff was kind and compassionate and promoted people's privacy and dignity. Staff gave clear explanations for treatment and encouraged patients to reach their goals.

Responsive

- The community health services for adults were not always planned and delivered in a way that met people's needs, particularly with regard to people being able to access the right care at the right time for non-urgent needs. There were very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation.
- Waiting list data held by the Trust was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear. Occupational therapists and physiotherapists did not work on the weekends and there was no plan to implement this.
- In some areas patients were found to be waiting over six months for dental treatment.

Summary of findings

- Guidance regarding the use of interpreting services was not consistently followed across all areas.
- There was a fast track discharge to enable patients to return home if they wished to die there
- Within community hospitals, patients had a very high range of activities, supported by volunteers, available to them which had a positive impact on the wellbeing of patients
- We found medical cover varied between community hospitals. During the day the level of cover was adequate. However, there were some concerns about the responsiveness of medical staff out of hours.
- Complaints were managed well and there was a robust method for investigating them. Most complaints were investigated and resolved at a local level. However the trust received very low numbers of complaints given its size and in a number of places it was difficult to find information about how to make a complaint.
- Staff understood the different needs of the children and young people and attempted to ensure that services were as flexible and accessible as possible to the widespread community.
- Within urgent care, waiting times had increased as demand for the service had increased. Staffing levels did not always match the activity and pattern of attendances. Referral processes to out of hours services were cumbersome and often entailed lengthy waits or travel to another hospital.
- Whilst premises were mostly fit for purpose waiting areas at the Dilke Memorial Hospital and at the Vale Community Hospital out of hours were cramped. The triage area at Stroud General Hospital was not enclosed and was not conducive to a confidential consultation and therefore did not protect people's privacy and dignity.
- Within the sexual health service, booking practices did not meet demand and consequently patients experienced problems getting through to make an appointment and often ended up attending a walk in clinic. This had resulted in patients being unable to access the treatment they required immediately as some procedures required staff to have additional competencies .

Well led

- Staff at all levels in the trust described how the culture had changed since the arrival of the current chief executive. Staff talked about a very open and very patient focused organisation. Many staff felt that they were highly valued and that openness and honesty was encouraged and rewarded.
- The listening into action programme, launched in March 2014 was having a significant impact. There was work going on across the trust to deliver the actions and improvements. The staff that the team met were universally positive about this initiative, even those who said that they had been sceptical at the start. Staff talked in terms of having ownership, feeling responsible and feeling that things were possible.
- At trust level the governance processes and the management of risk and quality were improving but were not yet sufficiently robust.
- The leadership of the community health service for adults supported learning and innovation. There were inspiring examples of innovation including the development of a health and social care complexity tool and some collaborative work with an industry provider in tissue viability services.
- There was some disconnection between frontline staff and the board in terms of awareness of core values and strategy.
- There was no strategy for end of life care. The trust-board lead for end of life care was unaware of the action plan devised from the 2014 report commissioned into end of life care services. There was no one person in a position to take end of life care forward and maintain responsibility for provision of the service.
- The leadership and governance around the reduction of falls was extremely good. We found that the multidisciplinary team working with various organisations, risk analysis and the development of innovative mitigating actions had a positive effect on outcomes in the community hospitals.
- Staff took pride in their work and being at the centre of the community. They wanted to come to work.
- The impact of change to the urgent care service had exposed deficiencies in governance and leadership of the service. It had exposed vulnerability in terms of staffing levels, skill mix, staff confidence and competence. Some steps had been taken to address this area of risk but this was not being managed in a structured way. There was no timeframe attached to

Summary of findings

this piece of work and risks did not appear to have been given sufficient attention or priority by the trust board. Board members were not visible or influential in urgent care.

We saw several areas of outstanding practice including:

- The seven day service provided by the children's community team.
- The volunteer groups were an integral part of the care team within community hospitals. It was clear that they were having a positive impact on patients' wellbeing by supporting patients, providing activities, and by representing 'patient's perspective at governance meetings'.
- There was a strong caring culture that was embedded throughout the community hospitals. Staff provided compassionate care which was respectful to people's needs and wishes. Wards were calm and happy places and feedback given to inspectors by patients, carers and relatives was continually positive. Patients said that staff went the extra mile and it was clear that the care they received went beyond their expectations.
- People's individual needs were met in all of the community hospitals . A range of social activities were arranged which were imaginative ways of enhancing patients' inpatient stay and improving their wellbeing.
- There was systematic approach to falls prevention. Data was collected, analysed and innovative mitigating actions were put in place. This was having a significant impact on patient care within the community hospitals.
- Innovation and creativity were encouraged and this was impacting positively on patient experience in community hospitals. Examples included the Vintage Room on Jubilee Ward at Stroud Community Hospital and the use of "twiddlemuffs". Patients and in particular patients living with dementia were using these muffs to occupy restless hands and there was evidence that their use had a soothing and comforting effect on patients.
- The community hospitals also had an embedded multidisciplinary approach to the care of patients.
- The sexual health service was an integrated service, with patients being able to access the necessary care and treatment in one place. The multidisciplinary approach enabled all staff to provide the right care, treatment and support to patients.
- The dental service had responded to the complex needs of their patients and had invested in a number of items of specialist equipment, such as a wheel chair tipper, a number of bariatric chairs and specialist x-ray equipment. This enabled staff to provide treatment in a safe effective and comfortable way for patients.
- As part of the dementia link work the dental service had produced a training video which consisted of two parts, one demonstrating a poor approach to oral care and the other showing best practice and how this would ensure a good outcome for the patient. The video was used to initiate discussion at training sessions for community and care home staff.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure medicines administered to children within the complex care team are administered safely.
- Ensure there is a process in place to audit the prescription of medicines by health visitor prescribers.
- Ensure that staff trust wide have the necessary mandatory training and essential training to ensure safe care and treatment of patients and that the accuracy of data held by the trust in relation to mandatory training is improved.
- Ensure resuscitation trollies and equipment on them are checked in line with national guidance and that records of these checks are suitable for the purpose they are intended.
- Ensure that all documentation relating to the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) include the completion of a Mental Capacity Assessment, to ensure that the patient's consent and decisions around best interests are served.
- Ensure DNA CPR forms include reference to discussions with patients and relatives and must be stored in such a way as to ensure all staff providing care are alerted to them.

Summary of findings

- Review and take prompt action to ensure that MIiUs are consistently staffed by sufficient numbers of suitably qualified, experienced and skilled staff.
- Ensure that patients arriving at MIiUs receive prompt assessment (triage) by an appropriately trained and experienced registered nurse.
- Develop and improve systems, processes and governance arrangements across all MIiUs to assure high quality, effective and safe care and treatment.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

The five questions we ask about the services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

Overall we judged services provided by Gloucestershire Care Services NHS trust as requiring improvement for safety. We judged safety in the urgent care service to be inadequate. This is because we were not assured that people were adequately protected from the risk of avoidable harm. We were concerned that some patients waited too long to be assessed by a registered nurse on arrival at Minor Injuries and Illness unites and that unregistered practitioners were undertaking this task without adequate training or supervision. We judged the care provided by the sexual health service, childrens and young peoples service and end of life service as good for safety. However we judged safety as requiring improvement within minor injuries units, community adult services and community inpatient services.

Staff reported incidents using the on-line reporting system and were encouraged to report, however in places it was felt tolerance to incidents was too high. This meant staff did not always report incidents and near misses.

Infection prevention and control practices were followed. Equipment was correctly serviced and maintained, though were required to be shared across wide geographical areas at times. When this occurred, staff did not keep ongoing service or cleanliness records to ensure equipment was clean and fit for purpose. We also found medical supplies such as dressings and skin preparations were stored in a cupboard above room temperature which meant that the effectiveness of the ingredients could not be guaranteed. Not all emergency equipment such as resuscitation trolleys were appropriately checked.

Staff were knowledgeable about the trust safeguarding process however staff in the community adult teams were not required by the trust to complete the safeguarding awareness level 2 course. Within MIiU's we could not be assured that assessments were consistently taking place or that referral rates were appropriate because there was no oversight of safeguarding. However all staff were clear about recognising possible signs of abuse or neglect of children and young people and their responsibilities

Mandatory and competence training records and records of staff appraisals were variable. Records differed locally from those held centrally. The level of compliance for mandatory training was not adequate to ensure staff were able to provide safe care and treatment for patients.

Summary of findings

We could not be assured that MIiUs were consistently staffed by sufficient numbers of appropriately qualified, experienced and skilled staff. Staffing levels and skill mix had not been adjusted in response to increased and activity and a changing profile of presentations.

Some patients waited too long to be assessed by a registered nurse on arrival at MIiU and at times unregistered practitioners were undertaking this task without adequate training or supervision.

Premises were mostly fit for purpose, clean and appropriately equipped. However the layout of some MIiUs meant that waiting patients, including children, were not adequately observed. At Tewkesbury Hospital there were some safety issues. Bathroom lights turned off while patients were in them due to the timings of the movement sensors there. Nurses were not able to observe patients at all times due to 'blind spots' in the single bed rooms.

The level of compliance for mandatory training was not adequate to ensure staff were able to provide safe care and treatment for patients. There was disparity between locally held and trust held training data and there was little oversight or understanding of the scale of the problem by the trust.

Duty of Candour

- The statutory Duty of Candour had been introduced within the trust. The staff we spoke to were aware of the duty of candour and of the need to apologise to patients and relatives in incidents of moderate and severe harm.
- Staff talked about being open and honest in their everyday practice and described how the open approach was positively encouraged.

Safeguarding

- There were process in place to ensure the safeguarding of vulnerable adults and children, however processes were not subject to audit within Minor Injuries Units to ensure all concerns were captured and acted upon, and board oversight and assurance was limited.
- The Director of Nursing was the Board lead on safeguarding. There was a corporate safeguarding team comprising clinical and managerial staff. There was an operational safeguarding group that fed into the clinical senate and governance committee.
- There were effective arrangements in place for children. Partnership working was strong with monthly meetings, nurse links into departments and safeguarding champions.

Summary of findings

- Incident data on adults was well articulated, similar data on children needed further development.
- The data on training needed to be strengthened. Locally teams had information on safeguarding training and completion looked satisfactory but overall trust information was less reliable and needed strengthening.
- There was evidence of reporting on safeguarding to the quality and performance and governance committees. In January 2015 the quality and performance report included a quarterly safeguarding performance dashboard and included information on serious case reviews. There was no specific regular report on safeguarding to the Board outside the annual report.

Incidents

- Staff reported incidents using the on-line reporting system and were encouraged to report, however in places it was felt tolerance to incidents was too high. This meant staff did not always report incidents and near misses.
- Staff across the trust told us that they were encouraged to report incidents and that a no blame culture was being promoted. Lessons from incidents were discussed at some team meetings but some staff told us that they did not always get feedback on the incidents they had reported.
- The results of the NHS staff survey were below (worse than) the England average in terms of the fairness and effectiveness of incident reporting procedures and also for the percentage of staff reporting errors, near misses or incidents reported.
- Pressure ulcers and slips and falls accounted for the majority of incidents reported. Reports on incidents and actions were reported to the trust quality and performance committee.
- The low rate of incident reporting was on the trust risk register.
- Feedback on incidents was not consistent across all services although we saw evidence of learning from incidents, for example in community health services for adults.

Staffing

- Staffing levels and skill mix were reviewed although the lack of detailed specification of some services within the block contract meant that the trust was finding it challenging to manage increasing demands for services. This featured on the trust risk register. Staffing in terms of vacancies and turnover was a challenge in all services.

Summary of findings

- The trust was experiencing recruitment difficulties, particularly with senior (band six) district and senior community nurses. Vacancies had increased in the six months prior to the inspection. There was also an issue with nurse retention. These were the top two risks on the Human Resources risk register.
- The trust had a detailed work programme to address these issues which was monitored through the workforce steering group. The actions included reviewing job descriptions, centralising recruitment, running preceptorship and return to practice programmes. At the time of the inspection it was noted that these were decreasing risks.
- The trust used bank and agency staff to ensure that save staffing levels were maintained.
- In community services there was not an established case management tool although one was being developed but had not been implemented at the time of the inspection.

Are services effective?

Requires improvement

Overall the effectiveness of services requires improvement. Improvements are needed in Urgent care and End of Life Services, the remaining services were judged as good.

Patients were treated in accordance with best practice and recognised national guidelines, however within MIiU's there was little evidence available to demonstrate this was the case. Within most services, such as community adults, childrens and young peoples and sexual health, staff were engaged in monitoring and improving outcomes for patients. We saw how outcome monitoring, national, and local audit data was influencing practice particularly within the sexual health service and community hospitals. Teams worked together and there was good evidence of multidisciplinary working.

In places there were difficulties accessing information about patients on the electronic record keeping system because internet connectivity was not always available, particularly in rural areas.

In addition social care staff and health care staff used different patient record systems which complicated the process of obtaining up to date information and important alerts at the point of referral.

Within 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, explanations for the reason for the decision to withhold resuscitation were not always clear. Records of discussions with patients and their relatives, or of reasons why decisions to withhold resuscitation were not always documented. Patients with long-term conditions who might have been in the last year of life were not

consistently recognised by staff throughout the trust. Where patients were identified with end of life care needs, they had their needs assessed and reviewed and had pain and other symptoms managed effectively.

Whilst there was evidence that staff were given opportunities for training and professional development, the trust was unable to provide evidence that all staff employed were appropriately qualified and competent to carry out their roles effectively. There was little regular supervision, including clinical supervision, of nursing staff across the organisation. In addition the trust was not able to fully assure us that people's needs were assessed and care and treatment delivered in accordance with current legislation because not all staff had received training in the Mental Capacity Act 2005.

Evidence based care and treatment

- Care and treatment was evidence based in community in patient services. Care was given in line with policies which were based on evidence and in line with national guidance. Staff were encouraged to comment on and challenge policies and this was influencing changes and improvements through the listening in action process.
- The trust participated in several national audits including those for stroke, parkinsons, intermediate care, chronic obstructive pulmonary disease and diabetes foot care.
- Care and treatment was evidence based in community services for adults and children and young people. We saw evidence of holistic assessment and treatment following best practice and incorporation of NICE guidelines. The electronic patient record keeping system included tabs which linked the user to clinical guidelines. These were attached to the assessment templates and were based upon best practice and NICE guidelines. Therapy staff had reviewed the NICE guidelines for falls as part of a peer development opportunity. As a result, exercise classes were designed to conform to best practice in falls prevention. The heart failure nurse had produced referral guidelines for the service plus a patient information booklet which were both based upon NICE guidelines.
- Care and treatment was evidence based in sexual health services. There was evidence that the trust took part in local, regional and national audits relevant to the service. Care and treatment followed the guidelines produced by the British

Association of sexual health and HIV and signed off by the National Institute for Health and Care Excellence. Changes in national guidelines were acted on promptly and there was evidence of discussion of changes at team meetings.

- The effectiveness of services in the community for patients at the end of their lives required improvement. Evidence based care had been implemented, but not necessarily for all patients who were in the last year of their life. In line with NICE guidance (QS13 End of Life Care for Adults) use of the Liverpool Care Pathway had been phased out in 2014 and replaced with the 'shared care record', although this has yet to be audited to determine if it was effective. The trust had implemented the five core recommendations for care of patients in the last few days and hours of life in the Department of Health's End of Life Care Strategy 2008. It had also implemented recommendations of 'One chance to get it right' published by the Leadership Alliance for care of the Dying people 2014. As a result unnecessary investigations, blood tests and continued use of medicines were regularly reviewed.
- End of life care within the hospital was focused on the recognition of patients who might be approaching the last few days and hours of life. The Department of Health's End of Life Care Strategy (2008) and NICE quality standards for end of life care (2011) included recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. Clinical staff on the wards we visited did not demonstrate this understanding that end of life could cover an extended period, or that patients might have benefited from early discussions and care planning.
- The trust was not currently working towards accreditation of provision of end of life care. Many trusts and hospices are currently working towards the Gold Standards Framework as this is considered to be best practice. Staff were aware of the Advanced Care Plan (ACP) but we did not see any evidence of its use. ACP is a key part of the Gold Standards Framework Programmes. It should be included consistently and systematically so that every appropriate person is offered the chance to have an advance care planning discussion with the most suitable person caring for them.
- In community services for children and young people policies and guidelines were developed in line with national guidelines. These included the National Institute for Health and Care Excellence (NICE) guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. The children's and young peoples service

provided all the core requirements of the Department of Health's healthy child programme. This includes early intervention, developmental reviews, screening, prevention of obesity and promotion of breast feeding.

- There was a comprehensive set of treatment guidelines available on line for all MIiU nurses for a range of minor injuries and illnesses and we saw some evidence that staff were familiar with these. However the trust had limited evidence to show that guidelines were consistently complied with because this was not subject to audit.

