Gloucestershire Care Services NHS Trust

R1J

Community health inpatient services

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1J06	Cirencester Hospital		
R1J10	Dilke Memorial Hospital		
R1J11	Lydney and District Hospital		
R1JX2	North Cotswolds Hospital		
R1J13	Stroud General Hospital		
R1J18	Tewkesbury Community Hospital		
R1J07	Vale Community Hospital		

This report describes our judgement of the quality of care provided within this core service by Gloucestershire Care Services NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement 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.

Where applicable, we have reported on each core service provided by Gloucestershire Care Services NHS Trust and these are brought together to inform our overall judgement of Gloucestershire Care Services NHS Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Overall rating for this core service Good

We rated Gloucestershire Care Services NHS Trust as'good' overall for its inpatients service. This trust provided inpatient services at seven community hospitals with 196 beds between them. Care was provided by nurses, healthcare assistants and allied health professionals. Medical cover was provided either by visiting consultants from the local acute trust or by general practitioners.

We rated safety as'requires improvement'. We found a proactive culture of incident reporting and safety performance within all of the community hospitals. However the threshold of what staff considered a reportable incident varied. We saw medicines were appropriately managed according to local policy. Records were mostly complete and concise and the managementof patient risk was well documented. The wards were well staffed according to safer staffing requirements. There were deviations from this but matrons were able to justify the reasoning behind this. Some elements of the environment at Tewkesbury Hospital were not conducive to safe patient care. Bathroom lights turned off automatically while patients were in the bathroom and nurses were not able to observe patients at all times.

We rated effectiveness to be 'good'. We found positive examples of evidence-based practice being utilised at all of the hospitals. We saw evidence of how changes to best practice had influenced change in both practice and policy. We found an outstanding culture of multidisciplinary working embedded throughout the organisation. Multidisciplinary team meetings were effective and detailed discussions took place about the needs of patients and carers. We saw a fully integrated approach to the management and recording of care records using an integrated care form, allowing all disciplines to work together effectively. Nutrition, hydration and pain relief were managed effectively. Staff were mostly positive about the quality of their appraisals and support received in relation to gaining competencies. However, in surgery staff felt that opportunity to maintain certain competencies was limited due to limited access to specific types of care.

We rated caring to be 'outstanding'. Environments were calm and happy places. We saw examples of care where nurses and doctors sat with patients to have casual, friendly conversation and were laughing with them. We found that there was a strong patient-centred culture within all of the community hospitals and that patients, carers and relatives were active partners in their care. Patients said that they were treated excellently and that all grades/disciplines always tried to spend as much time as possibleth them. Care offered by staff was kind and compassionate and promoted people's privacy and dignity. In some hospitals we found that all staff, including external contractors, treated rooms as if they were patients' homes and asked for permission to enter. Staff recognised and respected people's needs and always took this into account when delivering care. Patients said that they were always treated as an individual and that they were always asked for consent when an intervention from a staff member was needed.

We rated responsiveness as 'good'. We found that the service was planned and delivered to meet people's needs. The average length of stay was 16.9 days which was slightly above the trusts target. Targets had been set to ensure the correct mix of direct access (admittion through GP's) and acute access patients. We found elements of outstanding practice in the community hospitals. The range of activities available to patients met their needs. Examples of these included strawberries and cream being available during the Wimbledon tennis tournament, drama therapy, and pampering sessions. We found that medical cover varied between sites. Some cover was provided by general practitioners and others by consultants from the local acute trust. There were some concerns about the responsiveness of this cover out of hours. We found that most complaints were managed well at local level..

We rated the well-led domain as 'good'. We found that the service vision and strategy were substantive, measurable and realistic and that projects for improvement were making progress. We found a positive culture of risk management and managers had good oversight of risks. Risk assessments and risk registers were comprehensive and information was disseminated appropriately. The leadership and governance around the reduction of falls

Summary of findings

was outstanding. 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 hospitals. We saw very good local leadership in all of the community hospitals and this was reflected in the culture of the staff. Matrons led by example and were supportive of all their staff. However, we found that there was a disconnection between the community hospitals and the executive team. Staff said that communication from the executive team had little meaning and that the staff were not widely visable in the community hospital although this had been improving.

We found two breaches of regulations. Firstly, we found that resuscitation trollies were not appropriately checked and there was some inconsistency in recording of these checks. We also found that the level of compliance for mandatory training did not provide assurance that staff were appropriately trained to provide safe care and treatment for patients. There was disparity between local records and records held centrally by the trust. A level of compliance was recorded differently at a local level than that held by the trust and there was little trust oversight.

Summary of findings

Background to the service

Information about the service

Gloucestershire Care Services NHS Trust provided adult inpatient services for 196 beds (general practitioner and nurse-led) in 10 wards over seven locations and employs nurses, therapists and healthcare assistants to provide rehabilitation care for the county of Gloucestershire. All of the hospitals also had a dedicated workforce of volunteers.

During our inspection we visited Cirencester Hospital, Stroud General Hospital, Lydney and District Hospital, Dilke Memorial Hospital, North Cotswolds Hospital, Vale Community Hospital and Tewkesbury Community Hospital. Day case surgery was performed at Stroud and Tewkesbury Hospitals and included orthopaedic, ophthalmology, vascular and general surgery.

The inspection team consisted of Care Quality Commission inspectors, specialist advisors, and an expert by experience. We spoke with 92 staff, 39 patients and 11 carers or relatives. The staff we spoke with were a mixture of managers, matrons, sisters, nurses, healthcare assistants, healthcare professionals, students, volunteer's cleaners and porters

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 this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.

How we carried out this inspection

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 service and asked other organisations to share what they knew. We carried out an announced visit on 24, 25 and 26 June 2015. We also conducted unannounced inspections on 4 July 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

Summary of findings

observed how patients were being cared for and talked with patients attending the clinics to seek their views. We reviewed care or treatment records of patients who used the service.

What people who use the provider say

Feedback from patients we spoke with during our visits confirmed they were all happy with the way they were treated by staff. Comments we received via comments card were also entirely positive. Comments included: "my elderly mother has and continues to receive first class care on this ward, the staff always show compassion". Another said "the care has been excellent; everyone has been helpful cheerful and very caring".

One patient we spoke with said "They are treating me brilliantly; I am only in for day surgery. Food is not too bad, we are given choices. Care is very good; the nurses have made me feel very comfortable". Another said that "I have always loved Stroud Hospital, everyone here is lovely and caring, they treat you very well"

Good practice

- The volunteer groups were an integral part of the care team. 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, visable patient-centred culture that was embedded throughout the community hospitals. Staff provided compassionate care in partnership with patients and relatives with total respect and understanding to people's needs and wishes.
- People's individual needs were met in all of the community hospitals . A range of social activities were arranged such as opportunities to enjoy strawberries and cream during the Wimbledon tennis tournament or attend activities such as 'pampering' sessions, exercise sessions and drama therapy. These were all imaginative ways of enhancing patients' inpatient stay and improving their wellbeing.
- There was a detailed and innovative approach to falls management and prevention. A multidisciplinary approach was used to collect data, analyse it and mitigating actions were put in place. This was having a significant impact on patient care. Examples of this was the introduction of a 'tagging system' for 1:1 care (ensuring that one member of staff was always in the room for support) and safety huddles.
- There was a multidisciplinary approach embedded throughout the community hospitals. This was evident both through ongoing care of the patient with the integrated care record, and through multidisciplinary team meetings to enable effective discharge planning.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- Ensure that staff have the necessary mandatory 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 that 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.