Patient outcomes

- Community hospitals monitored quality and outcomes through a performance dashboard. The dashboard reported against a range of trust targets including the Friends and Family test, readmission rates, infection control, length of stage, delayed transfer, safety thermometer and prescribing. Each measure was reported against expectations and breaches were reported.
- The sexual health service took part in part in relevant audits and outcomes from these were shared with staff.
- The trust did not contribute to the Royal College of Physicians National Care of the Dying Audit 2014. The standards of care evaluated in this audit are based on the End of Life Care Strategy (DH, 2008) and reflect recent national policy guidance. However, we were told the trust was taking part in 'Voices': a National Survey of Bereaved people. This was a survey which collected the views on the quality of care provided to a friend or relative in the last three months of life. It was commissioned by the Department of Health and NHS England, with data collection due to commence in September 2015. The trust was not working towards an independent accreditation standard such as the gold standards framework, nor were staff using an end of life quality assessment tool. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the standard of the best.
- In community services for children and young people clinical pathways were in place and gave clear and consistent guidance across the therapy services. Outcomes were measured to ensure that the needs of children and young people were being met in the service. The trust scored above the England average for the children receiving appropriate immunisations. As an example, 97.5% of appropriate children had received the triple vaccination (Dtap / IPV / HiB) compared to an England average of 96.3%.

- Although the trust received overwhelmingly positive feedback from people who used MIiUs, they provided little evidence to demonstrate that care and treatment provided in MIiUs achieved positive outcomes for people. The trust participated in a limited number of local audits so they could benchmark their practice and performance against best practice. Audit reports provided to us contained incomplete action plans and there was limited evidence that areas for improvement had been widely shared with staff and acted upon.
- The trust participated in a number of Commissioning for quality and innovation targets. All the community hospitals were meeting these targets. The community services for adults had been all their targets for 2014/15 and the stop smoking service exceeded its target of 2332 for 2014/15 by 150 patients. This service was on track to meet the target for the first quarter of 2015, currently 163 towards a target of 615 by end of September.
- In community services for children and young people audits were carried out to monitor performance and maintain standards. We saw evidence that at least one clinical audit was carried out each year that was relevant and timely to the therapy service. There were ongoing record keeping audits across all therapies; parent child interaction, triage and outcome audits in speech and language; sling provision audit in occupational therapy and exercise compliance and spasticity audits in physiotherapy.

Multidisciplinary working

- The team observed multi-disciplinary meetings at Cirencester and Lydney hospitals. The meetings were attended by a senior nurse, a doctor, occupational therapist, physiotherapist, social worker, a lead for the integrated care team and a mental health nurse from the local mental health trust. These were effective meetings where each patient was discussed in detail and patient choice was considered.
- The team observed effective multi-disciplinary working between trust staff and social workers employed by the local authority.
- Multidisciplinary working was clearly evident in the integrated community teams. Nursing, therapy and social care staff were committed to working together to meet the individual needs of their patients.
- Each of the six localities was working toward more cohesive integration. Integration with social care teams was identified as a key theme from the 'Understanding You' events held by the Trust. Managers voiced concerns that the future separation of

managerial responsibility for social care staff threatened the progress made to date in relation to integrated care planning. Nursing staff were sometimes based in different locations to therapy staff and this may have contributed to slower integration between these staff. Several staff remarked that integration between therapy and nursing staff was an on-going focus.

- There was a fully integrated multi-disciplinary approach to the management of care records. Patients were asked to sign a consent form to enable records to be shared in this way.
- The sexual health service was an integrated service with patients being able to access care and treatment in one place. The service worked closely with other relevant bodies such as the Terence Higgins Trust and the Gloucester Rape and Assault Service.
- The Specialist Palliative Care Occupational Therapist attended multi-disciplinary meetings held at the hospice for end of life patients in their care Community nurses were invited to the GP Gold Standard Frameworks meetings; however attendance was reported as poor due to pressure of workloads
- In community services for children and young people we saw evidence that staff worked professionally and cooperatively across different disciplines and organisations. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment. Staff told us they were most proud of the integrated work across all disciplines. The health visitor and school nursing teams worked in partnership with others on a daily basis, including GPs, social services, midwives and schools.
- Changes to the provision of the out of hours GP service had caused some difficulties at some hospitals. At Lydney and District and the Dilke Hospitals staff reported that there was a good relationship with the OOH provider but when GPs were not co-located with MIius they were not able to provide a seamless service. They also told us that because that referral was via a central telephone hub, there were frequent delays in obtaining appointments. At Stroud Hospital however, where the OOH service was co-located we saw good partnership working between the two services during our unannounced visit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Summary of findings

- Staff in community hospitals told us that they were aware of the relevant consent and decision making requirements of legislation and guidance. At Cirencester and Stroud hospitals staff were able to talk members of the team through the process.
- The team saw an assessment format that was used to help staff assess the capacity of patients to make decisions about their care.
- The trust used a deprivation of liberty policy that had been developed in partnership with local health and social care providers. Staff at Cirencester and Stroud were aware of recent safeguards being put in place.
- Nursing and therapy staff in the integrated community teams and specialist services showed awareness of the need for mental capacity assessments to take place but tended to refer to other clinicians such as the G.P, mental health teams or social workers to complete the assessments. An audit completed by the Wheelchair service highlighted that mental capacity was rarely assessed when decisions were made about choices of wheelchair.
- Staff in the sexual health service were aware of the appropriate approaches to obtaining consent including awareness of the Gillick competence. Consent was sought if a patient declined a chaperone and the member of staff felt they required a chaperone for their own protection. The patient records viewed by the team showed that consent had been obtained appropriately.
- Staff asked for patients' consent prior to delivering any care for patients at the end of their life. This was recorded on the electronic patient record system. Patients were also asked to give consent for their information to be shared with other healthcare professionals such as GPs and specialist palliative care nurses. We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation (DNAR CPR) forms on three hospital wards and in two patients' homes. These were yellow stickers attached to notes. There appeared no standard place for them in a patient's records and in some notes it was difficult to find them. Therefore the form could easily be missed by healthcare workers.
- None of the DNAR CPR forms showed references to patients' mental capacity, and this was not easily found in other medical or nursing notes. It was not evident from patients' records which patients had or did not have mental capacity regarding making decisions around resuscitation. This meant it was not

possible for the trust to audit how decisions had been made; whether advance decisions had been respected; whether legal proxies had been consulted; or whether national guidance had been followed.

- Throughout the inspection we observed staff asking children and young people for their consent. Staff were aware of Gillick competencies and gave us examples of how consent was used. Fore example the immunisation team obtained consent before clinics from pupils' parents. This was checked with the pupil during the clinic and their consent was also sought. Where pupils suddenly refused, their wishes were respected and discussed privately and / or with parents depending on the needs and wishes of the young person.
- In the urgent care service we saw evidence in patients' records that they were asked for their verbal consent before examinations, interventions and treatments were carried out. However we saw that some staff used a stamp to confirm "consent options discussed" but it was not documented what options or alternatives had been discussed. Staff we spoke with demonstrated knowledge and understanding of the Mental Capacity Act 2005 and their responsibilities in respect of patients who may not have the capacity to consent. They told us that they involved and consulted relatives and sometimes GPs, in decision making. An audit of clinical records in November 2014 highlighted poor documentation of consent. An action plan had been developed but had not been updated to show that actions had been taken to improve performance.

Are services caring?

Good

We judged that all services were good for caring with the exception of the community inpatient service which we judged to be outstanding.

Overwhelmingly all service users reported care that was delivered with kindness and compassion and there was a strong, visable patient-centred culture. Within community hospitals patients said staff went the extra mile and it was clear that the care they received went beyond their expectations. It was clear that the anxieties of patients and their relatives were alleviated with the caring nature of all of the staff. Within community hospitals patients, carers and relatives were active partners in care and worked in partnership with staff.

Care offered by staff promoted people's privacy and dignity.

Compassionate care

Summary of findings

- People are treated with kindness, dignity and respect while they receive care and treatment. Feedback about the care in community hospitals was overwhelmingly positive. This information came from the comment cards completed in advance of the inspection, from the observations and conversations that took place during the inspection and from information provided by Healthwatch.
- In February 2015, the trust launched the "hello my name is…" campaign with staff. This focused on making their initial personal contact with a service user and staff introducing themselves by name, making a personal connection. Throughout our inspection we saw staff being part of this campaign. Staff wore name badges and we observed how they always introduced themselves patients and relatives and in the services for young people this introduction was made to the child, young person and parents.
- The NHS Friends and Family Test had been introduced in the 12 months before the inspection and in the last quarter of 2014/15 had been extended to all services. Response rates were low for the services that had recently begun to collect data but shoed an incease as the process became embedded. Of all staff respondents in the last year 77.8% of staff stated that it was likely or extremely likely that they would recommend to the trust as a place as a place to receive care.
- The trust's overall PLACE scores for cleanliness, privacy, dignity and well being and facilities wre above the national average with all trust locations scoring above (better than) the national average in three out of four of the metrics.
- In the community hospitals we observed staff speaking with patients in a respectful manner and offering them choices. One patient was observed laughing and joking with the staff and they told us "this helped to pass the time". One patient with complex needs told us they were "being well looked after by the staff and had no complaints"patients said that they were confident that their privacy and dignity were always maintained and that they found this encouraging. We also observed external contractors (such as engineers) knock on doors and ask patients if they were allowed to come in. They would tell them exactly what they were going to do and how long they would take to do it. One member of staff we spoke with said "All of the staff treat the rooms as if it was the patient's home while at the hospital."
- In community services for adults we observed, staff showed respect for patients and their families and a commitment to promoting the dignity of patients. Cinderford district nursing team were recognised by the 'Celebrating You' awards, winning

the 'caring 'category**.** The needs of patients with complex needs were considered with compassion. On home visits patients were given reassurance and clear explanations. In a cardiac rehabilitation class, patients were greeted by name and encouraged to share their concerns on a one to one basis. Feedback from Healthwatch described the staff at the outpatients department at Tewkesbury as kind, caring, polite, friendly and informative.

- In the community services for young people we accompanied some staff including health visitors on home visits. We saw that all the staff we accompanied were extremely friendly and professional at all times. We observed staff taking time to talk to children in an age appropriate manner and involved and encouraged both children and parents as partners in their own care.
- In the HIV service carried out a patient survey in 2014 in which 256 surveys were distributed, with 99 being completed and returned. The responses were mainly positive with 97% of patients stating they had been treated with respect and dignity and that the staff were friendly and 93% felt they had sufficient privacy during their appointment. There were issues about the environment at both the Hope House and Milson Street clinics that were impacting on privacy and dignity, with awkward silences in crowded waiting rooms, conversations at the recrptionn desk being overheard and patietns sat so close together that it was difficult to complete forms privately.
- The team found that patients who were at the end of their lives were treated with compassion. During visits to patients in the community we found staff delivering high standard of care. They were kind and showed empathy, respect and compassion to the patient and their carers/relatives. We spoke with five patients receiving end of life care. They all spoke highly of the staff and felt fully supported in their environments and their needs were being addressed.

Understanding and involvement of patients and those close to them

- People who use services and those close to them are involved as partners in their care. In the community inpatient services we observed that patients were actively included in ward rounds and conversations about their care. We saw in medical notes that relatives and carers were actively involved in a 'patients first contact assessment' to ensure that patients' and family's needs and goals were met. When discharge planning family meetings were held with the patients, their families, nurses, occupational therapists and social workers.

Summary of findings

- In the community service for adults staff involved patients and carers in the planning of care during visits to patients in their own homes. Nursing staff empowered patients by giving information regarding their condition and their care plan. Therapy staff gave patients information to make informed decisions about options for assistive equipment in their homes. In an education class, staff checked patients understanding and provided clear explanations.
- In the community services for young people we accompanied some staff including health visitors on home visits. We observed how one health visitor took extra time and care to make sure the mother understood the purpose of the visits and the information given.
- In the community services for children and young people parents told us that staff always involved them in decisions about care and treatment for their children. We observed good examples of how staff involved children and young people as well as their families.
- In the sexual health service patients told us they had received written information from staff regarding their treatment and conditions which had also been explained to them on a one to one basis during their consultation. The quality survey conducted by the HIV service in 2014 found that 83% of patients considered they were involved in decisions that were made about their treatment and 76% felt they had had a choice and say in what was happening with their treatment. 97% felt they were given information by staff in an understandable way, they could ask the questions they wanted to and that staff listened to them.
- Patients who were at the end of their lives and those close to them were involved with their care. We spoke with four relatives in a community hospital and one relative in a patient's home. They told us they had been consulted about decisions and understood what was happening and why. Some family members had been invited to a multi-disciplinary meeting with staff to discuss future care needs for their relative. The patients we spoke with all acknowledged that they had been involved in their care, their wishes had been taken into consideration and they had an understanding of what was happening to them.
- In a trust-wide audit of clinical records in the urgent care sevice, undertaken in November 2014, 93% of records contained evidence of information given to the patient and 92% contained evidence of information given to relatives/carers. The records we looked at provided good evidence that patients had

received clear explanations of their condition and given advice about after care, including what do if their condition worsened or they had concerns. We witnessed staff showing patients and their relatives their x-rays and explaining their injuries to them.

Emotional support

- People using services and those close to them receive the support they need to cope emotionally with their care, treatment and the condition that they are dealing with. People are supported to maintain their contact and relationships with their families, carers and friends.
- In the community inpatient services we observed that family members were welcomed onto wards and offered a seat by the nurses' station whilst they were updated about how their relative had been overnight. One carer we spoke with said that staff were teaching her how to provide personal care once her husband had been discharged and that "staff explained everything to me".
- In the community services for adults patients told us they felt listened to and that staff understood their needs. We observed a therapy visit where a patient with a debilitating illness was given emotional support. The respiratory telehealth service gave reassurance and an explanation of symptoms. Staff gave positive encouragement to focus on rehabilitation goals and the team saw examples of how this had been achieved for individuals.
- In the community services for children and young people parents told us they felt supported emotionally by staff. We observed staff providing emotional support to children, young people and their parents during their visit. A parent who had received support from the therapy staff said they were always available for support and advice. They told us "They are always positive and never give up on treatment".
- In the sexual health service patients told us staff were respectful of their wishes to have friends or family support them during their appointment. The HIV patient survey carried out in 2014 found that 91% of patients were able to discuss their worries or concerns with the staff and 94% felt that staff listened to what the patient said.
- Community hospitals reported good links with local chaplains of various denominations. We spoke with a chaplain at Stroud General Hospital who was on call for 24 hours per day. The chaplain said "it was a good place to die." They said they felt they were "a resource for staff and patients." The chaplain was able to offer time to sit with patients and able to assist them

with their worries and concerns. The EOL action plan suggested a work plan looking at spiritual care however at the time of inspection the chaplain, who had a vast amount of experience, had not been involved in ways to take the actions forward.

- Community staff contacted relatives of the deceased on the day to offer support and advice, they then followed this up one week later with a visit or a call to the relatives. The community nurses and community hospital staff were able to signpost relatives for further bereavement support to, for example,charitable organisations.
- Staff treated people using the urgent care service with compassion, kindness, dignity and respect. Feedback we received from patients and relatives was entirely positive and this was consistent with the feedback captured by the trust in friends and family test surveys. All of the staff: patient interactions we observed were positive, from the receptionists who greeted people in a friendly and helpful manner, through to the nursing staff who exhibited sensitivity, care and a sense of humour, where appropriate.
- In the urgent care service staff were sensitive to people' anxiety and distress. We saw several examples of staff taking patients and relatives to a private room and providing reassurance and comfort.

Are services responsive to people's needs?

Requires improvement

Overall we judged that the responsiveness of services as requiring improvement. Individually urgent care, sexual health, community adult services, dental and end of life services required improvement. We judged the services for childrens and young persons and community inpatients to be good.

Community inpatients had a wide range of activities available to them. We observed the positive impact these activates had on the wellbeing of patients.

Medical cover varied across community hospitals. During the day the level of cover was adequate. However, there were some concerns about the responsiveness of medical staff out of hours.

Complaints were generally managed well throughout all areas. Whilst the number of formal complaints was low compared to the England averge, most complaints were addressed when presented as concerns, investigated and resolved at a local level.

Access to services varied. Within the end of life service there was a fast track discharge to enable patients to return home if they wished to die there. Within the sexual health service there was a single point of contact booking line which was managed at Hope House. This

service did not meet demand and consequently patients experienced problems getting through to make an appointment and often ended up attending a walk in clinic. This resulted in patients being unable to access the treatment they required immediately as some procedures required staff to have additional competencies not always available at walk in clinics. There were very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation. Waiting list data was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear.

Within the dental services waiting times for patients in some areas exceeded six months.

Whilst the urgent care service was consistently exceeding targets in respect of time spent in MIiU and the time people waited for treatment, waiting times had increased as demand for the service had risen and particularly at weekends as staffing levels did not always match the activity and pattern of attendances.

Referral processes to out of hours services were cumbersome and often entailed lengthy waits or travel to another hospital. Joint working between these two services needed to improve to ensure care pathways were convenient and reliable.

Premises were mostly fit for purpose and were appropriately accessible and laid out; however waiting areas at the Dilke Memorial Hospital and at the Vale Community Hospital out of hours were cramped and the triage area at Stroud General Hospital was not enclosed and therefore not conducive to a confidential consultation. Some areas within side rooms at Tewkesbury hospital had 'blind spots' which meant staff could not always observe patients and lights were such that they went out after a short while when patients used the ensuites.

Communication with patients whose first language was not English was assisted by the use of interpreters, translators and written information provided in a number of languages

Service planning and delivery to meet the needs of local people

- The trust provided services that were commissioned through a block contract. The trust has identified that the lack of clear service specifications in respect of that contract is a key

strategic risk for them and this was rated as a high red (15) on the board assurance framework. The trust has recognised that continued increases in demands for services is restricting flexibility and capacity to respond to needs for services to be provided in a different way or in different settings. The trust consider that there is insufficient scrutiny given to proactive capacity planning across the whole of the health and social care economy in Gloucestershire.

- The services provided do reflect the needs of the local population but capacity is an issue. There were long waits for some services very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation. Waiting list data was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear.
- Individual services worked hard to meet the needs of patients. For example in community inpatient services the lack of activities for patients had been raised with staff. We saw that hospitals had introduced many activities, such as high tea, bingo, exercise classes, 'pampering' sessions (for example massages), and games evenings. We saw consideration had been given to what might be important to the patient when deciding upon activities. For example, during the Wimbledon tennis tournament strawberries and cream were being provided for patients in the day room. They were able to watch tennis on a large TV in the company of other patients.
- Co-ordination of services for patients with complex care needs was good and this was supported through multi-disciplinary working involving other providers involved in health and social care.
- In September 2014 a report was commissioned to assess the end of life services for Gloucestershire Care Services. From this report an action plan/work stream was developed for community hospitals. There was work being carried out on the actions agreed but few had been completed. Due to the newness of the action planning there were no audits available to test its effectiveness. There was no evidence of an end of life strategy within the trust; however the action plan suggested a five year countywide strategy should be developed in the future.

Meeting needs of people in vulnerable circumstances

Summary of findings

- The trust worked well with people in vulnerable circumstances. For the integrated community teams, meeting the needs of people in very rural areas was a challenge. The teams worked closely with 'village agents' (employed by borough councils) who had a comprehensive knowledge of resources in the local area. The Tewkesbury integrated community team were based in the same building as police services and staff have developed good links which aided identification of people who needed help from either service. Managers recognised that more could be done to engage with 'hard to reach' groups of patients.
- The homeless health service saw approximately 40 people daily, providing access to services such as immunisation, vaccination, health promotion and screening, drug and alcohol advice, mental health advice, podiatry and family/child/women's/men's health and development. An outreach service was provided where staff worked in pairs in collaboration with religious organisations to make contact with people in vulnerable areas of the city. The Kingham reablement unit worked closely with voluntary organisations to find suitable accommodation for homeless patients.
- At Stroud Hospital on Jubilee ward they had a 'tag' system in place in one of the bays used for observing patients who required more support and care from staff. This system ensured that a member of staff was always present in the bay and could not leave until 'tagged' by another member of staff. This was to help reduce the incident of falls and to observe patients who were confused.
- The wheelchair service had introduced a 'choose and book' system which had reduced the rates of non attendance to the clinic. The cardiac rehabilitation service worked with the acute trust and the local university to produce a training DVD for attendees which enabled patients to continue their education in the comfort of their homes.
- A steering group was in operation in the trust regarding the care and treatment of patients living with learning disabilities. The group included a user of services. Staff were confident of how to access specialist staff for support and advice if needed when providing care and treatment for people with a learning disability.
- Hospital and community staff had support and advice from a link nurses for people with dementia. The end of life link nurses worked with the dementia link nurses to provide care to those

patients with both end of life needs and an encroaching dementia. There was recognition by staff that an individualised approach was needed to support patients with dementia as they approached the end of life.

- Patients who attended the minor injuries units with mental health problems were treated sympathetically but staff told us they had no specific training or guidance to assess people's mental health needs or provide appropriate care. They told us they sought support from the mental health crisis team employed by the local mental health trust. The response from this service was variable and there was limited availability of private spaces where vulnerable patients could be observed or available staff to observe them. Staff told us if they had concerns about a patient's safety they would arrange for them to be transferred to an emergency department.

Access to right care at the right time

- The community health services for adults were not always planned and delivered in a way that met people's needs, particularly with regard to people being able to access the right care at the right time for non-urgent needs. There were very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation.
- Waiting list data held by the Trust was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear. Occupational therapists and physiotherapists did not work on the weekends and there was no plan to implement this.
- Access to care in the urgent care service was good. The trust consistently exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at MIiU. Annual performance for 2014/15 was 99.8%, with 95% spending less than two hours in the department. In April and May 2015 the time spent in the department had increased slightly, with 95% of patients spending two hours and ten minutes and two hours and 15 minutes in minor injuries units respectively.

Learning from complaints and concerns

Summary of findings

- In 2013/14 the trust had recorded 78 complaints. In 2014/15 63 complaints had been recorded. This is extremely low for a trust of this size and the team explored the reasons for this. All the staff that were spoken to about this, without exception, were aware of this low level.
- The trust had a complaints manager who addressed formal complaints received. An investigating officer was allocated to complete a full investigation of the complaint, The complaints manager was responsible to feedback to the complainant within 25 days.
- The team confirmed that 63 was an accurate account of the recorded complaints held centrally although it was not clear that there was similar accuracy in different service areas.
- The new complaints policy and procedure was ratified in May 2015 and the ethos, approach and culture described in it will be new to staff. This approach had not been widely promoted or shared with staff at the time of the inspection.
- The previous trust complaints team were disbanded in March 2015 and a new patient experience team formed, with staff working to different roles and under an interim manager. This was a move to achieve a more productive outcome on patient experience and move away from the previous less proactive approach to complaints management. This new team recognised they have not embedded the new approach to complaints management as described in the complaints policy yet or put all the systems and actions needed to make it easier to make and manage complaints. They were also still adapting to their new roles and have had an interim manager since August 2014 with a new substantive leader taking up post in July 2015.
- Many staff do not feel confident yet to encourage people to complain. Their approach is to get local resolution quickly, which is comendable, however it can prevent some of these people making a complaint about a local service to a local leader for fear of possible consequences. This is particularly the case in the care at home services. People are less likely to make a complaint, even though it could be the right avenue. None of the issues raised by patients and others and resolved locally are recorded anywhere and therefore no audit trail. This means that all the learning is lost to the trust unless the local senior staff makes a point of sharing it. There was quite a paternalistic view by many as they presumed the fix they adopted promptly was always the solution and couldn't offer any examples of how they subsequently evaluate their interventions. No evidence was seen that people are positively encouraged to complain

Summary of findings

- There were new posters and leaflets in place across the trust. However they had a focus on people giving feedback and raising concerns. How to complain is included in the literature but it was not immediately obvious to the reader or that it is encouraged by the trust. There were leaflets available in reception areas at the minor injuries units; however we found there were given three different leaflets at different units. One leaflet entitled Tell us about your experience with us invited people to share their experience by recording these within a space provided within the leaflet. This could then be placed in a comments box in the department or posted to the service experience team. A second leaflet entitled How do I give feedback or make a complaint? outlined the complaints process and invited people to contact the service experience team. The leaflet also contained details of external organisations which could support people with their complaint. A third leaflet entitled We value your feedback (dated November 2013), which was available at Lydney and District Hospital directed people to the Patient Advice and Liaison Service (PALS). We judged this to be confusing for both staff and patients
- In a number of areas, in particular satellite services and on some wards in community hospitals there was very limited information about how to make a complaint and in some cases there was no information at all. In the sexual health service not all of the complaints which had been investigated locally were reflected on the trusts complaints log. It was therefore not clear who maintained the overview for all of the complaints received by the trust or if the number of recorded complaints was accurate.
- In services for children and young people staff encouraged children, young people and their parents or carers to provide feedback about their care and questionnaires were available in clinics asking parents to indicate how likely they were to recommend services to friends and family.
- Across the trusts services the staff have created a supportive, caring and family feel to how care is delivered. This is likely to create an atmosphere which discourages some people from complaining if a possible complainant is not sure if they want or need to complain or not.

Are services well-led?

Requires improvement

Overall we judged that improvements were required in the leadership of services. Individually we judged that improvements

were required in urgent care and end of life care and at trust level. We judged the leadership in sexual health services, services for children and young people, community inpatients, dental services and community adult services to be good.

At trust level we found that governance processes and the management of risk and quality were improving but were not yet sufficiently robust. The executive team, with the exception of the chief executive, were relatively inexperienced but had insight into the issues. As a team the executives are very patient focused and this was particularly notable in the support areas of finance and estates. The chief executive has had a significant and positive impact both internally and externally. The listening into action programme has had a galvanising effect and staff were well engaged with it.

Most services were aware of the trust vision and strategy however we found within the community adults and community inpatient services there was some disconnection between frontline staff and the board in terms of awareness. Most staff were very positive about working for the trust

In general, people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

Governance processes were variable. Risk registers reflected the key areas of concern however there was insufficient assurance around safeguarding at board level. The trust-board lead for end of life care was unaware of the action plan devised from a recently commissioned report into end of life care services. There was no strategy for end of life care and there was no one person in a position to take end of life care forward and maintain responsibility for provision of the service, however local leadership was found to be good.

The impact of change to the out of hours service provision had been significant and had exposed deficiencies in governance and leadership of the urgent care service, exposing vulnerability in terms of staffing levels, skill mix, staff confidence and competence. Some steps had been taken to address this area of risk but this was not being managed in a structured way. The risks did not appear to have been given sufficient attention or priority by the trust board. Board members were not visible or influential in urgent care.

There was insufficient and variable information available to demonstrate the urgent care service was fit for purpose and able to respond to changing demands. Information about the workforce was particularly poor and we could not be assured that that short term steps taken to mitigate risks in relation to staffing were adequate.

Summary of findings

Governance arrangements were in place to monitor audit outcomes, risks and incidents. Risk management systems were in operation and identified that the service manager assessed risks within the service and escalated them to senior management when necessary.

Within the community inpatient service, leadership and governance around the reduction of falls was extremely good. We found that the multidisciplinary team working with various organisations, risk analysis and the development of innovative mitigating actions had a positive effect on outcomes in the community hospitals.

Vision and strategy

The trust vision was

"To be the service people rely on to understand them and organise their care around their lives".

The trust also uses the strap line "Understanding you" on internal and external corporate documents.

The trust had stated their values are to be Caring, Open, Responsible and Effective and these were referred to as CORE. These values had been developed in consultation with staff. A series of corresponding behaviours had been developed as follows.

Caring

- Respecting and valuing others
- Acting in the best interests of service users

Open

- Open in our communication
- Connecting with other and working across boundaries

Responsible

- Owning our actions
- Professional in attitude

Effective

- Ensuring the best outcomes
- Realising your full potential

The team were shown a core values framework that included detailed definitions of each of the behaviours across four categories. The categories were all colleagues, supervisors/managers/team leaders, middle managers/heads of service and deputy directors/ directors. The framework also listed behaviours that would indicate areas for improvement. At the time of the inspection this had not been communicated to staff.

Summary of findings

The trust had plans to place to introduce values based recruitment and appraisal.

The trust had stated six strategic objectives as follows.

- Achieve the best possible outcomes for our service users through high quality care;
- Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work;
- Provide innovative community services that deliver health and social care together;
- Work as a valued partner in local communities and across health and social care
- Support individuals and teams to develop the skills, confidence and ambition to deliver our vision;
- Manage public resources wisely to ensure local services remain sustainable and accessible.

Staff displayed an awareness and understanding of the overall vision of the trust and of the values. Aside from the senior staff involved in the work on the values framework staff were less clear about expected behaviours and how they might align to the values. The trust had a plan to address this through the work described above.

The trust were developing a vision for community hospitals and involving partners such as primary care and Healthwatch in that. There was a recognition that the trust had not been particularly good at articulating the nursing vision.

Staff were aware of the overall strategy and approach as it related to their particular role and service. It was less clear that progress against the delivery of the strategy was monitored and reported in a consistent way outside the annual quality report. Progress was reported in terms of the different services and against major projects such as the introduction of the information technology system known as System one.

Governance, risk management and quality measurement

- The trust had set out their governance arrangements in the board assurance framework which was reviewed annually. The framework summarised the strategic risks faced by the trust and linked these to the six strategic objectives referred to above. It also summarised the corporate risk register and this contained the most significant operational risks that had been identified by staff. Within the framework the owners of risks were identified and there were actions against the gaps in assurance and controls. The actions added up to a significant

programme of work to improve risk management and assurance. Governance and risk management was maturing but was not yet well embedded. However the arrangements did enable the trust to recognise when help was needed externally and to frame their requests for that appropriately. The lack of maturity in some governance areas was a significant challenge for the inspection team in obtaining trust wide data. There was readily available information for services and locations but looking across the organisation was more of a challenge.

- The non executive directors talked about the organisation being new and about systems and processes needing to develop. They were involved appropriately as chairs and members of Board committees and described their commitment to patients and staff. Executive and non executive directors took part in a programme of quality visits to a range of locations and there was a predetermined schedule. The programme included both community hospitals and community services such as podiatry and the community nursing service. Feedback from these visits was recorded and included non executives raising questions about available training.
- Changes had been made to the governance framework and arrangements from April 2015 that included changes to the board committee structures. These changes had been made to reduce duplication between sub committees and to refocus on strategic rather than operational matters. The Quality and Performance Committee was the key committee providing assurance to the board on all issues related to clinical and professional care, clinical governance systems and clinical risk management. It was also responsible for reviewing service delivery and monitoring improvement plans. The team heard that this was a pressured committee and that at times the discussion was too focused on the operational rather than strategic issues. There were plans to address this through board development.
- The trust had recognised that improvements in clinical governance were needed and there had been significant changes in both the team responsible for leading this and in the systems in place. These changes had increased in pace in the six months before the inspection with new roles having been created and staff still learning. There was a recognition that systems for risk, serious incidents, reporting and consistency of data and information were not fully embedded and that the evidence of improvement was not available yet. The quality

and safety team displayed a determination to drive the necessary improvements. The medical director was involved in the service improvement planning process which the team considered to be unusual.

- At the time of the inspection action was being taken to put a comprehensive board development plan into place. There were also improvements underway including the introduction of a board agenda cycle plan and new board paper templates were being introduced in July 2015 to improve consistency.
- There were clear programmes for internal and external audit.

Leadership of the provider

- With the exception of the chief executive all executive directors are in their first substantive posts and consequently are a relatively inexperienced team compared to other similar trusts. There had been some recent changes with the medical director recently appointed and the director of nursing going on secondment to a national role. There was a good functioning relationship between the chair and chief executive. The trust was using the foundation trust pathway as a framework for improvements and developments that were needed in any case. The achievement of foundation trust status was not being focused on as an end in itself. The leadership team had a consistent view of priorities around workforce and culture, sustainability and patient safety.
- Staff across the trust, staff side and partners all described the positive improvements in relationships since the appointment of the chief executive. Staff talked about the greater visibility of executives. Staff told us that they felt supported by the senior team, especially those who worked in the trust headquarters building. Staff side described positive relationships and productive discussions with the trust since the appointment of the chief executive. Regular meetings are held and there is an open door policy to enable issues to be raised between scheduled meetings.
- The effectiveness of communication from senior leadership appeared to be variable. The main communication tool was team brief. There was not a regular message from the chief executive. Staff told us that some senior managers were better at cascading messages than others. This was borne out by the variation of awareness of key corporate messages amongst the

staff that the inspection team met. As part of the listening in action programme, described below, the executive team had visited 53 sites across the trust to meet staff and discuss strategy and plans.

- It was difficult to establish from Board papers and minutes whether the non executives provided effective challenge and support to the trust. The non executive directors who met with the team felt that they did provide this but that this had not been recorded. There was some evidence from a recent observation of the board by another regulator that the level of challenge could be improved. At the time of the inspection there were plans in place for board development. It was clear to the team that both executive and non executive directors were committed to making the Board as effective as possible and to make the quality and safety of services a top priority.
- The trust was not meeting three of their priority areas related to staff, appraisal rates, sickness and training. The target for appraisals was 95% and at the time of the inspection was at 78%. There are plans to change the timing of the appraisal round to help increase this. The 12 month rolling average for sickness absence was 4.9% against a target of 3% and was higher than the England average of 4.2%. The single biggest reason for absence was stress, anxiety and depression. Actions to address this include a review of self certification and return to work interview arrangements, a review of the stress management policy and stress management training for managers. The target for mandatory training was 80% and achievement of that varied by course and at trust level varied between 71% and 88%.
- The trust considered that their relationships with partners was good. All partners referred to the openness of the organisation and recognised improvements in engagement but some expressed frustration with the pace of improvement.

Culture within the provider

- Staff at all levels in the trust described how the culture had changed since the arrival of the current chief executive. Staff talked about a very open and very patient focused organisation. Many staff felt that they were highly valued and that openness and honesty was encouraged and rewarded. Staff who had worked in commercial organisations felt that the culture was “amazing” in comparison and described this in terms of the support for colleagues and the focus on what was best for patients.

- The leadership recognised that some community staff had been through a period of prolonged change with some community staff having had five different employers over the last seven years. The listening into action programme was providing a route for long standing issues to be identified and tacked. Staff across the trust talked positively about the impact of the listening into action programme and this included staff who said they were initially sceptical about it.
- The culture was very patient focused and across all the services there was a determination to provide the best care possible. It was particularly notable that staff working in support services, for example estates and finance, were very focused on patients and the quality and safety of care.