Action the provider SHOULD take to improve

Summary of findings

- 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

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We judged safety as requiring improvement. Patients were not always adequately protected from avoidable harm. Resuscitation trollies were not always appropriately checked. 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.

We found a proactive culture of safety and incident reporting and safety performance within all of the community hospitals. Staff were able to describe their responsibilities in relation to incident reporting and could give examples where they had to used the incident reporting process. We found that learning was disseminated to ward teams and changes to policy and process had occurred as a result. However, the threshold of what staff considered a reportable incident varied and some teams did not receive regular feedback from incidents.

Medicines were appropriately managed. Medical records were mostly complete, concise and the management of patient risk was well documented. We saw risk assessments and plans which mitigated safety concerns for patients and appropriate monitoring and assessment of patients' care.

All wards were well staffed according to safer staffing requirements (requirements for the minimum levels of staff on an adult inpatient ward).

The environment was mostly fit for purpose; however 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.

Detailed findings

Safety performance

- There had been 14 serious incidents requiring investigation (SIRI) between January 2014 and January 2015. Of these incidents, nine had been falls and two

had been grade three pressure ulcers (full thickness tissue loss). Others had included a delayed transfer from a community hospital to an acute provider, and one case of infection (Clostridium Difficile or C Difficile). Stroud Community Hospital had the highest reported number of SIRIs with a total of five between April 2014 and March 2015, including three falls, a grade three pressure ulcer, and a delayed discharge to an acute hospital.

- The trust used the NHS Safety Thermometer for recording levels of harm free care. This is a national tool that provides a way of trusts measuring and comparing their performance in four key areas of safety; falls, pressure ulcers, venous thromboembolism (VTE) and urinary tract infections (UTI's) in patients with catheters. This required the data for one day a month to be collected and analysed. Data provided by the trust showed fluctuating results for falls (average of 3.4 per month), pressure ulcers (average of 11.9 per month) and UTI's.
- It is considered good practice by many trusts to display safety thermometer results. We saw that there was inconsistency in how this data was displayed in the community hospitals. One hospital had on display a poster stating they were working towards 100% harm free care. We also saw graphs displayed showing safety performance. However, when asked about it, staff found them difficult to interpret and explain to inspectors. We also saw "no harm" certificates which were issued by the trust to a ward if they had gone at least one month harm free. We saw at one hospital that the number of falls was displayed.
- The trust listed their priorities for the year 2014 to 2015 in their quality account. One priority was to reduce the number of falls in community hospitals. The trust had made a number of pledges to meet their goal and these included "routinely monitoring their performance in minimising harm from falls whilst maintaining each patient's independence and supporting their rehabilitation". There were 911 falls reported in 2014/15. This was less than the previous year when 1006 falls were reported. A falls prevention group had been created which focused on an action plan around reducing falls. Data showed a continued reduction in falls reported between April 2014 and January 2015 in all community hospitals, with the exception of Tewkesbury Community hospital, which was just over their target from the previous year. This hospital identified this as an issue and actions were taken around it and during our inspection had the lowest number of falls of any of the community hospitals.
- The trust was committed to reducing the number of incidents relating to pressure ulcers and had made a number of pledges to help achieve this target. For example, "ensuring that the specialist tissue viability nurse (TVN) reviewed and reported against all acquired grade two, three and four pressure ulcers". We spoke with the TVN service who told us all grade three and four pressure ulcers were reported via the trust's electronic reporting system and they then assessed and reviewed.. The trust's target for a reduction of hospital acquired pressure ulcers was less than 170 from the previous year 2013/2014. For the year 2014/2015 there were 119 acquired pressure ulcers of grades one to three. The trust had no hospital acquired grade four pressure ulcers during this time period.
- Patients were assessed for risks of venous thromboembolism or blood clots. The trust had a target for 2014/15 which required that 95% of patients had a VTE risk assessment completed. The trust had exceeded their target, achieving 98%.
- The trust undertook mortality reviews in their community hospitals. We saw records of learning the trust wanted to take forward from these, for example, to improve the recording and review of resuscitation status, to improve the recording of conversations with the patient and their family and improve the legibility of recording in patients' medical records.

Incident reporting, learning and improvement

- We reviewed board papers that raised concerns regarding a lack of understanding about incident reporting in some areas and that feedback need to be communicated more effectively to raise awareness. However we found a positive culture towards incident reporting, and found that lessons were learned when things went wrong.
- Staff in all community hospitals were able to describe the processes of reporting an incident via the electronic

reporting system. Staff told us this was easy to do, although time consuming. Many staff we spoke with had reported incidents. However, not all staff said they had received feedback once they had reported an incident.

- Senior staff told us about the learning that was shared following a SIRI investigation. We saw a completed investigation following a fall that resulted in a patient fracturing their hip. This listed areas for improvement. This was then discussed at the matrons' clinical and patient safety meetings and was then shared with all staff on all wards across community hospitals by matrons.
- A senior manager told us that there was a good culture of incident reporting in the community hospitals. However they were aware that they were low reporters when compared nationally. The trust was taking action to identify the causes of this. The exercise was ongoing but had identified that medication errors (for example, missed dose of medicines) were not routinely being reported. This had been discussed at the board, at governance meetings and on the wards to identify how to make improvements.
- We found the threshold for staff reporting incidents was high which resulted in a culture of under reporting. Some staff said they would not report missed medicines errors routinely and would not record when medical notes were not completed appropriately. This meant staff missed opportunities to learn from such incidents.
- Day surgery teams described reporting incidents but not receiving feedback. The staff felt this was restricting their opportunities to learn and improve from incidents.
- Falls had been identified as a high risk in community hospitals. The trust had set up a falls best practice group to develop the service and to influence policy on falls prevention. Trust managers had oversight of this group and were working towards meeting the National Institute of Clinical Standards for this. 'John's campaign' (a national programme raising awareness for needs of patients with dementia) had been considered as part of this. Lessons were also being learnt to prevent falls and ideas were being considered from multiple staff groups in the hospitals.
- A senior manager told us that the trust had always had a culture of being open and honest when mistakes were made and said that the introduction of Duty of Candour in November 2014 made processes more robust. Senior staff in the community hospitals told us they were aware of the duty of candour and followed its principles. The duty of candour sets out explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment.
- It was also explained that the phrase "duty of candour" was not well known throughout the hospitals. However, staff knew what the duty was, how it had been implemented and could give examples of where they had used it. One member of staff said that they always inform patient of incidents and commented that "honesty does not skew expectations".