Fit and proper persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust worked to the NHS employment standards and pre-employment checks covered criminal record, financial background, identity, right to work, employment history, professional registration and qualification check. The trust conducted a check with any and all relevant professional bodies (for example, medical, financial and legal) and undertook due diligence checks for senior appointments. This for example, would exclude candidates who could not demonstrate they were capable. The trust was introducing additional checks for non-executive directors and included routine checks on the companies house website to identify any disbarment from running a business.
- The trust had amended their appraisal system and executive contracts to include the FPPR and to add it to the annual update to the declarations of interests of board members, a declaration that they remain fit and proper persons.
- We reviewed the personnel files of one executive and two non executive directors on the board, all have been appointed since the Regulation came into force . The files provided evidence that relevant checks had been done in line with trust policy.
- The trust had decided, after taking legal advice, that they did not require a disclosure and barring (DBS) check for all executives and non executives. The trust had stopped their rolling programme of DBS checks following an audit in 2010 (undertaken by the predecessor organisation). Job descriptions

had been reviewed to decide which posts required ongoing registration and for those posts (medical director, nursing director, director of transformation and director of finance) all staff had been checked by apart from the medical director whose check was in progress. The trust are required to ensure that all appointees are of good character in order to comply with Schedule 4 part 2 of the Regulation. The trust confirmed their intention to undertake a basic DBS check for all board members.

Staff engagement

- The listening into action programme, launched in March 2014 was a key platform for engagement with staff. The trust had held five "big conversations" which had led to the identification of nine themes that would have an impact on the working lives of staff. The second stage had started in March 2015 and there was work going on across the trust to deliver the actions and improvements. The staff that the team met were universally positive about this initiative, even those who said that they had been sceptical at the start. Staff talked in terms of having ownership, feeling responsible and feeling that things were possible.
- The trust has a staff forum as a communication and feedback mechanism.

Public engagement

- Public engagement with individual community hospitals was strong with volunteers deployed in a range of roles and strong and supportive leagues of friends investing in services, facilities and equipment. When asked about wider public engagement senior staff talked in terms of formal consultations. The director of service transformation described how Healthwatch were engaged in developing a shared vision for the trust through their involvement on the transforming services group.
- The trust had a Your Care Your Opinion Group. This was a public feedback forum, held regularly and attended by between 50 -100 members of the public.
- The trust planned to develop engagement with the public through the membership scheme that would come as part of the foundation trust work.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Head of Hospital Inspections, Care Quality Commission

The team of 34 included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, a palliative care nurse, a sexual health consultant and specialist sexual health nurse, a health visitor, a child safeguarding lead, a school nurse, directors of nursing, an ex chief executive, a governance lead, registered nurses, community nurses and an expert by experience who had used services.

Why we carried out this inspection

We inspected Gloucestershire Care Services NHS Trust as part of our comprehensive community health services inspection programme.

How we carried out this inspection

During our inspection we reviewed services provided by Gloucestershire Care Services NHS Trust across Gloucestershire. We visited community hospital wards, minor injuries units and outpatient clinics. We accompanied district nursing teams on visits to people in their homes where they were receiving treatment. We visited sexual health clinics and locations where dental services were delivered.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before visiting, we reviewed a range of information we hold about the core services and asked other organisations to share what they knew, this included Health watch. We carried out an announced visit on 23 – 26 June and 18 – 21 August 2015. During the visit we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We carried out an unannounced visit on 4 and 6 July 2015

Information about the provider

Gloucestershire Care Services NHS Trust provides a number of services to the population of 596,984 living across the county of Gloucestershire. The demographics for Gloucestershire show an age distribution similar to the England average. The health of people in Gloucestershire is generally better than the England average. Deprivation is lower than average, however about 14.7% (15,500) children live in poverty. Life expectancy for both men and women is higher than the

Summary of findings

England average, however life expectancy is 7.9 years lower for men and 5.8 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

Gloucestershire Care Services NHS Trust has a total of 19 registered locations, including 7 hospital sites with a total of 196 beds, 9 dental locations and community teams registered at the trust headquarters.

The Trust provides healthcare in seven local authority areas i.e. Gloucester, Cheltenham, Tewkesbury, Stroud, North Cotswolds, South Cotswolds and the Forest of Dean

Over the year 2014-15, the trust recorded 1,124,198 service user contacts across Gloucestershire.

The trust provides the following core services:

- Community adults
- Community inpatients
- End of life care
- Urgent care services
- Children and young people's services
- Sexual Health
- Dentistry

Gloucestershire Care Services NHS Trust was formed in 2013 and employes approximately 2,700 staff. The organisation had an income of about £114.1million during 2014-15, and at the end of the year returned a surplus of £1.5 million. The trust has been formed in unusual circumstances. A community interest company had been planned but this was successfully challenged through the judicial review process and in the circumstances an exception to national policy was agreed and a new NHS community trust had been formed. Changes in the leadership of the organisation had followed with the chief executive leaving.

There have been two CQC inspections at locations registered to Gloucestershire care services NHS trust, namely Stroud General Hospital in December 2013 and Southgate Morrings in April 2014. The services were found to be compliant against the outcomes inspected.

What people who use the provider's services say

The 'friends and family test' was undertaken in all areas. Whilst response rates were low, the overwhelming number of patients responded that they would be 'extremely likely' or likely' to recommend the service to friends and family.

We reviewed feedback from Health watch. This is the independent consumer champion in health and care that gathers the views of people who use services. Feedback was mixed for occupational therapy and physiotherapy, and identified long waits for physiotherapy appointments. For speech and language therapy, feedback was mostly negative, and centred on lack of contact. In podiatry, feedback was again mixed, praise given for a thorough and prompt service whilst in the clinic, negative feedback focussed on difficulty getting an appointment. For nursing, feedback was mixed, some patients and their families reported excellent service while others identified problems getting hold of nurses and poor communication between nursing staff. However patients and families who we spoke with during our onsite inspection told us that staff were caring and were always approachable.

Within the sexual health service, patients spoke of feeling respected by the staff who had welcomed them and put them at their ease. Comments were made of the professionalism of the staff and their kind and caring approaches.

Patients spoke highly of the service, praising the attention and care provided. There were some negative comments received on comments cared which described a lack of car parking and the cost of parking at Hope House. Patients also talked and wrote about the difficulties using the booking line due to it often being engaged or being cut off when put on hold. Patients also told us about long waits of up to four hours when attending the walk in services. However, patients did not complain about this as they felt they had eventually been provided with a good service. One patient said that although they had to wait they knew the clinicians would provide them with as much time needed and did not feel rushed which they appreciated.

Summary of findings

Without exception feedback from patients we spoke with during our visits to the MIiUs confirmed they were all happy with the way they were treated by staff. Comments we received via comments card were also entirely positive.

Within the end of life service patients and relatives spoke in the most positive and glowing terms about the kindness of the staff and the service they had received.

Good practice

- The seven day service provided by the children's community team
- The volunteer groups were an integral part of the care team within community hospitals. It was clear that they were having a positive impact on patients' wellbeing by supporting patients, providing activities, and by representing 'patient's perspective at governance meetings'.
- There was a strong caring culture that was embedded throughout the community hospitals. Staff provided compassionate care which was respectful to people's needs and wishes. Wards were calm and happy places and feedback given to inspectors by patients, carers and reatives was continually positive. Patients said that staff went the extra mile and it was clear that the care they received went beyond their expectations.
- People's individual needs were met in all of the community hospitals . A range of social activities were arranged which were imaginative ways of enhancing patients' inpatient stay and improving their wellbeing.
- There was systematic approach to falls prevention. Data was collected, analysed and innovative mitigating actions were put in place. This was having a significant impact on patient care within the community hospitals.
- Innovation and creativity were encouraged and this was impacting positively on patient experience in community hospitals. Examples included the Vintage Room on Jubilee Ward at Stroud Community Hospital and the use of "twiddlemuffs". Patients and in particular patients living with dementia were using these muffs to occupy restless hands and there was evidence that their use had a soothing and comforting effect on patients.
- The community hospitals also had an embedded multidisciplinary approach to the care of patients.
- The sexual health service was an integrated service, with patients being able to access the necessary care and treatment in one place. The multidisciplinary approach enabled all staff to provide the right care, treatment and support to patients.
- The dental service had responded to the complex needs of their patients and had invested in a number of items of specialist equipment, such as a wheel chair tipper, a number of bariatric chairs and specialist x-ray equipment. This enabled staff to provide treatment in a safe effective and comfortable way for patients.
- As part of the dementia link work the dental service had produced a training video which consisted of two parts, one demonstrating a poor approach to oral care and the other showing best practice and how this would ensure a good outcome for the patient. The video was used to initiate discussion at training sessions for community and care home staff.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST or SHOULD take to improve

The provider must:

- Ensure medicines administered to children within the complex care team are administered safely.
- Ensure there is a process in place to audit the prescription of medicines by health visitor prescribers.

Summary of findings

- Ensure that staff trust wide have the necessary mandatory training and essential training to ensure safe care and treatment of patients and that the accuracy of data held by the trust in relation to mandatory training is improved.
- Ensure resuscitation trollies and equipment on them are checked in line with national guidance and that records of these checks are suitable for the purpose they are intended.
- Ensure that all documentation relating to the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) include the complempletion of a Mental Capacity Assessment, to ensure that the patient's consent and decisions around best interests are served.
- Ensure DNA CPR forms include reference to discussions with patients and relatives and must be stored in such a way as to ensure all staff providing care are alerted to them.
- Review and take prompt action to ensure that MIiUs are consistently staffed by sufficient numbers of suitably qualified, experienced and skilled staff.
- Ensure that patients arriving at MIiUs receive prompt assessment (triage) by an appropriately trained and experienced registered nurse.
- Develop and improve systems, processes and governance arrangements across all MIiUs to assure high quality, effective and safe care and treatment.

The provider should:

- Take action to address waiting lists for therapies in the community health services for adults.
- Ensure medical and nursing supplies are stored in temperature controlled areas as detailed on manufacturer's instructions
- Understand the shortfalls in recording of risk assessments and individualised care plans in the integrated community teams.
- Strengthen the reporting on the assurance of effectiveness of safeguarding arrangements to the trust board.
- Review the policy for mandatory training with reference to intercollegiate guidelines produced by the Royal College of Paediatrics and Child Health in relation to the safeguarding training requirements for nursing and therapy staff in the community health services for adults.
- Ensure all learning from incidents relating to end of life care is disseminated across all areas of the trust.
- Monitor and audit patient outcomes of those receiving end of life care.
- Develop an end of life five year strategy.
- Strengthen the executive lead for end of life to ensure recognition of the service at trust board level, as well as identify an overall lead to take service forward and maintain responsibility for the provision of the end of life service.
- Investigate incident reporting levels in urgent care. Encourage staff to report incidents, including near misses and ensure these are acted upon and lessons learned and disseminated.
- Ensure that patients seated in MIiU waiting areas can be observed by staff.
- Ensure that in the MIiU at Stroud general hospital, triage takes place in an enclosed and private area to allow private discussion and examination.
- Improve monitoring systems and take appropriate action to ensure that MIiU premises and equipment are regularly cleaned.
- Improve joint working with the provider of out of hours GP services to ensure that the care pathway is seamless and the service convenient and reliable.
- Work with the local mental healthcare trust and emergency departments to ensure that MIiU staff are supported to assess and select the appropriate care pathway for patients presenting with mental health concerns.
- Ensure medication and records held at clinics in colleges should remain confidential and not be accessible by college staff. Records stored at the Milsom Street Centre should be secured at all times.
- Ensure patient records, including proformas, are reviewed to consistently reflect clearly the name of the staff completing the records and that all areas completed fully.

Summary of findings

- Ensure records are maintained to identify cleaning of all equipment and treatment areas. Systems for checking emergency equipment should be reviewed to consistently demonstrate the process was followed.
- Maintain an audit trail of all medications ordered, stored and returned to pharmacy in community clinics
- Review the numbers of staff on duty to ensure they are consistently at a level at all times to provide effective and responsive service within the sexual health service.
- Review the arrangements of staff returning to Hope house alone after the clinic is closed. Staff safety procedures, such as the use of panic alarms at the Misom Street Centre should be monitored.
- Review the waiting areas of clinics within the sexual health service.
- Take steps to improve the relationship between staff in the community hospitals and the executive team as staff feel there is a disconnection between these levels of management.

Gloucestershire Care Services NHS Trust

Detailed findings

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Overall we judged services provided by Gloucestershire Care Services NHS trust as requiring improvement for safety. We judged safety in the urgent care service to be inadequate. This is because we were not assured that people were adequately protected from the risk of avoidable harm. We were concerned that some patients waited too long to be assessed by a registered nurse on arrival at Minor Injuries and Illness unites and that unregistered practitioners were undertaking this task without adequate training or supervision. We judged the care provided by the sexual health service, dental service, childrens and young peoples service and end of life service as good for safety. However we judged safety as requiring improvement within minor injuries units, community adult services and community inpatient services.

Staff reported incidents using the on-line reporting system and were encouraged to report, however in places it was felt tolerance to incidents was too high. This meant staff did not always report incidents and near misses.

Infection prevention and control practices were followed. Equipment was correctly serviced and maintained, though were required to be shared across wide geographical areas at times. When this occurred, staff did not keep ongoing service or cleanliness records to ensure equipment was clean and fit for purpose. We also found medical supplies such as dressings and skin preparations were stored in a cupboard above room temperature which meant that the effectiveness of the ingredients could not be guaranteed. Not all emergency equipment such as resuscitation trolleys were appropriately checked.

Staff were knowledgeable about the trust safeguarding process however staff in the community adult teams were not required by the trust to complete the safeguarding awareness level 2 course. Within MIiU's we could not be assured that assessments were consistently taking place or that referral rates were appropriate because there was no oversight of safeguarding. However all staff were clear about recognising possible signs of abuse or neglect of children and young people and their responsibilities

Mandatory and competence training records and records of staff appraisals were variable. Records

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

differed locally from those held centrally. The level of compliance for mandatory training was not adequate to ensure staff were able to provide safe care and treatment for patients.

We could not be assured that MIiUs were consistently staffed by sufficient numbers of appropriately qualified, experienced and skilled staff. Staffing levels and skill mix had not been adjusted in response to increased and activity and a changing profile of presentations.

Some patients waited too long to be assessed by a registered nurse on arrival at MIiU and at times unregistered practitioners were undertaking this task without adequate training or supervision.

Premises were mostly fit for purpose, clean and appropriately equipped. However the layout of some MIiUs meant that waiting patients, including children, were not adequately observed. At Tewkesbury Hospital there were some safety issues. Bathroom lights turned off while patients were in them due to the timings of the movement sensors there. Nurses were not able to observe patients at all times due to 'blind spots' in the single bed rooms.

The level of compliance for mandatory training was not adequate to ensure staff were able to provide safe care and treatment for patients. There was disparity between locally held and trust held training data and there was little oversight or understanding of the scale of the problem by the trust.

Our findings

Incident reporting, learning and improvement

- Staff across all services were aware of the incident reporting mechanisms and were confident in reporting relevant incidents in a timely manner. However within urgent care, thresholds for reporting were found to be too high, which resulted in some incidents and near misses being under reported. Feedback and shared learning from incidents was reported to be in place. Whilst staff predominantly said they received feedback from incidents, a small proportion reported feeling that feedback was not always given.
- Processes were in place to ensure incident s were investigated with board level oversight of all serious incidents.
- Staff reported incidents using the on-line reporting system and were encouraged to report, however in places it was felt tolerance to incidents was too high. This meant staff did not always report incidents and near misses.
- Staff across the trust told us that they were encouraged to report incidents and that a no blame culture was being promoted. Lessons from incidents were discussed at some team meetings but some staff told us that they did not always get feedback on the incidents they had reported.
- The results of the NHS staff survey were below (worse than) the England averagw in terms of the fairness and effectiveness of incident reporting procesures and also for the percentage of staff reporting errors, near misses or incidents reported.
- Pressure ulcers and slips and falls accounted for the majority of incidents reported. Reports on incidents and actions were reported to the trust quality and performance committee.
- The low rate of incident reporting was on the trust risk register.
- Feedback on incidents was not consistent across all services although we saw evidence of learning from incidents, for example in community health services for adults.

Duty of candour

- The statutory Duty of Candour had been introduced within the trust. The staff we spoke to were were aware of the duty of candour and and of the need to apologise to patients and relatives in incidents of moederate and severe harm.
- Staff talked about being open and honest in their everyday practice and described how the open approach was positively encouraged.

Safeguarding

- There were process in place to ensure the safeguarding of vulnerable adults and children, however processes were not subject to audit within Minor Injuries Units to ensure all concerns were captured and acted upon, and board oversight and assurance was limited.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- The Director of Nursing was the Board lead on safeguarding. There was a corporate safeguarding team comprising clinical and managerialm staff. There was an operational safeguarding group that fed into the clinical senate and governance committee.
- There were effective arrangements in place for children. Partnership working was strong with monthly meetings, nurse links into departments and safeguarding champions.
- Incident data on adults was well articulated, similar data on children needed further development.
- The data on training needed to be strengthened. Locally teams had information on safeguarding training and completion looked satisfactory but overall trust information was less reliable and needed strengthening.
- There was evidence of reporting on safeguarding to the quality and performance and governance committees. In January 2015 the quality and performance report included a quarterly safeguarding performance dashboard and included information on serious case reviews.There was no specific regular report on safeguarding to the Board outside the annual report.

Medicines management

- Medicines were stored appropriately in the majority of areas inspected including being refrigerated where required. However at the Dilke Memorial Hospital we found the medicines fridge unlocked. There were systems in place to ensure that fridge temperatures were regularly checked. We found all fridge temperatures were within the correct range during our visit. However, at the Dilke Memorial Hospital recording of fridge temperatures was inconsistent and there were no records to demonstrate that checks had taken place during April 2015. At the Vale Community Hospital there was no evidence that fridge temperatures were checked. At Lydney and District Hospital temperature checks had not been recorded on five days during May and five days during June 2015. We could not be assured therefore that medicines stored there were safe to use.
- Within one community clinic we identified dressings stored in a cupboard in the eves, whose temperature had exceeded the maximum safe storage temperature. We raised this with the trust who acted on this immediately.
- With the exception of the childrens complex care team, administration of medicine was found to be in accordance with the providers policies.
- Some health visitors within the health visiting teams, were able to prescribe medicines from a predetermined and approved list. Each health visitor prescriber was able to order a prescription pad. However, there were no arrangements locally to audit the use of these pads. This meant that there was no system in place to effectively monitor the usage of these prescriptions or to prevent their misuse.
- At Cirencester Hospital and Lydney and District Hospital we found that anaphylactic response kits (used to respond to patients who have had an acute allergic reaction) had broken seals. This meant we could not be assured this equipment and medicines were safe to use.
- An anticipatory prescribing medication chart was available for use and linked to the trust's shared care record for the expected last days of life. This chart was prepopulated with the four most common symptom and pain relieving medicines, with guidance of dose and frequency. There was additional space on the chart for other specific medicines to be added to meet individuals needs as required
- There had been a recent change to pharmaceutical provider within the community hospitals service. This change had occurred with little disruption

Safety of equipment and facilities

- The trust estates team had a good awareness of care environment needs. The head of estates had become a dementia champion and the needs of people living with dementia had been a key influence in the design of new facilties, for exampleTewksbury Hospital, and the refurbishment of older parts of the estate, for example Stroud Hospital. Staff across the trust, and in particular staff in community hospitals, talked about the responsiveness and effectiveness of the estates team in terms of the safety of facilities.
- Premises and facilities were mostly fit for purpose.
- Not all standard checks of equipment were carried out in line with national guidelines and trust policies. The details of inspection findings are in the core service reports. Examples included resuscitation trollies which were not checked appropriately according to Resuscitation Council Guidelines in some of the community hospitals.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- Most of the equipment within community hospitals was maintained by an external company who routinely checked and replaced equipment and medical gasses. All the equipment checked by the inspection team was within its servicing date.

Records management

- At the time of the inspection the trust was part way through the implementation of single electronic patient record that could be updated in real time. At the time of the inspection the system was being used by the integrated community teams, occupational therapists, physiotherpaists, the home oxygen assessment service and some of the community hospitals and minor injuries units. The team found that those staff who had been using the system for the longest time were confident and competent with it and had found it a significant improvement on the previous arrangements.
- Records management varied in the different core services. In the community hsopitals the team found that medical notes were accurate, complete, legible and up to date.
- Medical records were stored securely in the community hospitals.
- In the community servies the team checked 20 records on the electronic patient record system and of these 50% were missing an assessment of the risk of malnourishment, malnutrition or obesity, 35% were missing individualised care plans and 25% were missing a risk assessment of developing a pressure ulcer. Nursing staff acknowledged that documentation of care had not been as thorough since the electronic system was introduced. This was a result of some staff being unsure of the full functionality of the system and additional support was being provided to them.
- Risk assessments and records were well completed in end of life care.
- A review of nine sets of records in community services for children and young people found them to be clear and contemporaneous.
- Paper records were in use in sexual services and contained documentation completed by patients and staff. They wre generally in good order although not all entries were signed. Secure storage was available in all clinics although the team observed that records were left unlocked during the clinic at Milsom street.
- The team reviewed a sample of records in all the minor injury units visited.They were mostly legible and complete.

Cleanliness and infection control

- Cleaning services were managed in house and the community hospitals and services visited appeared clean. Cleaning routines and rotas had been adapted to take account of patient needs, for example there was no cleaning scheduled during meal times on wards. Cleaning had been increased in those areas where building work was being undertaken.
- The estates team worked with the infection control team to plan services.
- The role of director of infection prevention and control (dipse) was undertaken by the director of nursing supported by an infection control committee that reported to the quality and performance committee which was a sub committee of the board. The arrangements were effective in ensuring that changes were made in line with national guidance. The trust had identified leads for infection control in each locality. Performance against tolerance levels was reported and there were robust arrangements in place for outbreak management.
- There was an audit programme in place that covered prescribing, education and induction. The trust is also engaged with county wide groups, for example the cdifficile strategy meeting which is co-ordinated by the clinical commissioning group.

Mandatory training

- The trust was unable to provide reliable training data to demonstrate that all staff were up to date with mandatory training in safety systems, processes and practices of essential training such as resuscitation.
- Trust wide records did show that the targets for mandatory training were not being met .The target for mandatory training was 80% and achievement of that varied by course and at trust level varied between 71% and 88%.
- The majority of staff that we spoke to told us that they were up to date with their training but not all were able to provide evidence of this. The staff we met who generally worked overnight told us that it was particularly difficult for them to attend training.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Assessing and responding to patient risk

- There were variable approaches to the assessment of and response to risk in different services.
- In community health services for adults the inconsistencies in record keeping meant that staff did not always have a clear overview of a patient's medical status over time. There was some inconsistency in the approach to pressure wound assessment and action and some of the staff we spoke to were not aware of the national guidance about this. Appropriate checks were being made in places, for example moving and handling assessment in patients homes and checking blood pressure and pulse rates before starting a cardiac rehabilitation class.
- Patients were not always assessed promptly on arrival in the minor injury units and consequently the trust was not consistently meeting the national standard that requires 95% of patients to be assessed within 15 minutes of arrival.
- Staff recognised and responded to risks well in the community service for children and young people.
- Good processes and procedures were in place in the sexual health service and staff were seen to be following these consistently.
- Staff in the community hospitals were confident aout the policies and procedures to be followed to assess and respond to risk. National guidelines and tools were in use for example the the adult modified early warning score and the malnutritional universal screen tools.
- Patient risks were assessed and responded to well when patients were at the end of their life.

Staffing levels and caseload

- Staffing levels and skill mix were reviewed although the lack of detailed specification of some services within the block contract meant that the trust was finding it challenging to manage increasing demands for services. This featured on the trust risk register. Staffing in terms of vacancies and turnover was a challenge in all services.
- The trust was experiencing recruitment difficulties, particularly with senior (band six) district and senior community nurses. Vacancies had increased in the six months prior to the inspection. There was also an issue with nurse retention. These were the top two risks on the Human Resources risk register.
- The trust had a detailed work programme to address these issues which was monitored through the workforce steering group. The actions included reviewing job descriptions, centralising recruitment, running preceptorship and return to practice programmes. At the time of the inspection it was noted that these were decreasing risks.
- The trust used bank and agency staff to ensure that save staffing levels were maintained.
- In community services there was not an established case management tool although one was being developed but had not been implemented at the time of the inspection.

Managing anticipated risks

- The trust was part of the systems reliance group for Gloucestershire and so was engaged in the identification and management of anticapted risks across the system. The trust had increased community bed capacity in the winter of 2014/15 although overall there had been a significant problem in the county with the acute trust declaring a major incident in January 2015. Events to learn the lessons from the last winter were planned to be held following the inspection. Although there was no doubt of the commitment of staff to this there was an issue about whether the Board, and in particular non executive directors, were sufficiently sighted on these issues and had the information they needed to be assured on the suffiency of the actions being proposed and taken.
- Staff were aware of the lone working policy and used this consistently.

Major incident awareness and training

- At the time of the inspection a new business continuity plan had been introduced for handling major incidents. The plan identified key contact details and a general pathway. More specific protocols for scenarios such as bad weather were under development.
- There was a 24 hour on call rota for senior managers and an executive was on call at all times.
- Staff at community hospitals were familiar with and had practised "lock down" arrangements which were signed to keep people safe by restricting access to and from the hospital. Alarms were in place to call porters and to summon the police if circumstances required that.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

Overall the effectiveness of services requires improvement. Improvements are needed in Urgent care and End of Life Services, the remaining services were judged as good.

Patients were treated in accordance with best practice and recognised national guidelines, however within MIiU's there was little evidence available to demonstrate this was the case. Within most services, such as community adults, childrens and young peoples and sexual health, staff were engaged in monitoring and improving outcomes for patients. We saw how outcome monitoring, national, and local audit data was influencing practice particularly within the sexual health service and community hospitals. Teams worked together and there was good evidence of multidisciplinary working.

In places there were difficulties accessing information about patients on the electronic record keeping system because internet connectivity was not always available, particularly in rural areas.

In addition social care staff and health care staff used different patient record systems which complicated the process of obtaining up to date information and important alerts at the point of referral.

Within 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms, explanations for the reason for the decision to withhold resuscitation were not always clear. Records of discussions with patients and their relatives, or of reasons why decisions to withhold resuscitation were not always documented. Patients with long-term conditions who might have been in the last year of life were not consistently recognised by staff throughout the trust. Where patients were identified with end of life care needs, they had their needs assessed and reviewed and had pain and other symptoms managed effectively.

Whilst there was evidence that staff were given opportunities for training and professional development, the trust was unable to provide evidence that all staff employed were appropriately qualified and competent to carry out their roles effectively. There was little regular supervision, including clinical supervision, of nursing staff across the organisation. In addition the trust was not able to fully assure us that people's needs were assessed and care and treatment delivered in accordance with current legislation because not all staff had received training in the Mental Capacity Act 2005.

Our findings

Evidence-based care and treatment

- Care and treatment was evidence based in community in patient services. Care was given in line with policies which were based on evidence and in line with national guidance. Staff were encouraged to comment on and challenge policies and this was influencing changes and improvements through the listening in action process.
- The trust participated in several national audits including those for stroke, parkinsons, intermediate care, chronic obstructive pulmonary disease and diabetes foot care.
- Care and treatment was evidence based in community servces for adults and children and young people. We saw evidence of holistic assessment and treatment following best practice and incorporation of NICE guidelines. The electronic patient record keeping system included tabs which linked the user to clinical guidelines. These were attached to the assessment templates and were based upon best practice and NICE guidelines. Therapy staff had reviewed the NICE guidelines for falls as part of a peer development opportunity. As a result, exercise classes were designed to conform to best practice in falls prevention. The heart failure nurse had produced referral guidelines for the service plus a patient information booklet which were both based upon NICE guidelines.
- Care and treatment was evidence based in sexual health services. There was evidence that the trust took part in local, regional and national audits relevant to the service. Care and treatment followed the guidelines produced by the British Association of sexual health and HIV and signed off by the National Institute for Health and Care Excellence. Changes in national guidelines were acted on promptly and there was evidence of discussion of changes at team meetings.
- The effectiveness of services in the community for patients at the end of their lives required improvement. Evidence based care had been implemented, but not necessarily for all patients who were in the last year of

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

their life. In line with NICE guidance (QS13 End of Life Care for Adults) use of the Liverpool Care Pathway had been phased out in 2014 and replaced with the 'shared care record', although this has yet to be audited to determine if it was effective. The trust had implemented the five core recommendations for care of patients in the last few days and hours of life in the Department of Health's End of Life Care Strategy 2008. It had also implemented recommendations of 'One chance to get it right' published by the Leadership Alliance for care of the Dying people 2014. As a result unnecessary investigations, blood tests and continued use of medicines were regularly reviewed.

- End of life care within the hospital was focused on the recognition of patients who might be approaching the last few days and hours of life. The Department of Health's End of Life Care Strategy (2008) and NICE quality standards for end of life care (2011) included recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. Clinical staff on the wards we visited did not demonstrate this understanding that end of life could cover an extended period, or that patients might have benefited from early discussions and care planning.
- The trust was not currently working towards accreditation of provision of end of life care. Many trusts and hospices are currently working towards the Gold Standards Framework as this is considered to be best practice. Staff were aware of the Advanced Care Plan (ACP) but we did not see any evidence of its use. ACP is a key part of the Gold Standards Framework Programmes. It should be included consistently and systematically so that every appropriate person is offered the chance to have an advance care planning discussion with the most suitable person caring for them.
- In community servies for children and young people policies and guidelines were developed in line with national guidelines. These included the National Institute for Health and Care Excellence (NICE) guidelines. Policies were available to all staff via the trust intranet system and staff demonstrated they knew how to access them. The children's and young peoples service provided all the core requirements of the Department of Health's healthy child programme. This includes early intervention, developmental reviews, screening, prevention of obesity and promotion of breast feeding.
- There was a comprehensive set of treatment guidelines available on line for all MIiU nurses for a range of minor injuries and illnesses and we saw some evidence that staff were familiar with these. However the trust had limited evidence to show that guidelines were consistently complied with because this was not subject to audit.

Pain relief

- Four pathway tracking assessments in inpatient community services found that pain assessments were consistently completed. We observed good practice in plain relief on the wards in community hospitals.
- In community services for adults the team saw examples of pain relief being considered during home visits, in reablement settings and the gold standards framework meeting and complex care review meetings. We observed a home visit with a palliative care patient where options for pain relief were discussed with the patient and their family. We observed a home visit where a patient's self-management of pain was considered and therapy goals were adjusted to accommodate their pain control. In a referral centre meeting, professionals discussed options for pain relief including use of a patch to enable a patient to have more sustained relief from pain which would facilitate their independence in activities of daily living.
- The sexual health service prioritised patients in pain for appointments and advice. Staff in the service were knowledgable about pain relief in relation to specific treatments and patient records shows that pain relief had been offered when required.
- Pain relief was well managed for patients at the tnd of their lives. We saw evidence of a pain management care plan with clear entries for managing intermittent pain and the effectiveness of the analgesia used. Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to be given to allow promptly management of any changes in patients' pain or other symptoms. Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times.
- Where necessary children's pain was assessed using a variety of methods suitable for children and young

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

people. For instance using smiley and sad faces for younger children. There was guidance in care plans about pain management for children where it was appropriate.

- In the urgent care service staff used a pain assessment tool to assess levels of pain and this was recorded on the emergency assessment record. Children's pain was assessed using an age appropriate tool where children were asked to point at faces to indicate their level of pain. In an audit of clinical records undertaken in November 2014, 88% of records evidenced that where a patient was in pain, a pain assessment had been carried out using a validated rating scale. Only 54% of records evidenced that pain relief was administered during the period of care/treatment. We checked a sample of records at each MIiU we visited and found that pain scores were not always completed. At Cirencester Hospital we observed a patient being assessed by a nurse. Their pain was assessed using a pain assessment tool and they were given appropriate pain relief promptly

Nutrition and hydration

- Nutrition and hydration assessments were consistently completed in inpatient community services. Weight was assessed on a weekly basis and the records completed appropriately. On Jubilee Ward at Stroud Hospital we found evidence of action being taken in response to an identified risk of malnutrition.There was evidence from audits that nutritional risk assessments were being undertaken and the trust's guidelines for oral nutrition for adults were being followed.
- In community services for adults staff ensured that patients were adequately fed and hydrated during their treatment sessions. In cardiac rehabilitation, patients were frequently offered refreshments during their class. On home visits staff offered food and made drinks for patients. At the Kingham Reablement Unit patients were encouraged to make their own breakfast and hot drinks in a communal kitchen. In this way patients were able to make choices and regain the skills needed to manage their nutrition and hydration needs post discharge.
- Nutrition and hydration was well managed for patients at the end of their lives. We observed a nurse discussing this with a patients. Screening tools were used to determine how best to support patients. A patient in receipt of palliative care, for example, had been assessed using the Malnutrition Universal Screening Tool (MUST). This had led to a referral to the Speech and Language Team due to difficulties the patient had with swallowing. We saw evidence of daily fluid charts in use and recorded appropriately.
- In community services for children and young people we saw guidance around a child's nutritional needs were recorded in their individual plan of care. We observed a speech therapist's feeding assessment of a child who was attending a local nursery. The visit was arranged to coincide with the lunch break and the child was observed eating a packed lunch thereby enabling the therapist to make an assessment of the safety and suitability of foods.

Use of technology and telemedicine

- The specialist respiratory telehealth service aimed to prevent hospital admission using a teleconferencing system which was available for patients with chronic obstructive pulmonary disease or brittle asthma. During April 2015, 59 patients were using telehealth. Use of this system avoided the need for four patients to be admitted to hospital. Information was collated via a tablet device. Patients used a decision tree and specific questions triggered alerts to the respiratory nurse. The system was colour coded and available in different languages. Nurses were available during office hours with back up from the out of hour's service outside of these times. Telehealth calls were structured using a written prompt sheet that signposted clinicians to required actions. Faulty equipment was replaced within 3-5 days. Feedback from Healthwatch was positive: "it's brilliant for peace of mind and not having to bother the surgery".

- Telecare support and assistance was provided at a distance by means of sensors. Between March 2015 and May 2015, 272 patients began to use telecare, 203 of these were managed within the integrated community teams and 69 by the countywide specialist service. Gloucestershire Stop Smoking offered an online advice service as an option for service users wanting to access support to quit smoking.

Approach to monitoring quality and people's outcomes

- Community hospitals monitored quality and outcomes through a performance dashboard. The dashboard reported agabinst a range of trust taregts including the

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Friends and Family test, readmission rates, infection control, length of stage, delayed transfer, safety thermometer and prescribing. Each measure was reported against expectations and breaches were reported.