Safeguarding

- Most staff we spoke with could describe their responsibilities to safeguard people from abuse. Staff were able to give examples of when they had to escalate concerns to their line manager and said that any concerns were addressed quickly. Some staff said it was beneficial having a social worker on site to act as the link between them and the local authority. There were at team of social workers who attended the wards and multidisciplinary team meetings each morning. Each hospital was assigned a social worker.
- There was a safeguarding hotline available 24/7. Staff also had access to the local authority for advice. There were safeguarding flow charts available to staff displayed on office walls to highlight the correct safeguarding process for staff to follow in the event of a concern.
- Adult and child safeguarding training was provided as part of induction and covered both adults and children. Once this had been completed staff undertook a three yearly update via e-learning. Qualified nurses also attended the local county council's safeguarding training. Whilst staff we spoke with said they had received safeguarding training, matrons were unable to provide any data to support this.

Medicines

- We looked at medicines management at four community hospitals. We found that medicines were ordered, stored and used safely within the legal frameworks. A safe and secure handling of medicines

checklist had been used at ward level annually to check that medicines were stored appropriately. We were told each site/service was responsible for taking any action required and this would be reviewed at the next annual check.

- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with the Misuse of drugs Act 1971 and its associated regulations. The Standard Operating Procedures for Controlled Drugs had been reviewed and updated in April 2015. Incidents involving controlled drugs were reported via the Trust's incident reporting system. These were investigated by the Accountable Officer for controlled drugs.
- The trust had recently changed the pharmacy providing their services. Following this change none of the inpatient units had an on-site pharmacy but all received a twice weekly clinical pharmacy visit, with one having three visits each week. Each unit had a weekly medicines top up service to ensure medicines were available for patients. However one ward in one of the community hospitals had opened after the change of pharmacy provider had occurred. Staff told us they did not receive any clinical pharmacy visits or a weekly top up of medicines. The head of medicines management told us this ward had not been included in the contract with the pharmacy provider and they were considering what level of service was needed. Alternative arrangements had been made to ensure that the ward and patients were kept safe. The trusts pharmacists were on site and worked closely with the provider to ensure all patients got their required medicines.
- Medicines were delivered to the inpatient units twice a day Monday to Friday and on Saturday mornings. Arrangements were also in place in case medicines were needed outside of standard working hours. We saw an example of a medicines management newsletter dated June 2015 giving additional information to staff about the new pharmacy arrangements.
- The Trust used the same prescription and administration record sheets as the local acute trust; many patients had been transferred from this acute trust. We looked at 38 records on the units we visited. Records showed that staff had given patients their medicines as prescribed for them. On the morning of our inspection we saw staff had not recorded whether they had given one person their prescribed antibiotic. Staff contacted the previous nurse to check whether the medicine had been given so they could give it later.
- There was space to record medicines reconciliation on patients' prescription and administration records. If patients had been transferred from the acute hospital this had sometimes been completed by staff there. Other charts had no record of medicines reconciliation. Staff told us they used information from the patient's GP, or a hospital discharge letter, or the continuing prescription and administration chart to make sure patients medicines were reconciled and they received the correct medicines whilst in hospital. It was not clear whose responsibility it was to make sure that medicines were always reconciled. This meant there were sometimes delays in this process.
- Systems were in place for staff to record medicine errors. Information provided by the Trust showed 360 medication incidents had been reported for 2013-14 and 228 for 2014-15. Staff we spoke with confirmed they knew how to report medicines errors. The head of medicines management told us reviewed all medicines related incidents. We saw feedback from incidents reported in a Medicines Management Newsletter for June 2015. As a result staff were able to learn from these events and reduce the risk of them recurring.
- Patient Group Directives (PGD) allow specified health care professionals to supply and / or administer a medicine directly to a patient with an identified clinical condition without the need for a prescription or an instruction from a prescriber. National guidance was followed in the production of PGDs to ensure they were safe to use.
- Monthly Hospital Antibiotic Prudent Prescribing Indicator (HAPPI) audits were carried out to monitor the five key factors associated with antibiotic prescribing. The results for 2014-15 showed improvement from the previous year. Staff on one unit showed us an example of a tool, they used regularly, for assessing medicines management; this included looking at a sample of five patients' prescription charts to check medicines had been given correctly.
- The Trust had a policy, including risk assessment, and storage to support limited self-administration of

medicines. Staff told us this was usually limited to the use of inhalers and insulin injections if patients had been assessed as able to manage this. This policy was due to be reviewed. Staff were able to ask the pharmacy to provide medicines in weekly compliance aids if they assessed that patients would benefit from this at home.

Environment and equipment

- We found resuscitation trollies were not checked appropriately according to Resuscitation Council Guidelines in some of the community hospitals. At North Cotswolds, Lydney, Cirencester and Stroud Hospitals records showed that defibrillator checks were only done weekly. This increased the risk of the equipment not being maintained appropriately. At North Cotswolds and Cirencester Hospitals there was a daily checklist for the defibrillator; however there were occasions where the records showed the check had not been carried out daily.
- Daily checks of the suction equipment at North Cotswolds Hospital were not always conducted. We found seven occasions in the month prior to inspection where checks had not been completed.
- We raised our concerns about the resuscitation trollies and at North Cotswold's Hospital we were presented with an action plan to raise awareness of the importance and the process for checking the resuscitation trolley. This was in draft format and did not identify dates to achieve the mitigating actions.
- Tewkesbury Hospital historically had the highest rate of patient falls of any of the community hospitals. At Tewkesbury Hospital each patient had an individual room with an ensuite. We found that each room had several 'blind spots' both in the corridor (the nurses could not see in all of the rooms at the same time), and in the room itself. We identified several places where a patient could stand without being visible to nurses unless they were in the room. We also found that the bathrooms were poorly designed and did not have adequate space for wheelchair access. The doors into the bathrooms were folding doors which could confuse patients, thereby increasing the risk of falls. We were also told that the lights in the bathroom went out after a short amount of time. This meant lights could go out when people were seated on the toilet. We were told that emergency pull alarms could not be heard by nurses if the door to a room was closed. We were told that more speakers had been ordered so that nurses could hear but they had waited several months to get funding approved by the trust We raised these concerns with the trust during the announced inspection and were told that immediate action would be taken to mitigate these risks. We visited Tewksbury hospital as part of the unannounced inspection and found that no mitigating actions had been implemented.
- One of the patient rooms at Tewkesbury Hospital had been awaiting repairs for some time to a shower which was running water too hot. This meant the shower had been put out of order and any patient who stayed in this room had to use a shower in a different part of the ward. We were told there were delays in repairs occurring here as the building was still under responsibility of the builders. For example, staff described a delay of five months to get a keypad fixed on a door.
- At Tewkesbury Hospital in the post-anaesthesia care unit in day surgery call bells could only be heard in the day unit, increasing the risk of a patient requiring assistance not receiving it. This was recorded on the risk register and processes had been put in place to ensure that staff were are never in there on their own. This had been on the risk register since April 2014.
- We observed at Lydney and District Hospital there was a cleaning cupboard within the controlled area of the diagnostic imaging suite. Staff were entering this area without being supervised by a radiographer (as stipulated by the trust's local rules) and had not received any training concerning the principles of the local radiation protection rules for that unit. This meant that there was an increased risk to exposure of radiation to staff.
- All the equipment we checked was within its servicing date and was tested for electrical safety. Most of the equipment was maintained by an external company who routinely replaced equipment and medical gasses.
- We were shown a variety of slings available at Cirencester Hospital for use with the hoists. Different sized hoists were available depending on the assessed needs of patients.
- All but one of the community hospitals, had achieved higher than the England average scores for condition, appearance, and maintenance scores of 95.2% in PLACE