- The sexual health service took part in part in relevant audits and outcomes from these were shared with staff.
- The trust did not contribute to the Royal College of Physicians National Care of the Dying Audit 2014. The standards of care evaluated in this audit are based on the End of Life Care Strategy (DH, 2008) and reflect recent national policy guidance. However, we were told the trust was taking part in 'Voices': a National Survey of Bereaved people. This was a survey which collected the views on the quality of care provided to a friend or relative in the last three months of life. It was commissioned by the Department of Health and NHS England, with data collection due to commence in September 2015. The trust was not working towards an independent accreditation standard such as the gold standards framework, nor were staff using an end of life quality assessment tool. The Gold Standards Framework (GSF) is a model that enables good practice to be available to all people nearing the end of their lives, irrespective of diagnosis. It is a way of raising the level of care to the standard of the best.
- In community services for children and young people clinical pathways were in place and gave clear and consistent guidance across the therapy services. Outcomes were measured to ensure that the needs of children and young people were being met in the service. The trust scored above the England average for the children receiving appropriate immunisations. As an example, 97.5% of appropriate children had received the triple vaccination (Dtap / IPV / HiB) compared to an England average of 96.3%.
- Although the trust received overwhelmingly positive feedback from people who used MIiUs, they provided little evidence to demonstrate that care and treatment provided in MIiUs achieved positive outcomes for people. The trust participated in a limited number of local audits so they could benchmark their practice and performance against best practice. Audit reports provided to us contained incomplete action plans and there was limited evidence that areas for improvement had been widely shared with staff and acted upon.

Outcomes of care and treatment

- The trust participated in a number of Commissioning for quality and innovation targets. All the community hospitals were meeting these targets. The community services for adults had been all their targets for 2014/15 and the stop smoking service exceeded its target of 2332 for 2014/15 by 150 patients. This service was on track to meet the target for the first quarter of 2015, currently 163 towards a target of 615 by end of September.
- In community services for children and young people audits were carried out to monitor performance and maintain standards. We saw evidence that at least one clinical audit was carried out each year that was relevant and timely to the therapy service. There were ongoing record keeping audits across all therapies; parent child interaction, triage and outcome audits in speech and language; sling provision audit in occupational therapy and exercise compliance and spasticity audits in physiotherapy.

Competent staff

- The trust was not meeting their targets for appraisal and mandatory training at the time of the inspection. There was a lack of confidence in the overall trust data and the team found that local and organisation level records on training and appraisal did not always match. That said the trust had systems in place to identify training and learning needs and provided training to meet those needs.
- Staff were being encouraged tor develop and to reflect on their own needs through the listening into action programme.
- Staff in all community hospitals were encouraged to undertake addiditional course either in house or externaky. The team met heatthcare workeders who had undertaken the care certificate training (developed following the Cavendish Review) and other staff who had completed diplomas or degrees in healthcare. Staff talked positively about regular clinical supervision and appraisal.
- The community service for adults was not meeting targets for appraisal. Appraisal rates in the integrated community teams were below the countywide rates at 66.2% and for the specialist nursing teams this was 78.2%.In the Cheltenham ICT, 52.3% of appraisals were overdue. In the overnight nursing team, 68.2% of appraisals were overdue. Clinical supervision was variable across the service although there were very positive examples of clinical training.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The sexual health service was performing well on levels of appraisal, at 87% against a target of 80%, and training. Staff in the service spoke positively about appraisal as a two way process.
- Each area we visited had an enthusiastic end of life lead/champion. This was a member of the nursing staff who were involved in teaching sessions and planning further learning. The champions explained how they were able to access advice from specialist palliative care teams from the local acute hospital and local hospices. Staff we spoke with were committed to providing good end of life care. We spoke with two nurses who had or were completing the certificate in end of life care; other staff were aware of and had completed the end of life online training.
- In community services for children and young people health visitors had a preceptorship programme in place for newly qualified staff which extended for six months. As part of this programme, staff were given protected learning time and were allocated a preceptor with whom they had regular meetings. The programme also included a range of competencies each member of staff had to complete before they could practice independently. The school nurses recieved a comprehensive induction programme with core competencies they were required to achieve before being able to work alone. The allied health professionals received clinical supervision using reflective practice. This took place on an individual and group basis every three months.
- The community services for children and young people were, as a team, performing very well in the completion of appraisals with some teams at 100%. All the staff we spoke to during this inspection confirmed they had received regular appraisals and supervision.
- The trust could not provide assurance that staff were appropriately qualified and competent to carry out their roles effectively in the urgent care service. A process to assess the training needs of all staff had recently been developed but this had not been formally launched or consistently rolled out. Appraisal rates varied widely at different minor injuries units from 55.6% at Tewkesbury Hospital to 100% at North Cotswolds Hospital and Dilke Memorial Hospital and Lydney and District Hospital. There was not a formal programme of clinical supervision for nurses in this service.

Multi-disciplinary working and and co-ordinatation of care pathways

- The team observed multi-disciplinary meetings at Cirencester and Lydney hospitals. The meetings were attended by a senior nurse, a doctor, occupational therapist, physiotherapist, social worker, a lead for the integrated care team and a mental health nurse from the local mental health trust. These were effective meetings where each patient was discussed in detail and patient choice was considered.
- The team observed effective multi-disciplinary working between trust staff and social workers employed by the local authority.
- Multidisciplinary working was clearly evident in the integrated community teams. Nursing, therapy and social care staff were committed to working together to meet the individual needs of their patients.
- Each of the six localities was working toward more cohesive integration. Integration with social care teams was identified as a key theme from the 'Understanding You' events held by the Trust. Managers voiced concerns that the future separation of managerial responsibility for social care staff threatened the progress made to date in relation to integrated care planning. Nursing staff were sometimes based in different locations to therapy staff and this may have contributed to slower integration between these staff. Several staff remarked that integration between therapy and nursing staff was an on-going focus.
- There was a fully integrated multi-disciplinary approach to the management of care records. Patients were asked to sign a consent form to enable records to be shared in this way.
- The sexual health service was an integrated service with patients being able to access care and treatment in one place. The service worked closely with other relevant bodies such as the Terence Higgins Trust and the Gloucester Rape and Assault Service.
- The Specialist Palliative Care Occupational Therapist attended multi-disciplinary meetings held at the hospice for end of life patients in their care Community nurses were invited to the GP Gold Standard Frameworks meetings; however attendance was reported as poor due to pressure of workloads
- In community services for children and young people we saw evidence that staff worked professionally and cooperatively across different disciplines and

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

organisations. Staff reported good multidisciplinary team working with meetings to discuss children and young people's care and treatment. Staff told us they were most proud of the integrated work across all disciplines. The health visitor and school nursing teams worked in partnership with others on a daily basis, including GPs, social services, midwives and schools.

- Changes to the provision of the out of hours GP service had caused some difficulties at some hospitals. At Lydney and District and the Dilke Hospitals staff reported that there was a good relationship with the OOH provider but when GPs were not co-located with MIius they were not able to provide a seamless service. They also told us that because that referral was via a central telephone hub, there were frequent delays in obtaining appointments. At Stroud Hospital however, where the OOH service was co-located we saw good partnership working between the two services during our unannounced visit.

Referral, transfer, discharge and transition

- It was clear from the records and observastions of multi-disciplinary meetings that patients were not discharged unless packages of care had been completed and implemented.
- The trust undertook audits of all transfers resulting in admissions after 9pm . 3.4% of transfers to community hospitals were taking palce between 11pm and 5 am with the most common cause being ambulance delays. The trust was addressing this with the ambulance and local acute trust.
- There was a single point of access for patients. Staff told us the system worked well but that sometimes not enough information was gathered.
- The community health service for adults worked closely with other services to promote a seamless journey for patients in their care. The community nursing teams attended the complex care discharge planning meeting at local hospitals. The rapid response service worked closely with the integrated discharge team at the accident and emergency department. Therapists from inpatient departments carried out initial reviews of patients following discharge from an inpatient setting. This enabled good continuity of care.
- The sexual health service worked closely with the sexual assault referral centre to ensure that follow up appointments were given in a timely way. Referrals were made to other organsations if the trust could not provide a service in the time needed.
- Access to in patient beds for all patients across Gloucestershire was managed by Single Point of Access (SPA). This contributed to patients at the end of their life being in their preferred place of care when being discharged from an acute hospital or admitted from home via their GP. All the trust's community hospitals stated they provided end of life care but there there were no designated end of life beds. The specialist palliative occupational therapy team was available to all adults with life limiting illnesses who were registered with a Gloucestershire GP. Referrals were completed by the GP through an electronic referral form on the trust website or through verbal communication with other health care professionals. Referrals were prioritised by the occupational therapy team depending upon the needs of the patient.
- Children and young people services shared information with GPs other healthcare professionals and where appropriate other agencies such as education either via the electronic patient records system or via reports or verbal / written communication. Where children needed specialist support, protocols were in place to make sure appropriate referrals were made. We saw evidence that referrals and discharges were fully discussed and agreed with parents / carers and where possible the child or young person. Children seen by the health visitor were transferred to the school nurses at the age of five years
- In the urgent care service patients were given advice following treatment. This was both verbal advice and written guidance on what to expect with their condition, how to care for themselves and when to seek further help. This was referred to as 'safety netting'. We saw that this was well documented in patients' records. We saw that patients were referred appropriately to other health professionals for follow up, for example the falls clinic and the fracture clinic. Discharge letters were automatically generated when emergency assessment records were completed and these were sent to patients' GPs so that any follow up or after care could be arranged.

Availability of information

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- The new single electronic patient record system enabled staff in areas that had adopted the system to access all records inclusing test results, diagnostic imaging and letters. This information was available through existing computer records but was not updated in real time.
- Information was available to patients, relatives and carers. Advice covered nutrition and hydration, dementia, learning disabilities, communication and infection prevention.
- In community services for adults the use of electronic patient record keeping system and difficulties with mobile working were identified as key themes from the 'Understanding You' events held by the Trust. Access to clinical information was problematic due to connectivity to electronic patient record keeping system and staffs unfamiliarity and discomfort with the use of technology in community environments.
- The paper based records in the sexual health service meant that notes were not always available of a patient attended at another clinic.
- We observed good use of the electronic patient record system for patients who were at the end of their life. This was accessible to all staff including those working out of hours. Care records were available for external care staff, such as care agencies and hospice nurses, visiting patients at home. At the time of inspection one third of GPs had access to the electronic patient record system.Staff had access to the trust intranet page. This held up to date information leaflets for families and patients and a link to the local acute hospital trust palliative care web page where guidelines for symptom control were available.
- There was a 24-hour advice line for health care professionals to access specialist palliative care support and advice. This was provided by community palliative care nurses with consultants employed by the hospice.Staff we spoke with appreciated the support of the specialist palliative care nurses (SPCN) for out of hour's advice and support. A member of staff told us "I have learnt a lot from the clinical nurse specialist about complex symptom control, especially nausea and agitation management."
- In the urgent care service staff had access to relevant patient information. There was an electronic patient information system which held patients' personal information, details, such as their next of kin and their family doctor, and details of previous attendances at MIiUs. For new patients this information was entered at the time of arrival. For returning patients, the information was checked and amended as necessary by the receptionist. Emergency assessment records generated for each MIiU attendance would be pre-populated with this information so that nursing staff were aware of these details when they assessed patients.

Consent

- Staff in community hospitals told us that they were aware of the relevant consent and decision making requirements of legislation and guidance. At Cirencester and Stroud hospitals staff were abl;e to talk members of the team through the process.
- The team saw an assessment format that was used to help staff assess the capacity of patients to make decisions about their care.
- The trust used a deprivation of liberty policy that had been developed in partnership with local health and social care providers. Staff at Cirencester and Stroud were aware of recent safeguards being put in place.
- Nursing and therapy staff in the integrated community teams and specialist services showed awareness of the need for mental capacity assessments to take place but tended to refer to other clinicians such as the G.P, mental health teams or social workers to complete the assessments. An audit completed by the Wheelchair service highlighted that mental capacity was rarely assessed when decisions were made about choices of wheelchair.
- Staff in the sexual health service were aware of the appropriate approaches to obtaining consent including awareness of the Gillick competence. Consent was sought if a patient declined a chaperone and the member of staff felt they required a chaperone for their own protection. The patient records viewed by the team showed that consent had been obtained appropriately.
- Staff asked for patients' consent prior to delivering any care for patients at the end of their life. This was recorded on the electronic patient record system. Patients were also asked to give consent for their information to be shared with other healthcare professionals such as GPs and specialist palliative care nurses. We reviewed six Do Not Attempt Cardio Pulmonary Resuscitation (DNAR CPR) forms on three hospital wards and in two patients' homes. These were

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

yellow stickers attached to notes. There appeared no standard place for them in a patient's records and in some notes it was difficult to find them. Therefore the form could easily be missed by healthcare workers.

- None of the DNAR CPR forms showed references to patients' mental capacity, and this was not easily found in other medical or nursing notes. It was not evident from patients' records which patients had or did not have mental capacity regarding making decisions around resuscitation. This meant it was not possible for the trust to audit how decisions had been made; whether advance decisions had been respected; whether legal proxies had been consulted; or whether national guidance had been followed.
- Throughout the inspection we observed staff asking children and young people for their consent. Staff were aware of Gillick competencies and gave us examples of how consent was used. Fore example the immunisation team obtained consent before clinics from pupils' parents. This was checked with the pupil during the clinic and their consent was also sought. Where pupils suddenly refused, their wishes were respected and discussed privately and / or with parents depending on the needs and wishes of the young person.
- In the urgent care service we saw evidence in patients' records that they were asked for their verbal consent before examinations, interventions and treatments were carried out. However we saw that some staff used a stamp to confirm "consent options discussed" but it was not documented what options or alternatives had been discussed. Staff we spoke with demonstrated knowledge and understanding of the Mental Capacity Act 2005 and their responsibilities in respect of patients who may not have the capacity to consent. They told us that they involved and consulted relatives and sometimes GPs, in decision making. An audit of clinical records in November 2014 highlighted poor documentation of consent. An action plan had been developed but had not been updated to show that actions had been taken to improve performance.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We judged caring to be good in all services with the exception of the community inpatient service where we judged it to be outstanding.

Overwhelmingly all service users reported care that was delivered with kindness and compassion and there was a strong, visible patient-centred culture. Within community hospitals patients said staff went the extra mile and it was clear that the care they received went beyond their expectations. It was clear that the anxieties of patients and their relatives were alleviated with the caring nature of all of the staff. Within community hospitals patients, carers and relatives were active partners in care and worked in partnership with staff..

Care offered by staff promoted people's privacy and dignity.

Our findings

Dignity, respect and compassionate care

- People are treated with kindness, dignity and respect while they receive care and treatment. Feedback about the care in community hospitals was overwhelmingly positive. This information came from the comment cards completed in advance of the inspection, from the observations and conversations that took place during the inspection and from information provided by Healthwatch.
- In February 2015, the trust launched the "hello my name is…" campaign with staff. This focused on making their initial personal contact with a service user and staff introducing themselves by name, making a personal connection. Throughout our inspection we saw staff being part of this campaign. Staff wore name badges and we observed how they always introduced themselves patients and relatives and in the services for young people this introduction was made to the child, young person and parents.
- The NHS Friends and Family Test had been introduced in the 12 months before the inspection and in the last quarter of 2014/15 had been extended to all services. Response rates were low for the services that had recently begun to collect data but shoed an incease as the process became embedded. Of all staff respondents in the last year 77.8% of staff stated that it was likely or extremely likely that they would recommend to the trust as a place as a place to receive care.
- The trust's overall PLACE scores for cleanliness, privacy, dignity and well being and facilities wre above the national average with all trust locations scoring above (better than) the national average in three out of four of the metrics.
- In the community hospitals we observed staff speaking with patients in a respectful manner and offering them choices. One patient was observed laughing and joking with the staff and they told us "this helped to pass the time". One patient with complex needs told us they were "being well looked after by the staff and had no complaints"patients said that they were confident that their privacy and dignity were always maintained and that they found this encouraging. We also observed external contractors (such as engineers) knock on doors and ask patients if they were allowed to come in. They would tell them exactly what they were going to do and how long they would take to do it. One member of staff we spoke with said "All of the staff treat the rooms as if it was the patient's home while at the hospital."
- In community services for adults we observed, staff showed respect for patients and their families and a commitment to promoting the dignity of patients. Cinderford district nursing team were recognised by the 'Celebrating You' awards, winning the 'caring 'category**.** The needs of patients with complex needs were considered with compassion. On home visits patients were given reassurance and clear explanations. In a cardiac rehabilitation class, patients were greeted by name and encouraged to share their concerns on a one to one basis. Feedback from Healthwatch described the staff at the outpatients department at Tewkesbury as kind, caring, polite, friendly and informative.
- In the community services for young people we accompanied some staff including health visitors on home visits. We saw that all the staff we accompanied were extremely friendly and professional at all times. We observed staff taking time to talk to children in an age appropriate manner and involved and encouraged both children and parents as partners in their own care.
- In the HIV service carried out a patient survey in 2014 in which 256 surveys were distributed, with 99 being completed and returned. The responses were mainly positive with 97% of patients stating they had been

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

treated with respect and dignity and that the staff were friendly and 93% felt they had sufficient privacy during their appointment. There were issues about the environment at both the Hope House and Milson Street clinics that were impacting on privacy and dignity, with awkward silences in crowded waiting rooms, conversations at the recrptionn desk being overheard and patietns sat so close together that it was difficult to complete forms privately.

- The team found that patients who were at the end of their lives were treated with compassion. During visits to patients in the community we found staff delivering high standard of care. They were kind and showed empathy, respect and compassion to the patient and their carers/ relatives. We spoke with five patients receiving end of life care. They all spoke highly of the staff and felt fully supported in their environments and their needs were being addressed.

Patient understanding and involvement

- People who use services and those close to them are involved as partners in their care. In the community inpatient services we observed that patients were actively included in ward rounds and conversations about their care. We saw in medical notes that relatives and carers were actively involved in a 'patients first contact assessment' to ensure that patients' and family's needs and goals were met. When discharge planning family meetings were held with the patients, their families, nurses, occupational therapists and social workers.
- In the community service for adults staff involved patients and carers in the planning of care during visits to patients in their own homes. Nursing staff empowered patients by giving information regarding their condition and their care plan. Therapy staff gave patients information to make informed decisions about options for assistive equipment in their homes. In an education class, staff checked patients understanding and provided clear explanations.
- In the community services for young people we accompanied some staff including health visitors on home visits. We observed how one health visitor took extra time and care to make sure the mother understood the purpose of the visits and the information given.
- In the community services for children and young people parents told us that staff always involved them in decisions about care and treatment for their children. We observed good examples of how staff involved children and young people as well as their families.
- In the sexual health service patients told us they had received written information from staff regarding their treatment and conditions which had also been explained to them on a one to one basis during their consultation. The quality survey conducted by the HIV service in 2014 found that 83% of patients considered they were involved in decisions that were made about their treatment and 76% felt they had had a choice and say in what was happening with their treatment. 97% felt they were given information by staff in an understandable way, they could ask the questions they wanted to and that staff listened to them.
- Patients who were at the end of their lives and those close to them were involved with their care. We spoke with four relatives in a community hospital and one relative in a patient's home. They told us they had been consulted about decisions and understood what was happening and why. Some family members had been invited to a multi-disciplinary meeting with staff to discuss future care needs for their relative. The patients we spoke with all acknowledged that they had been involved in their care, their wishes had been taken into consideration and they had an understanding of what was happening to them.
- In a trust-wide audit of clinical records in the urgent care sevice, undertaken in November 2014, 93% of records contained evidence of information given to the patient and 92% contained evidence of information given to relatives/carers. The records we looked at provided good evidence that patients had received clear explanations of their condition and given advice about after care, including what do if their condition worsened or they had concerns. We witnessed staff showing patients and their relatives their x-rays and explaining their injuries to them.

Emotional support

- People using services and those close to them receive the support they need to cope emotionally with their care, treatment and the condition that they are dealing with. People are supported to maintain their contact and relationships with their families, carers and friends.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- In the community inpatient services we observed that family members were welcomed onto wards and offered a seat by the nurses' station whilst they were updated about how their relative had been overnight. One carer we spoke with said that staff were teaching her how to provide personal care once her husband had been discharged and that "staff explained everything to me".
- In the community services for adults patients told us they felt listened to and that staff understood their needs. We observed a therapy visit where a patient with a debilitating illness was given emotional support. The respiratory telehealth service gave reassurance and an explanation of symptoms. Staff gave positive encouragement to focus on rehabilitation goals and the team saw examples of how this had been achieved for individuals.
- In the community services for children and young people parents told us they felt supported emotionally by staff. We observed staff providing emotional support to children, young people and their parents during their visit. A parent who had received support from the therapy staff said they were always available for support and advice. They told us "They are always positive and never give up on treatment".
- In the sexual health service patients told us staff were respectful of their wishes to have friends or family support them during their appointment. The HIV patient survey carried out in 2014 found that 91% of patients were able to discuss their worries or concerns with the staff and 94% felt that staff listened to what the patient said.
- Community hospitals reported good links with local chaplains of various denominations. We spoke with a chaplain at Stroud General Hospital who was on call for 24 hours per day. The chaplain said "it was a good place to die." They said they felt they were "a resource for staff and patients." The chaplain was able to offer time to sit with patients and able to assist them with their worries and concerns. The EOL action plan suggested a work plan looking at spiritual care however at the time of inspection the chaplain, who had a vast amount of experience, had not been involved in ways to take the actions forward.
- Community staff contacted relatives of the deceased on the day to offer support and advice, they then followed this up one week later with a visit or a call to the relatives. The community nurses and community hospital staff were able to signpost relatives for further bereavement support to, for example,charitable organisations.
- Staff treated people using the urgent care service with compassion, kindness, dignity and respect. Feedback we received from patients and relatives was entirely positive and this was consistent with the feedback captured by the trust in friends and family test surveys. All of the staff: patient interactions we observed were positive, from the receptionists who greeted people in a friendly and helpful manner, through to the nursing staff who exhibited sensitivity, care and a sense of humour, where appropriate.
- In the urgent care service staff were sensitive to people' anxiety and distress. We saw several examples of staff taking patients and relatives to a private room and providing reassurance and comfort.

Promotion of self-care

- People using services are routinely involved in their care both in terms of planning that care and in terms of taking action that will promote their health and well being. In one of the community hospitals we observed staff asking patients questions about what their goals were for their stay and supporting them in that. One physiotherapist asked a patient "what do you want to achieve while in this hospital?" informing their treatments on the needs of the patient.
- At the Kingham reablement unit, patients and families were encouraged to be involved in the decision to commence the rehabilitation programme. Carers were encouraged to provide weekly input and to be part of the multidisciplinary meeting.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Overall we judged that the responsiveness of services as requiring improvement. Individually urgent care, sexual health, community adult services, dental services and end of life services required improvement. We judged the services for childrens and young persons and community inpatients to be good for this domain.

Community inpatients had a wide range of activities available to them. We observed the positive impact these activates had on the wellbeing of patients.

Medical cover varied across community hospitals. During the day the level of cover was adequate. However, there were some concerns about the responsiveness of medical staff out of hours.

Complaints were generally managed well throughout all areas. Whilst the number of formal complaints was low compared to the England average, most complaints were addressed when presented as concerns, investigated and resolved at a local level.

Access to services varied. Within the end of life service there was a fast track discharge to enable patients to return home if they wished to die there. Within the sexual health service there was a single point of contact booking line which was managed at Hope House. This service did not meet demand and consequently patients experienced problems getting through to make an appointment and often ended up attending a walk in clinic. This resulted in patients being unable to access the treatment they required immediately as some procedures required staff to have additional competencies not always available at walk in clinics. There were very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation. Waiting list data was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear. within the dental service, some patients waited in excess of six months for treatment.

Whilst the urgent care service was consistently exceeding targets in respect of time spent in MIiU and the time people waited for treatment, waiting times had increased as demand for the service had risen and particularly at weekends as staffing levels did not always match the activity and pattern of attendances.

Referral processes to out of hours services were cumbersome and often entailed lengthy waits or travel to another hospital. Joint working between these two services needed to improve to ensure care pathways were convenient and reliable.

Premises were mostly fit for purpose and were appropriately accessible and laid out; however waiting areas at the Dilke Memorial Hospital and at the Vale Community Hospital out of hours were cramped and the triage area at Stroud General Hospital was not enclosed and therefore not conducive to a confidential consultation. Some areas within side rooms at Tewkesbury hospital had 'blind spots' which meant staff could not always observe patients and lights were such that they went out after a short while when patients used the ensuites.

Communication with patients whose first language was not English was assisted by the use of interpreters, translators and written information provided in a number of languages

Our findings

Planning and delivering services which meet people's needs

- The trust provided services that were commissioned through a block contract. The trust has identified that the lack of clear service specifications in respect of that contract is a key strategic risk for them and this was rated as a high red (15) on the board assurance framework. The trust has recognised that continued increases in demands for services is restricting flexibility and capacity to respond to needs for services to be provided in a different way or in different settings. The trust consider that there is insufficient scutiny given to proactive capacity planning across the whole of the health and social care economy in Gloucestershire.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- The services provided do reflect the needs of the local population but capacity is an issue. There were long waits for some services very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation. Waiting list data was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear. Within the dental service patients in some areas waited in excess of six months for treatment.
- Individual services worked hard to meet the needs of patients. For example in community inpatient services the lack of activities for patients had been raised with staff. We saw that hospitals had introduced many activities, such as high tea, bingo, exercise classes, 'pampering' sessions (for example massages), and games evenings. We saw consideration had been given to what might be important to the patient when deciding upon activities. For example, during the Wimbledon tennis tournament strawberries and cream were being provided for patients in the day room. They were able to watch tennis on a large TV in the company of other patients.
- Co-ordination of services for patients with complex care needs was good and this was supported through multi-disciplinary working involving other providers involved in health and social care.
- In September 2014 a report was commissioned to assess the end of life services for Gloucestershire Care Services. From this report an action plan/work stream was developed for community hospitals. There was work being carried out on the actions agreed but few had been completed. Due to the newness of the action planning there were no audits available to test its effectiveness. There was no evidence of an end of life strategy within the trust; however the action plan suggested a five year countywide strategy should be developed in the future.

Equality and diversity

- Services currently being delivered had been planned to meet the needs of different people and staff in the individual services responded to individuals in a positive way. However given the lack of service specifications it was difficult to find evidence that servies were planned in a way that took account of age, disability, gender, gender reassignment, preganancy and maternity status, race, religion, belief or sexual orientation. The team saw many examples of equality and diversity being responded to on an individual basis. It was clear that trust staff, at provider level and within individual services, undertook the needs of their client groups and were aware of how needs were different in different communities.
- Exampes of responsiveness to the needs of different people included the provision of meals that took account of religious or cultural needs, for example Halal, at Cirencester Hospital. We also found that generally disabled access to the community hospitals was good. However, we did find in Stroud Hospital that some of the disabled parking bays were inacessable because of a mobile screening van.
- The diabetes service had developed an innovative education project designed for black and minority ethnic groups in conjunction with representatives from these groups. The seminars were delivered at community venues, with separate sessions held for specific groups such as Sahara Senali, Asian elders, Asian ladies, Asian men, Eastern African, and African Caribbean. The content was agreed by participants and was open to family members as well as patients, and involved practical cooking sessions. This encouraged meaningful participation in action based learning relevant to the patient and their support network in a protected environment.
- Staff working with children and young people told us about complex care situations where religious and cultural considerations had informed their care plans including consideration of Ramadan, understanding of patients and families belief systems in relation to medication and pain control, awareness of prayer routines when planning visit times. The areas we visited were accessible to disabled people with regards to access into the building and facilities they were able to use such as appropriate toilets, and where lifts were not available, ground floor consutation rooms.
- The sexual health service had Information leaflets were available in the clinics for people in their first language and there were posters in waiting rooms in Polish. A

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

transalation service via a language interpretation line was available when required. Staff were clear that relatives were not relied on to provide translation services.

Meeting the needs of people in vulnerable circumstances

- The trust worked well with people in vulnerable circumstances. For the integrated community teams, meeting the needs of people in very rural areas was a challenge. The teams worked closely with 'village agents' (employed by borough councils) who had a comprehensive knowledge of resources in the local area. The Tewkesbury integrated community team were based in the same building as police services and staff have developed good links which aided identification of people who needed help from either service. Managers recognised that more could be done to engage with 'hard to reach' groups of patients.
- The homeless health service saw approximately 40 people daily, providing access to services such as immunisation, vaccination, health promotion and screening, drug and alcohol advice, mental health advice, podiatry and family/child/women's/men's health and development. An outreach service was provided where staff worked in pairs in collaboration with religious organisations to make contact with people in vulnerable areas of the city. The Kingham reablement unit worked closely with voluntary organisations to find suitable accommodation for homeless patients.
- At Stroud Hospital on Jubilee ward they had a 'tag' system in place in one of the bays used for observing patients who required more support and care from staff. This system ensured that a member of staff was always present in the bay and could not leave until 'tagged' by another member of staff. This was to help reduce the incident of falls and to observe patients who were confused.
- The wheelchair service had introduced a 'choose and book' system which had reduced the rates of non attendance to the clinic. The cardiac rehabilitation service worked with the acute trust and the local university to produce a training DVD for attendees which enabled patients to continue their education in the comfort of their homes.
- A steering group was in operation in the trust regarding the care and treatment of patients living with learning disabilities. The group included a user of services. Staff were confident of how to access specialist staff for support and advice if needed when providing care and treatment for people with a learning disability.
- Hospital and community staff had support and advice from a link nurses for people with dementia. The end of life link nurses worked with the dementia link nurses to provide care to those patients with both end of life needs and an encroaching dementia. There was recognition by staff that an individualised approach was needed to support patients with dementia as they approached the end of life.
- Patients who attended the minor injuries units with mental health problems were treated sympathetically but staff told us they had no specific training or guidance to assess people's mental health needs or provde appropriate care. They told us they sought support from the mental health crisis team employed by the local mental health trust. The response from this service was variable and there was limited availability of private spaces where vulnerable patients could be observed or available staff to observe them. Staff told us if they had concerns about a patient's safety they would arrange for them to be transferred to an emergency department.

Access to the right care at the right time

- The community health services for adults were not always planned and delivered in a way that met people's needs, particularly with regard to people being able to access the right care at the right time for non-urgent needs. There were very long waiting lists for occupational therapy and physiotherapy services both within the integrated community teams and in musculoskeletal physiotherapy, musculoskeletal clinical assessment and treatment (MSKCAT), and pulmonary rehabilitation.
- Waiting list data held by the Trust was unreliable for the integrated community teams and for certain specialist services such as podiatry, respiratory home oxygen service and heart failure service which meant that senior managerial oversight was unclear. Occupational therapists and physiotherapists did not work on the weekends and there was no plan to implement this.
- Access to care in the urgent care service was good. The trust consistently exceeded the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at MIiU. Annual

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

performance for 2014/15 was 99.8%, with 95% spending less than two hours in the department. In April and May 2015 the time spent in the department had increased slightly, with 95% of patients spending two hours and ten minutes and two hours and 15 minutes in minor injuries units respectively.

Complaints handling and learning from feedback

- In 2013/14 the trust had recorded 78 complaints. In 2014/15 63 complaints had been recorded. This is extremely low for a trust of this size and the team explored the reasons for this. All the staff that were spoken to about this, without exception, were aware of this low level.
- The trust had a complaints manager who addressed formal complaints received. An investigating officer was allocated to complete a full investigation of the complaint, The complaints manager was responsible to feedback to the complainant within 25 days.
- The team confirmed that 63 was an accurate account of the recorded complaints held centrally although it was not clear that there was similar accuracy in different service areas.
- The new complaints policy and procedure was ratified in May 2015 and the ethos, approach and culture described in it will be new to staff. This approach had not been widely promoted or shared with staff at the time of the inspection.
- The previous trust complaints team were disbanded in March 2015 and a new patient experience team formed, with staff working to different roles and under an interim manager. This was a move to achieve a more productive outcome on patient experience and move away from the previous less proactive approach to complaints management. This new team recognised they have not embedded the new approach to complaints management as described in the complaints policy yet or put all the systems and actions needed to make it easier to make and manage complaints. They were also still adapting to their new roles and have had an interim manager since August 2014 with a new substantive leader taking up post in July 2015.
- Many staff do not feel confident yet to encourage people to complain. Their approach is to get local resolution quickly, which is comendable, however it can prevent some of these people making a complaint about a local service to a local leader for fear of possible consequences. This is particularly the case in the care at home services. People are less likely to make a complaint, even though it could be the right avenue. None of the issues raised by patients and others and resolved locally are recorded anywhere and therefore no audit trail. This means that all the learning is lost to the trust unless the local senior staff makes a point of sharing it. There was quite a paternalistic view by many as they presumed the fix they adopted promptly was always the solution and couldn't offer any examples of how they subsequently evaluate their interventions. No evidence was seen that people are positively encouraged to complain
- There were new posters and leaflets in place across the trust. However they had a focus on people giving feedback and raising concerns. How to complain is included in the literature but it was not immediately obvious to the reader or that it is encouraged by the trust. There were leaflets available in reception areas at the minor injuries units; however we found there were given three different leaflets at different units. One leaflet entitled Tell us about your experience with us invited people to share their experience by recording these within a space provided within the leaflet. This could then be placed in a comments box in the department or posted to the service experience team. A second leaflet entitled How do I give feedback or make a complaint? outlined the complaints process and invited people to contact the service experience team. The leaflet also contained details of external organisations which could support people with their complaint. A third leaflet entitled We value your feedback (dated November 2013), which was available at Lydney and District Hospital directed people to the Patient Advice and Liaison Service (PALS). We judged this to be confusing for both staff and patients
- In a number of areas, in particular satellite services and on some wards in community hospitals there was very limited information about how to make a complaint and in some cases there was no information at all. In the sexual health service not all of the complaints which had been investigated locally were reflected on the trusts complaints log. It was therefore not clear who maintained the overview for all of the complaints received by the trust or if the number of recorded complaints was accurate.
- In services for children and young people staff encouraged children, young people and their parents or

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

carers to provide feedback about their care and questionnaires were available in clinics asking parents to indicate how likely they were to recommend services to friends and family.

- Across the trusts services the staff have created a supportive, caring and family feel to how care is delivered. This is likely to create an atmosphere which discourages some people from complaining if a possible complainant is not sure if they want or need to complain or not.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Overall we found that leadership required improvement. We judged the services for sexual health, dental, childrens and young persons, community inpatients and community adult services to be good for the well led domain. Urgent care and end of life care required improvement.