assessments. The highest scoring hospital was Vale Community Hospital (99.6%) and the lowest scoring was Lydney and District Hospital (90.8) which was below the England average. This showed that the environments were in a good condition, had a good appearance and a good standard of maintenance. Lydney and District Hospital was in an old building and maintenance and repair was ongoing.

- Theatres were clean, tidy and free from clutter. Adequate storage was provided in these areas. Hazardous products, such as cleaning products, were suitably stored in locked metal cupboards.
- Staff at Tewkesbury Community Hospital told us how they managed their waste. There were different coloured bags for waste, for example, black was for every day rubbish, yellow for clinical waste and orange for infected clinical waste. Laundry was placed into red bags if soiled or infected and then into white laundry bags. Sharp instruments were disposed of in special containers. There was a system in place to collect food waste and recycling. External providers collected the waste from a designated area outside of the hospital building. Different coloured floor mops were used for certain areas, for example, patient rooms and the kitchen.
- All surgical kits/sets required for surgical procedures at Stroud General Hospital were cleaned at the Central Sterile Stores at the local acute hospital. Once a set/kit had been used at Stroud General Hospital it was packed up and sent to be re-sterilised. Deliveries and collections took place daily Monday to Friday. All equipment used was traceable and stickers were placed in patients' notes. If any implants were used during surgery details of these were also documented in patients' notes and in the theatre register for traceability.

Quality of records

- During our inspection we saw that medical notes were accurate, complete, legible and up to date. We reviewed 6 sets of medical notes. In one set of notes we found that the patient had been assessed in relation to moving and handling requirements and had scored 12 (assessed as a medium risk). However the plan of actions required had not been completed. We also found that not all staff who had written in or had undertaken risk assessments had signed and dated them when they had completed them.
- We saw in all community hospitals that medical records were stored securely in locked trollies.
- The trust was in the process of implementing a new computerised paperless records system. This had recently been introduced at Cirencester Hospital. Staff were able to show us the system but said they were still learning how to use it. The trust had provided extra staff to support the introduction of the new system.

Cleanliness, infection control and hygiene

- All wards and theatres we observed were clean. Staff were bare below the elbow in all clinical areas in accordance with trust policy. Staff in theatres wore appropriate clothing. We observed ward staff wearing protective clothing when required, for example when assisting patients with personal care. 'I am clean' stickers were used on all pieces of equipment, including alcohol gel dispensers stating when they were last cleaned.
- All community hospitals had a higher cleanliness score than the national average of 97.3%. The highest scoring hospital was Cirencester Hospital (99.88%) and the lowest scoring hospital was Lydney and District Hospital (97.4%).
- There were four cases of Clostridium Difficile reported in March 2015. One reported in Cirencester Hospital and three in Dilke Memorial Hospital, bringing the total number of cases in 2014/2015 to 17, against a tolerance level of 21. It was agreed with the Clinical Commissioning Group that eight of these cases were unavoidable in the trust's care.
- Patients who required 'barrier nursing' (this is where they were nursed in a side room and signage was on the door explaining the precautions required due to a possible infection) had gloves and aprons available outside their rooms. We observed staff following these instructions except for one occasion which we reported to the ward sister.
- Staff had the option to use 'single patient use' slings for hoists which mean they were discarded once the patient left hospital, or a sling that was then sent to the laundry

to be cleaned between patients. There were also sliding sheets available to help turn patients when they were in bed if they had limited mobility. These were 'single patient use' or material sheets that were also sent to be cleaned between patients. This was to prevent the risk of cross infection.

- Wards had infection control teams who managed monthly hand washing, mattress cleanliness, kitchen cleanliness, and corridor cleanliness audits. One member of staff we spoke with performed covert hand washing audits and had found that rates of compliance were maintained during this. This information was disseminated to the matron and senior sisters and was available on the shared computer drive. If areas were failing to achieve the minimum standards when audited, their audits were repeated every week or more regularly if required. Audits involved the estates team as well as the clinical team.
- The hospitals took part in Credits for Cleaning (C4C), an NHS approved monitoring package which performs random weekly audits of high, significant, and low risk areas. Results from these were averaging 99%, which was higher than the trusts target.
- We found that some of the buildings were new (such as North Cotswolds Hospital and Tewkesbury Hospital and some were older. Some staff told us they found complying with the infection control policies in relation to cleaning difficult. They told us that there was not always time to perform all tasks when required as there were 'nooks and crannies' and issues related to age of the buildings.

Mandatory training

- Statutory and mandatory training was undertaken via e-learning or face to face. When e-learning training was completed it was logged automatically with centrally held records held in the learning and development department. When completing face to face learning we were told the facilitator kept a paper copy register, the facilitator then logged the record centrally.
- There was clear discrepancy between the data provided by the trust and that held at a local level for mandatory training. We were shown data which indicated that the average rate of completion for mandatory training at North Cotswolds Hospital was 90% which was above the trust's target. However, data held locally showed an average of only 36%
- If staff repeatedly failed to attend booked training they would enter disciplinary procedures as they were unable to provide the level of care expected by the trust .
- Senior managers did not have oversight of compliance with mandatory training and could not provide us with data to demonstrated compliance or identify areas which required improvement. However, they felt confident that local managers would escalate any concerns to them. We were told that a computer programme to show mandatory training levels was being developed.
- Matrons were unable to provide us with figures of compliance for safeguarding training. One matron commented that they knew the staff well enough not to need a competency or mandatory training matrix.
- At North Cotswolds Hospital an action plan had been created to improve mandatory training compliance. A senior nurse had been made responsible for the training of the staff and was in the process of obtaining more accurate information. However this was not being replicated across all community hospitals.