At trust level we found that governance processes and the management of risk and quality were improving but were not yet sufficiently robust. The executive team, with the exception of the chief executive, were relatively inexperienced but had insight into the issues. As a team the executives are very patient focused and this was particularly notable in the support areas of finance and estates. The chief executive has had a significant and positive impact both internally and externally. The listening into action programme has had a galvanising effect and staff were well engaged with it.

Most services were aware of the trust vision and strategy however we found within the community adults and community inpatient services there was some disconnection between frontline staff and the board in terms of awareness. Most staff were very positive about working for the trust

In general, people were able to give their feedback on the services they received; this was recorded and acted upon where necessary.

Governance processes were variable. Risk registers reflected the key areas of concern however there was insufficient assurance around safeguarding at board level. The trust-board lead for end of life care was unaware of the action plan devised from a recently commissioned report into end of life care services. There was no strategy for end of life care and there was no one person in a position to take end of life care forward and maintain responsibility for provision of the service, however local leadership was found to be good.

The impact of change to the out of hours service provision had been significant and had exposed deficiencies in governance and leadership of the urgent care service, exposing vulnerability in terms of staffing levels, skill mix, staff confidence and competence. Some steps had been taken to address this area of risk but this was not being managed in a structured way. The risks did not appear to have been given sufficient attention or priority by the trust board. Board members were not visible or influential in urgent care.

There was insufficient and variable information available to demonstrate the urgent care service was fit for purpose and able to respond to changing demands. Information about the workforce was particularly poor and we could not be assured that that short term steps taken to mitigate risks in relation to staffing were adequate.

Governance arrangements were in place to monitor audit outcomes, risks and incidents. Risk management systems were in operation and identified that the service manager assessed risks within the service and escalated them to senior management when necessary.

Within the community inpatient service, leadership and governance around the reduction of falls was extremely good. We found that the multidisciplinary team working with various organisations, risk analysis and the development of innovative mitigating actions had a positive effect on outcomes in the community hospitals.

The trust was established in March 2013 and had existed for over two years at the time of the inspection however there was a sense that it was a new organisation. It appeared that the circumstances in which the organisation was formed had had a significant impact and that the organisation had only recently started to move on from that. The circumstances were that a community interest company had been planned but this was successfully challenged through the judicial review process and that in the circumstances an exception to national policy was agreed and a new NHS community trust had been formed. Changes in the leadership of the organisation had followed with the chief executive leaving. This had been a period of significant uncertainty for staff.

Our findings

Vision and strategy

The trust vision was

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

"To be the service people rely on to understand them and organise their care around their lives".

The trust also uses the strap line "Understanding you" on internal and external corporate documents.

The trust had stated their values are to be Caring, Open, Responsible and Effective and these were referred to as CORE. These values had been developed in consultation with staff. A series of corresponding behaviours had been developed as follows.

Caring

- Respecting and valuing others
- Acting in the best interests of service users

Open

- Open in our communication
- Connecting with other and working across boundaries

Responsible

- Owning our actions
- Professional in attitude

Effective

- Ensuring the best outcomes
- Realising your full potential

The team were shown a core values framework that included detailed definitions of each of the behaviours across four categories. The categories were all colleagues, supervisors/managers/team leaders, middle managers/ heads of service and deputy directors/directors. The framework also listed behaviours that would indicate areas for improvement. At the time of the inspection this had not been communicated to staff.

The trust had plans to place to introduce values based recruitment and appraisal.

The trust had stated six strategic objectives as follows.

- Achieve the best possible outcomes for our service users through high quality care;
- Understand the needs and views of service users, carers and families so that their opinions inform every aspect of our work;
- Provide innovative community services that deliver health and social care together;
- Work as a valued partner in local communities and across health and social care
- Support individuals and teams to develop the skills, confidence and ambition to deliver our vision;
- Manage public resources wisely to ensure local services remain sustainable and accessible.

Staff displayed an awareness and understanding of the overall vision of the trust and of the values. Aside from the senior staff involved in the work on the values framework staff were less clear about expected behaviours and how they might align to the values. The trust had a plan to address this through the work described above.

The trust were developing a vision for community hospitals and involving partners such as primary care and Healthwatch in that. There was a recognition that the trust had not been particularly good at articulating the nursing vision.

Staff were aware of the overall strategy and approach as it related to their particular role and service. It was less clear that progress against the delivery of the strategy was monitored and reported in a consistent way outside the annual quality report. Progress was reported in terms of the different services and against major projects such as the introduction of the information technology system known as System one.

Governance, risk management and quality measurement

- The trust had set out their governance arrangements in the board assurance framework which was reviewed annually. The framework summarised the strategic risks faced by the trust and linked these to the six strategic objectives refereed to above. It also summarised the corporate risk register and this contained the most significant operational risks that had been identified by staff. Within the framework the owners of risks were identified and there were actions against the gaps in assurance and controls. The actions added up to a significant programme of work to improve risk management and assurance. Governance and risk management was maturing but was not yet well embedded. However the arrangements did enable the trust to recognise when help was needed externally and to frame their requests for that appropriately. The lack of maturity in some governance areas was a significant

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

challenge for the inspection team in obtaining trust wide data. There was readily available information for services and locations but looking across the organisation was more of a challenge.

- The non executive directors talked about the organisation being new and about systems and processes needing to develop. They were involved appropriately as chairs and members of Board committees and described their commitment to patients and staff. Executive and non executive directors took part in a programme of quality visits to a range of locations and there was a predetermined schedule. The programme included both community hospitals and community services such as podiatry and the community nursing service. Feedback from these visits was recorded and included non executives raising questions about available training.
- Changes had been made to the governance framework and arrangements from April 2015 that included changes to the board committee structures. These changes had been made to reduce duplication between sub committees and to refocus on strategic rather than operational matters. The Quality and Performance Committee was the key committee providing assurance to the board on all issues related to clinical and professional care, clinical governance systems and clinical risk management. It was also responsible for reviewing service delivery and monitoring improvement plans. The team heard that this was a pressured committee and that at times the discussion was too focused on the operational rather than strategic issues. There were plans to address this through board development.
- The trust had recognised that improvements in clinical governance were needed and there had been significant changes in both the team responsible for leading this and in the systems in place. These changes had increased in pace in the six months before the inspection with new roles having been created and staff still learning. There was a recognition that systems for risk, serious incidents, reporting and consistency of data and information were not fully embedded and that the evidence of improvement was not available yet. The quality and safety team displayed a determination to drive the necessary improvements. The medical director was not involved in the service improvement planning process which the team considered to be unusual.
- At the time of the inspection action was being taken to put a comprehensive board development plan into place. There were also improvements underway including the introduction of a board agenda cycle plan and new board paper templates were being introduced in July 2015 to improve consistency.
- There were clear programmes for internal and external audit.

Leadership

- With the exception of the chief executive all executive directors are in their first substantive posts and consequently are a relatively inexperienced team compared to other similar trusts. There had been some recent changes with the medical director recently appointed and the director of nursing going on secondment to a national role. There was a good functioning relationship between the chair and chief executive. The trust was using the foundation trust pathway as a framework for improvements and developments that were needed in any case. The achievement of foundation trust status was not being focused on as an end in itself. The leadership team had a consistent view of priorities around workforce and culture, sustainability and patient safety.
- Staff across the trust, staff side and partners all described the positive improvements in relationships since the appointment of the chief executive. Staff talked about the greater visibility of executives. Staff told us that they felt supported by the senior team, especially those who worked in the trust headquarters building. Staff side described positive relationships and productive discussions with the trust since the appointment of the chief executive. Regular meetings are held and there is an open door policy to enable issues to be raised between scheduled meetings.
- The effectiveness of communication from senior leadership appeared to be variable. The main communication tool was team brief. There was not a regular message from the chief executive. Staff told us that some senior managers were better at cascading messages than others. This was borne out by the

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

variation of awareness of key corporate messages amongst the staff that the inspection team met. As part of the listening in action programme, described below, the executive team had visited 53 sites across the trust to meet staff and discuss strategy and plans.

- It was difficult to establish from Board papers and minutes whether the non executives provided effective challenge and support to the trust. The non executive directors who met with the team felt that they did provide this but that this had not been recorded. There was some evidence from a recent observation of the board by another regulator that the level of challenge could be improved. At the time of the inspection there were plans in place for board development. It was clear to the team that both executive and non executive directors were committed to making the Board as effective as possible and to make the quality and safety of services a top priority.
- The trust was not meeting three of their priority areas related to staff, appraisal rates, sickness and training. The target for appraisals was 95% and at the time of the inspection was at 78%. There are plans to change the timing of the appraisal round to help increase this. The 12 month rolling average for sickness absence was 4.9% against a target of 3% and was higher than the England average of 4.2%. The single biggest reason for absence was stress, anxiety and depression. Actions to address this include a review of self certification and return to work interview arrangements, a review of the stress management policy and stress management training for managers. The target for mandatory training was 80% and achievement of that varied by course and at trust level varied between 71% and 88%.
- The trust considered that their relationships with partners was good. All partners referred to the openness of the organisation and recognised improvements in engagement but some expressed frustration with the pace of improvement.

Culture across the provider

- Staff at all levels in the trust described how the culture had changed since the arrival of the current chief executive. Staff talked about a very open and very patient focused organisation. Many staff felt that they were highly valued and that openness and honesty was encouraged and rewarded. Staff who had worked in commercial organisations felt that the culture was "amazing" in comparison and described this in terms of the support for colleagues and the focus on what was best for patients.
- The leadership recognised that some community staff had been through a period of prolonged change with some community staff having had five different employers over the last seven years. The listening into action programme was providing a route for long standing issues to be identified and tacked. Staff across the trust talked positively about the impact of the listening into action programme and this included staff who said they were initially sceptical about it.
- The culture was very patient focused and across all the services there was a determination to provide the best care possible. It was particularly notable that staff working in support services, for example estates and finance, were very focused on patients and the quality and safety of care.

Fit and proper person requirement

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- The trust worked to the NHS employment standards and pre-employment checks covered criminal record, financial background, identity, right to work, employment history, professional registration and qualification check. The trust conducted a check with any and all relevant professional bodies (for example, medical, financial and legal) and undertook due diligence checks for senior appointments. This for example, would exclude candidates who could not demonstrate they were capable. The trust was introducing additional checks for non-executive directors and included routine checks on the companies house website to identify any disbarment from running a business.
- The trust had amended their appraisal system and executive contracts to include the FPPR and to add it to the annual update to the declarations of interests of board members, a declaration that they remain fit and proper persons.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- We reviewed the personnel files of one executive and two non executive directors on the board, all have been appointed since the Regulation came into force . The files provided evidence that relevant checks had been done in line with trust policy.
- The trust had decided, after taking legal advice, that they did not require a disclosure and barring (DBS) check for all executives and non executives. The trust had stopped their rolling programme of DBS checks following an audit in 2010 (undertaken by the predecessor organisation). Job descriptions had been reviewed to decide which posts required ongoing registration and for those posts (medical director, nursing director, director of transformation and director of finance) all staff had been checked by apart from the medical director whose check was in progress. The trust are required to ensure that all appointees are of good character in order to comply with Schedule 4 part 2 of the Regulation. The trust confirmed their intention to undertake a basic DBS check for all board members.

Public and staff engagement

- The listening into action programme, launched in March 2014 was a key platform for engagement with staff. The trust had held five "big conversations" which had led to the identification of nine themes that would have an impact on the working lives of staff. The second stage had started in March 2015 and there was work going on across the trust to deliver the actions and improvements. The staff that the team met were universally positive about this initiative, even those who said that they had been sceptical at the start. Staff talked in terms of having ownership, feeling responsible and feeling that things were possible.
- The trust has a staff forum as a communication and feedback mechanism.
- Public engagement with individual community hospitals was strong with volunteers deployed in a range of roles and strong and supportive leagues of friends investing in services, facilities and equipment. When asked about wider public engagement senior staff talked in terms of formal consultations. The director of service transformation described how Healthwatch were engaged in developing a shared vision for the trust through their involvement on the transforming services group. The trust had a Your Care Your Opinion Group. This was a public feedback forum, held regularly and attended by between 50 -100 members of the public. The trust planned to develop engagement with the public through the membership scheme that would come as part of the foundation trust work.

Innovation, improvement and sustainability

- The trust had a five year financial plan and was confident that savings could be made without impacting on care by tackling inefficiencies and by improvements in productivity. The Service Improvement Programme (SIP) was on course to deliver £2.5m in 2015/16 of which £1.5 m was associated with the saving of administrative costs from the implementation of an IT programme. Other savings had come from changes in procurement and a focus on agency spend.
- A significant part investment for improvement had been made with the introduction of mobile working and a new information technology system that provided a single patient record. That programme was being rolled out across the trust at the time of the inspection. The system enabled staff to enter and update patient records and to complete referrals more efficiently. Those teams who had been working with the system for a while talked positively about the improvements. Other teams were still getting used to the system and some were not aware of all the functionality available to them.
- Staff were encouraged to be innovative in service development. Examples included the development of a game called "swigger", developed with the police and community pharmacy, which was used to highlight alcohol related health issues to older people and the use of "twiddlemuffs". These muffs, made by volunteers and staff, were woollen muffs decorated with items that people could hold and fiddle with. Patients and in particular patients living with dementia were using these muffs to occupy restless hands and there was evidence that their use had a soothing and comforting effect on patients.
- The trust recognises and rewards innovation and high quality service through the Celebrating You staff awards. There had been 160 nominations for the latest round of the awards. The team saw examples of the filmed nominations for the awards. Talking to the teams and staff who had been nominated and received awards it was clear that this form of recognition was genuinely valued.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12: Safe care and treatment: 12(2)(g) the proper and safe management of medicines. The provider did not have systems in place within the childrens complex care team to make ensure medicines were administered safely to children. Medicines were drawn up by parents, left in unlabelled syringes ready for health care assistants to administer. This meant the staff could not be confident in what medicines they were actually administering which in turn placed the child at risk of receiving inappropriate medicnes or doses. The provider did not have systems in place to secure and audit how external prescriptions were used within the health visiting teams. Systems did not exist to safely monitor these prescription forms to prevent their misuse. Medication must be kept securely stored in all areas at all times Emergency medication must be checked regularly for expiry dates

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9: Person – centred care

This section is primarily information for the provider

Requirement notices

9(2) Providers must make sure that they provide appropriate care and treatment that meets people's needs, but this does not mean that care and treatment should be given if it would act against the consent of the person using the service

In some cases, people's preferences for their care or treatment may not meet their needs. Where this is the case, and people lack capacity or are detained under the mental health legislation, providers must act in accordance with the mental capacity Act 2005

9(3)(a) carrying out collaboratively with the relevant person, an assessment of the needs and preferences for care and treatment of the service user

9(3)(d) enabling and supporting relevant persons to make or participate in making, decisions relating to the service users care or treatment to the maximum extent possible

The trust was not providing the following information in relation to DNA CPR through faliling to:

- Provide effective recording of decisions about CPR in a form that is recognised and accepted by all those involved in the care of the patient
- Ensure effective communication with and explanation of decisions about CPR to the patient, or clear documentation of reasons why that was impossible or inappropriate
- Providing effective communication with and explanation of decisions about CPR to the patient's family, friends, other carers or other representatives, or clear documentation of reasons why that was impossible or inappropriate
- Providing effective communication of decisions about CPR among all healthcare workers and organisations involved with the care of the patient.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (Part 3); Good governance 17 (1) Systems and processes were not established and operating effectively to ensure compliance with the requirement in this part of the Act. - The provider conducted limited clinical audit and failed to act on identified areas for improvement. 17 (2) (a) - The provider had insufficient information to properely assesses whether the service was operating effectively and safely and was able to respond to changing demand.17 (2) (a)
	Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3): Safe care and treatment. 12 (1) The provider did not provide care and treatment in a safe way: - Patients arriving at MIiUs did not always receive prompt assessment (triage) by an appropriately trained and experienced registered nurse.12 (2) (a),(c) - The layout of some MIiUs did not ensure that patients seated in waiting areas could be observed by staff. 12 (2) (d) - There were inadequate systems in place to ensure that resusictation equipment was safe to use. 12 (2) (e) - We could not be assured that medicines were always strored at the correct temperatures 12 (2) (g) - Cleaning checklists were not consistely completed to show that cleaning tasks had been undertaken. 12 (2) (h)

This section is primarily information for the provider

Requirement notices

- The provider's systems to identify risks were not operating effectively. Staff were not consistently reporting concerns. 17 (2) (b)
- The provider failed to mitigate risks associated with staffing levels in an appropriate timescale. 17 (2) (b)

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18(1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. The provider must review the arrangements and accessibility of the system in place to enable patients to telephone the service to make an appointment.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 (1) (e) All premesis and equipment used by the service provider must be properly maintained. We found that resuscitation equipment was not being appropriately checked according to national guidance in the community hospitals. Evidence was found at Tewkesbury, North Cotswolds, Dilke Memorial Hospital, and Lydney and District Hospital showing that these checks had not been completed or appropriately recorded.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulation 12 (2) (c) Care and treatment must be provided in a safe way for service users. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – (c) ensuring that persons providing care or treatment to the service users have the qualifications, competence, skills and experience to do so safely.

We found evidence that levels of compliance for mandatory training were unacceptable and that the trust did not have appropriate oversight or control over this.