Assessing and responding to patient risk

- Staff we spoke with were confident of the processes and procedures if a patient collapses. There was either an internal phone number to contact the Minor Injuries Unit (if the hospital had one), or staff would call 999 for an emergency ambulance. However, in Lydney and District and Dilke hospitals we were told it it could take up to an hour for the emergency ambulance to arrive.
- The trust used the Adult Modified Early Warning Score (MEWS). Early warning scoring tools are used to aid recognition of deteriorating patients and are based on physiological parameters, which are taken when recording patient observations. The observations included in this scoring system include: temperature, pulse, blood pressure and respiratory rate. An aggregated score is then calculated. There is an

identified threshold score which, when reached this activates an escalation pathway. The escalation pathway outlines actions required for timely review ensuring appropriate interventions for patients.

- Allergies were clearly documented on the front of medication charts making them easy to see by all staff. We also saw in the notes completed MUST (malnutritional universal screen tools) assessments, insulin assessments, occupational therapist and physiotherapist assessments, and pressure ulcer assessments. All of these were completed in a timely way. Where actions had been identified they were clearly visible. Staff we spoke with were able to discuss with inspectors individual patient needs as a result of the actions stated.
- We saw for one patient on Jubilee ward at Stroud General Hospital the MEWS was being used and actions being followed. Staff had written some guidance on the form due to their medical condition that needed to be taken into account when calculating their score. On the back of this form it indicated the actions staff must take depending on the score.
- For patients that had undergone day surgery at Stroud General Hospital there was an escalation policy in place in the event that a patient became unwell. Staff were able to contact the surgeon or anaesthetist if they were still in the hospital or by telephone. Otherwise, patients were transferred to the local acute trust via emergency ambulance.
- 'Safety huddles' had been introduced for healthcare assistants to ensure appropriate assessment, and reassessment of patients at risk half way through the day. The healthcare assistant handover process was changed to focus on basic care and safety of patients. This introduced a safety focused mind-set in this staff group and better team working.
- Staff handovers when shifts changed were effective. We observed staff shared information about the care patients had received, changes to care plans, current clinical or social problems. These conversations happened at the end of the patient's bed so that they were involved in the discussions. However, discussions conversations could be heard by other patients in adjacent beds.

Staffing levels and caseload

- The bed occupancy rate for quarter two 2014/2015 was 93.9% which was higher than the England average of 87.6%. It is generally accepted that when occupancy rates rise above 85%, it can to start to affect the quality of the care provided to patients and the orderly running of the hospital.
- Trust board papers from May 2015 had highlighted that nurse recruitment continued to be a key priority for the trust. Whilst some progress had been made in attracting new nurses, sufficient challenges remained, in particular the recruitment of band 5 nursing staff.
- At North Cotswolds Hospital there was a registered nurse vacancy rate of 33%. We saw staff rotas and found that most shifts were filled correctly. We were assured that because of the vast supply of bank and agency workers the impact on patient care patient was low. However, sometimes managers had to cover vacant shifts, diverting them away from their managerial duties.
- Staffing levels were displayed on the walls of all the hospitals and during the time of the inspection wards were fully staffed according to their establishment. We were told that the staffing establishment was based on 85% bed occupancy which meant that staffing levels were not appropriate for the numbers of patients in the ward where bed occupancy rose above that level. For example, Tewkesbury Hospital had bed occupancy of 98.5%.
- Matrons told us they were able to obtain additional bank and agency staff if they felt it necessary, depending on the acuity of the patients, and senior staff were able to amend their staffing ratios depending on the assessed needs of the patients. For example, if the senior registered nurses on the ward felt they would benefit more from an extra HCA rather than a trained nurse they were able to change this. They also told us they were not always able to fill registered nurse vacancies with bank or agency staff. They told us agency staff were not always familiar with the ward and this put extra strain on the existing registered nurses. The staff told us they would rather have a HCA who was familiar with the ward and patients for continuity of care.
- Staff said that, compared with 12 months prior to the inspection, there were adequate staff to perform the required duties safely. Speech and language therapists said that they always met their 10 week waiting list

targets. Day surgery was fully staffed with one band 7 nurse, four operating department practitioners, two staff nurses and two healthcare assistants. A manager said that "staff enjoy working there and never want to leave".

- During the busy winter period 20 escalation beds were opened. Twelve of these were at Stroud General Hospital, five at Dilke Memorial Hospital and three at Lydney and District Hospital. This number was reduced to three in mid-April and all were closed by mid-May. We were told by staff that they were at full capacity but were able to increase staffing levels to match demand. The trust told us they did not breach single sex accommodation requirements wards during this period.

Managing anticipated risks

- Pre-assessments were carried out for all patients attending day surgery by the local acute trust prior to attending for their surgery at the community hospital. The community hospitals had their own strict eligibility criteria for surgery to minimise risks to patients. We were told by a manager that some patients "slip through the net" and inappropriate referrals were made. Staff were able to stop these referrals being made and incident forms were completed and were forwarded to the acute trust.
- Appropriate mitigating actions were introduced if a patient was identified as high risk. For example, if a patient had been identified as at high risk of falls, they were admitted into beds identified as 'high visibility/ observation' where nurses would be able to monitor appropriately. If the mitigating factors were not effective, one to one care was provided. One example of an action to reduce risk of falls was to have bed rails installed to reduce the risk of falls out of bed.
- Staff working on night shifts ensured that they observed patients every 15 minutes. There was no formal process around this but staff said it was best practice. Evidence of these checks was recorded in records on the computer systems.
- The World Health Organisation (WHO) surgical safety checklist was being used at the trust. This is an internationally recognised system of checks designed to prevent avoidable harm during surgical procedures. The trust used a different WHO surgical safety checklist for cataract surgery and for other surgery. A surgical safety briefing took place prior to each operation list and this was where all staff attended and discussed the operation they had planned.
- At Tewkesbury Community Hospital there were seat and bed alarms that were activated when a patient got up and this alerted staff via pagers. These were used for patients living with dementia and other patients who were confused, to help prevent falls.

Major incident awareness and training

- We saw in the community hospitals action cards for major incidents. There was an action card for certain members of staff for example, matron and team managers. These listed what actions they each needed to take in the event of a major incident. Staff we spoke with were trained in major incident management.

Good

Are services effective?

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

We found positive examples of evidence-based practice being utilised throughout the hospitals. We also saw how outcome monitoring, national, and local audit data was influencing practice.

We found a very positive culture of multidisciplinary working embedded throughout the organisation. Multidisciplinary team meetings were effective and discussed in detail the needs of patients and carers and involved all clinical disciplines from the community hospitals, as well as social workers, the mental health team and community teams.

Medical records provided evidence that nutrition, hydration and pain relief were managed effectively. Staff were aware of their responsibilities under the Mental Capacity Act 2005and Deprivation of Liberty Safeguards.

Staff received performance appraisal, although compliance varied in different services. Staff had access to learning and development nurses, clinical supervision and one to one support. However, in surgery staff felt the opportunity to maintain certain competencies was limited due to limited exposure to specific types of care.

Detailed findings

Evidence based care and treatment

- Policies were evidence based and in line with national guidance. Staff were encouraged to challenge and comment on best practice policies and this was fed into the governance meetings to influence change through Listening In Action (a programme developed to facilitate change and prompted ideas from staff). A staff member told us "Listening in Action is fantastic and gives permission to act. You feel you are going to make a difference".
- The trust participated in several national audits including the Sentinel Stroke National Audit Programme (SSNAP), the Parkinson's UK audit, and the National Audit of Intermediate Care (all of which had 100% submission from the trust). The trust also participated in the National Chronic Obstructive Pulmonary (COPD) audit and the National Diabetes Foot Care Audit (both of which had data collection ongoing).
- Audits were measured at a local level and fed up the organisation through the monthly matrons' governance meeting. Issues identified were escalated into the Transforming Community Hospitals group to influence policy and processes. A senior manager highlighted that this group had "drifted into operational work" (acting upon issues) rather than strategic (studying and planning to prevent issues). The work of this group had had a positive impact on patient care. For example wards had been renovated to become more 'dementia friendly' and engagement had taken place with volunteer groups to set up memory rooms.
- One example where practice had been changed as a result of audit was for the documentation audit. Workshops were held to train and teach all staff about the importance of accurate documentation and a 'look back' exercise was conducted to identify more specific themes. This was being re-audited.
- The staff in theatre at Stroud General Hospital were aware of the guidance from the National Institute for Health and Care Excellence (NICE) CG65 Inadvertent perioperative hypothermia: The management of inadvertent perioperative hypothermia in adults. The staff took patients' temperature pre and post operation and used warming blankets when required to maintain their core temperatures.
- We were told how 'John's Campaign' had influenced the community hospitals staff regarding care of people living with dementia. Lessons had been learned from the campaign and practice had changed as a result. For example, we were told about a patient who used to walk their dog at 2 o'clock every day. It was recorded by the nurses and someone accompanied them for their walk to ensure their safety.

Pain relief

Good

Are services effective?

- During our inspection we completed four pathway tracking assessments and found that pain assessments were consistently completed.
- Nurses politely asked patients if they were in any pain during ward rounds and nursing rounds.

We observed good practice in pain relief.

Nutrition and hydration

- Nutrition and hydration assessments were consistently completed. Weight was assessed on a weekly basis and records completed appropriately.
- We saw evidence that appropriate action had been taken in response to an identified risk of malnutrition. A patient on Jubilee Ward at Stroud General Hospital had been assessed as requiring monitoring. Their daily intake of fluids was being recorded and they were receiving thickened fluids and a food diet. They told us they had been on this regime since their admission to the acute trust and their transfer to this hospital. Their fluid charts had been completed in full. We saw in their records this person had been referred to the speech and language therapist.
- Audits were conducted to provide evidence of compliance for nutritional risk assessments and with the trust's oral nutrition guidelines for adults.

Patient outcomes

- Hospitals used a performance dashboard which reported against a range of trust-wide targets. Targets includes Friends and Family Test FFT) response rates, readmission rates, infection control, length of stay, delayed transfer, safety thermometer and prescribing. We were told that this data was used in governance meetings to influence changes in policy and practice and evidence where there were shortfalls in care. Each measure had a breach consequence (e.g. a report given to the board with an action plan) and identified a lead director with overall responsibility. Matrons told us that they monitored patient outcomes predominately based on discharge and length of stay information.
- The trust had a low number of acquired pressure ulcers. Information presented to us shows that in the previous year the trust had 57 pressure ulcers. However, only 18 of these were acquired in the hospital environment. The remaining 39 were inherited.
- CQUIN (Commissioning for Quality and Innovation) audits are set by the Clinical Commissioning Group as a driver for improvement. If a trust does not meet the targets set out in this they risk a financial penalty. The trust participated in several clinical audits, such as Last days of life CQUIN audit, audit of communication regarding discharge destination CQUIN audit, and an audit of dementia case planning. All community hospitals were meeting these targets.

Competent staff

- Staff received annual performance appraisal; however, there were differences in appraisal rates between staff groups in different hospitals. For example in Tewkesbury Hospital 18 members of staff (40%) staff were overdue their appraisal.. The appraisal rate at Stroud General Hospital was 96%. We saw conflicting data about the trust's target. Some records showed a trust target of 100% and others showed a target of 80%.
- Staff we spoke with were complimentary about the quality of the support received in the community hospitals. One member of staff said "I have regular clinical supervision and 1:1's with my manager so appraisals just become a formality".
- We were told that it could take several months for records to be updated between local and centralised data. An example of this was given when a senior nurse appraised a ward manager recently and the appraisal was sent via email, on the next report received from 'learning and development' the person appraised was marked as not complete/overdue.
- Most staff said that they were given time to perform training for competencies and were given blocks of time (a morning or an afternoon) dedicated to e-learning or training as required. This allowed them to maintain concentration without being distracted.
- On Jubilee Ward at Stroud General Hospital staff had an allocated clinical supervision day per week where a senior member of staff worked with other staff to monitor their competencies and help them to improve their skills and knowledge.
- Staff commented on the quality of particular courses. For example, staff felt confident to perform cannulation as they had attended a study day and received adequate supervision to perform their this task. Several

staff commented that any potential 'skills fade' e.g. the reduced opportunity for cannulation on a community hospital ward, was addressed by working in other departments (e.g. rotation to day surgery), and in-house refresher and retraining.

- In day surgery all staff were up-to-date with their appraisals and competencies. This data was readily available locally through the shared drive. We were told that where standards of practice dropped competency and theory based learning were used.
- A manager in surgery assured us that they were all competent to perform their jobs but was concerned that if a patient deteriorated quickly they may not have the experience to manage it effectively. This was due to lack of experience of working in those situations. We were told that they would have liked to rotate with the local acute trust to gain experience of these situations to ensure their competence. This risk had been mitigated by ensuring staff from the acute trust were present during procedures. The manager had tried to arrange meetings and set up rotations with the acute trust to gain more experience but we were told that there was little support from either the acute trust or senior managers in Gloucestershire Care Services. Examples we were given where this would be most beneficial was with acute temperature and acute airways management. Another manager said that there should be a professional lead for theatres to collaborate further with the acute trust and to follow up these identified risks.
- Staff in all hospitals were encouraged to undertake additional courses either in-house or externally. Staff we spoke with had undertaken the care certificate (developed as part of the Cavendish review which followed the Francis inquiry into training and support for healthcare workers), others had undertaken further diplomas or degrees in healthcare. Bank staff were also encouraged to undertake the same training. At North Cotswolds Hospital there were two members of bank staff who were undertaking nursing diplomas which were funded by the trust.

Multi-disciplinary working and coordinated care pathways

- We observed a weekly multidisciplinary meeting (MDT) on Windrush ward at Cirencester Hospital and at Lydney and District Hospital. In attendance was a senior nurse from the ward, the ward doctor, occupational therapist, physiotherapist, social worker, the lead for the integrated care team based in Cirencester and a mental health nurse from the local mental health trust. Each patient was discussed in detail to include any discharge plans and support that would be required. Staff told us when a patient was known to the community team they would do 'in-reach'. For example, one patient was known to the community occupational therapist and they visited the hospital to assist the hospital staff with planning their discharge. Staff also did 'outreach' where a member of hospital staff visited a patient in the community to maintain continuity of care. This meeting was very detailed and where extra information was required this was requested. For example, to assist the social worker with planning support for the discharge of a patient the ward staff and therapists were going to undertake a 48 hour care plan. Senior staff told us that a daily MDT took place Monday to Friday but didn't include all the members who attended on a Wednesday morning.
- We saw that patient choice was considered in the MDT process and options discussed for the patient. The social worker being part of this meeting was invaluable to discuss the detail of the discharge packages and it was clear that patients were not discharged unless the full package was completed and implemented. We also saw examples of effective multidisciplinary work between the trust and the local authority.
- Staff on Jubilee ward at Stroud General Hospital told us they also had a weekly MDT meeting where all patients were discussed with members of this team. This had taken place the day before our visit to the Hospital.
- There was a fully integrated multidisciplinary approach to the management of care records. A fully integrated care record had been developed and was in use across all the hospitals. This integrated care record was utilised by every team member involved in a patients care. This included the nurses, doctors, physiotherapists, and social workers. When asked about it we were told that this ensured that notes on separate pieces of paper were not missed and that everyone was aware of the other specialities' input. For example, in one patient's notes we observed information on movement in bed and what assistance they needed with transfers. The

patient told us they were on bed rest at present due to other medical conditions. This form covered the reasons for their admission to hospital and the patient confirmed these. We saw a risk assessment in relation to their risk of developing pressure ulcers; this patient was assessed as being at low risk but was on an air pressure relieving mattress as they had a pressure ulcer on their sacrum. We saw records were maintained of dressing changes and this patient also had other wounds that were being dressed. Risk assessments were also in place for falls and the use of bed rails. We saw other members had completed sections in this form, including the physiotherapist and doctor.

- The integrated care record was kept by the patient's bed and on admission all patients had to sign a consent form (which was kept in the front of the records) stipulating that they were happy for all staff to use the records and be available to them. We were told that by doing this it encouraged patients to take a more active part in their care and allowed them to look at their notes and ask questions if they were unsure of anything.

Referral, transfer, discharge and transition

- The trust performed an audit of all transfers resulting in admission after 9pm to understand at what point transfer delays were occurring. This audit suggested that the most common cause of delay was patients having to wait for arrival of an ambulance. A total of 3.4% of transfers to the community hospitals were happening between 11pm and 5am. We were told that this is reported as an incident and that the trust was in conversation with the ambulance service and the local acute provider to improve this.
- Patients were given a list of contact numbers when discharged to inform them of the most appropriate phone number to call (either a specialist in the acute trust, or their GP). Patients were also given an email address as an alternative form of communication. Staff contacted patients after discharge to see how they were getting on in their home or care setting.
- We were told by staff that the single point of access system (where all GP's, hospitals, and care homes call a single phone number to manage transfers) worked well but sometimes not enough information was gathered. Sometimes nurses had to go back to them to get more information about a patient.

Access to information

- Staff were able to access all blood results, diagnostic scans and letters through the computer system and said they found it easy to use.
- Staff at Tewkesbury Hospital were preparing for the introduction of the new electronic record system by performing a limited selection of ward rounds using the programme. This was used as a 'stepping stone' for staff before its full integration later in the year.
- We were told that the change to digital records was a positive change and had "revolutionised" work streams. Staff who had been using the system for a while were more complimentary than others who had been using it a short amount of time but were aware that this was a normal process as they acquired confidence. However, health visitors were unable to access all of the required information, which we were told could be frustrating. They also found it difficult to share information with other professionals in the hospital which meant not all staff would have all the required information available to them to treat patients.
- We saw information available to carers and relatives in the corridors. There was advice on being 'dementia friendly', nutrition and hydration, learning disabilities, communication, and infection prevention.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff told us they were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff were aware of when a patient would need a Mental Capacity assessment in relation to certain decisions. We spoke with a social worker who told us they assessed patients regarding their ability to make decisions about their discharge if they were involved in their care.
- At Cirencester and Stroud General Hospitals staff were able to tell us about the process for applying for Deprivation of Liberty Safeguard (DoLS). A DoLS was in place at Cirencester Hospital for one patient and one had recently been in place at Stroud General Hospital. A senior member of staff at Stroud General Hospital showed us the process they had gone through to apply for the DoLS and the authorisation they received.

Good

Are services effective?

- We saw in one patient's integrated care records an assessment format which was used to help staff assess patients' capacity to make decisions about their care.
- We saw a consent form was in place for the use of bed rails. We observed one in a patient's records and they had signed it.
- The trust used a DoLS policy which was developed in partnership with local health and social care providers, to ensure joint working when protecting vulnerable people.

Outstanding ☆

Are services caring?

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

Summary

We found that there was a strong, visible 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. Patients said that they were treated well and that staff always tried to spend as much time as possible with them. We saw examples of where patients and family members were informed immediately when something in a care plan changed. For example, the refusal of admission to a care home.

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. We saw examples of care where nurses and doctors sat with patients to have casual conversation and were laughing with them. It was clear that the anxieties of patients and their relatives were alleviated with the caring nature of all of the staff. Volunteers spent time talking to patients and asking if they had any concerns. If there were any, these were quickly and efficiently managed, for example needing personal care or wanting to take part in an activity.

Staff spoke of how the league of friends had invested money into the community hospitals to allow them to provide better care. This had a positive impact on the culture of the hospitals. We also saw positive examples of volunteers interacting with patients.

Care offered by staff was kind and compassionate and promoted people's privacy and dignity. In some hospitals we observed that all staff, including external contractors (such as engineers), treated rooms as if they were patients' homes and asked for permission to enter.

Staff were fully committed to working in partnership with patients and recognised and respected people's needs when delivering care. Patients said that they were always treated as individuals and that they were always asked for permission when an intervention from a staff member was needed. When carers and relatives came to the ward their needs were also addressed. A member of staff would sit with them and update them about the patient's care to ensure that they were fully informed. There was a chaplaincy service available to all patients if they required it.

Detailed findings

Compassionate care

- All staff we spoke with were clear that the care being delivered was patient-centred and that nothing was too much for them to ask. Staff we spoke with said that caring for the patients was what got them up each morning and we observed that this culture was embedded throughout the hospitals.
- Staff were going above and beyond their duties to ensure that patients were happy and well cared for. One patient in North Cotswolds Hospital said "the nurses always try and spend more time with you than necessary; one nurse took me for a walk in the garden". Another said that "they treat me very well, the staff are great". We observed all patients were spoken to by their first name and that staff were getting down to eye level to have conversations. We also found that during MDT meetings, ward rounds patients were also identified by their chosen name.
- Patients said that they were confident that their privacy and dignity were always maintained and that they found this encouraging. Staff spoke to patients with respect and dignity and politely asked patients for consent if anything needed to be done, for example blood pressure checks. We also observed at Tewkesbury Community Hospital 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."
- 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". Another patient said they "were always treated as an individual".

- We saw on multiple occasions at North Cotswold Hospital and Tewkesbury Community Hospital the matron walking around the ward greeting patients and asking how they were. One matron looked into every open door and said "good morning". It was clear that all of the staff had spent time to get to know their patients personally. One member of staff said "we are a family here, not just with the staff but including the patients and their relatives too".
- This compassionate care was reflected in the comment cards received prior to the inspection. We received 16 positive comments out of 18. One relative said "my elderly mother has and continues to receive first class care on this ward, the staff always show compassion". Another said "the care has been excellent; everyone has been helpful cheerful and very caring".
- We received overwhelmingly positive feedback from patients we spoke with. One patient said "They are treating me brilliantly, I am only in for day surgery. Food is not too bad, we are given choices. Care is very good; the nurses have made me feel very comfortable". Another said that "I have always loved Stroud Hospital, everyone here is lovely and caring, they treat you very well"
- Healthwatch Gloucestershire received positive feedback from both patients and relatives concerning the community hospitals. Patients described staff at Vale Community Hospital to be professional and kind. One example described an occasion when a patient was annoyed to have to ring a central booking system for an appointment, so the hospital did it on their behalf. At Lydney and District Hospital feedback said that patients were very happy with the experience and that the staff were lovely. Feedback for Dilke Memorial Hospital stated that they received excellent care there.

Understanding and involvement of patients and those close to them

- A PLACE (Patient Led Assessment of the Care Environment) audit of privacy, dignity and wellbeing showed that all hospitals wer performing above the England average of 95.2%. The highest score was North Cotswolds Hospital (93.5%) and the lowest score was Lydney and District Hospital (85.7%).
- We saw multiple examples of where public engagement has influenced the culture of the community hospitals. We observed volunteers going to each room in the community hospitals to ask patients if they were okay or had any concerns. We were told that if anything did arise it was handled quickly and efficiently for example for personal care, pain relief, or interest in activities. Volunteers were also seen sitting and talking to patients. We also observed volunteers having tea and cake with a patient. They were laughing together and it was clear that the patient was enjoying themselves. Staff also spoke of the support provided by the league of friends who had invested heavily in the community hospitals allowing them to facilitate a positive and proactive caring culture.
- We observed doctors sitting down with patients and their carers having casual conversation before closing the door for confidential conversations about care. This casual conversation fully included the patient's carer and the doctor asked how they were as well as the patient.
- Carers we spoke with were complimentary of the service provided by the staff at the hospitals. One of them said that "my husband has been here for three weeks and the care is wonderful". She went on to say "the multidisciplinary approach has been like a weight lifted off my shoulders. They understood all his needs".
- We were told by staff at Tewkesbury Community Hospital about a patient who always wanted to go for a walk at 2pm (as this was when he used to walk his dog). Arrangements were made by the staff to ensure that someone always went with him at this time.
- Patients were actively included in ward rounds and conversations about their care. We observed staff asking how patients were and if they needed anything extra for that day.
- 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.

- We observed that when something changed in a patient's plan both the patient and the family were informed immediately. One example of this at Lydney and Dilke Memorial Hospital was when a care home refused admission of one of the patients. The next day alternative plans were being arranged in the multidisciplinary team meeting and the patient was being kept informed. However, we did find one example where evening visitors were not informed of care to the same level as visitors during the day.
- We spoke with a relative at Stroud General Hospital and they told us their relative did not have the mental capacity to make decisions about their discharge. They were due to meet with the social worker to discuss discharge arrangements and if they required any extra support once home. They felt involved in the care of their relative.
- Patients said that call bells were answered quickly when they had to use them. Some patients said that they had no need to use call bells as staff were always around to manage their needs. We observed that call bells were answered within one minute both during the day and in the evening.

Emotional support

- At Lydney and Dilke Community Hospital we observed that visitors to the ward were welcomed politely and were offered to sit in armchairs by the nurses' station. Nurses sat with the visitors and explained how the patient had been overnight and if there had been any concerns before going in to see the patient.
- 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". 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 Cirencester Hospital patients had access to religious services if they requested it. A service took place twice weekly and volunteers supported patients to attend. If patients were not able to attend, Communion took place at their bedside once a week. A chapel was also available for patients and their visitors to use.

Good

Are services responsive to people's needs?

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

Summary

We judged the service to be good for responsive. We found that the service was planned and delivered to meet people's needs.

Patients had a very high range of activities available to them. We observed the positive impact these activates were having on the wellbeing of patients. We saw how vital the volunteers were to these sessions and observed the positive impact their input was having on patients' care.

We found medical cover varied between sites. Some cover was provided by general practitioners and some by consultants from a local acute trust. 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. We were shown examples where complaints had led to learning and saw how this learning had been disseminated and embedded in practice.

Detailed findings

Planning and delivering services which meet people's needs

- The average length of stay in the community hospitals was 16.9 days between April 2014 and March 2015. The ward with the longest average stay was Thames ward at Cirencester Hospital with 23 days and the shortest average stay was at the Vale Community Hospital with 14.3 days.
- Thames ward was an escalation ward (one kept ready to be opened and staffed if necessary to provide care during times of increased demand on the service). We were told that the length of stay was not attributed to the fact it was an escalation ward as they were fully staffed during this period.
- The trusts target was 14 days. We were told that although the target was there discharges were based on individual patient need rather than reaching a target.
- All admissions were managed through a single point of access which contacted the wards on a regular basis to discuss flow and the management of beds.
- Matrons held meetings with the local acute trust each Wednesday to discuss admissions and discharges. The community hospitals informed the acute trust of empty beds, or beds which would become empty three days in advance to ensure that the community hospitals were used to their full capacity.
- Plans were being developed in partnership with the mental health trust, acute trust, and general practitioners to learn lessons from the capacity issues experienced during the winter and to make the county more resilient to increased pressures during this time. A senior manager felt that relationships between there providers were improving as they had been 'tested' during the 2014/2015 winter period.
- A senior manager told us that during this escalation period in the winter, the trust had maintained single sex accommodation and that infection control standards did not drop.
- Lydney and District Hospital performed day surgery until a lift broke six months prior to the inspection. We were told that surgery activity had been absorbed by Stroud and Tewkesbury Hospitals without any impact on waiting times and the unit would not be re-opened. The lift was still not working properly at the time of our inspection. Staff said that this unit was used as an escalation ward over the winter period.
- At both North Cotswolds and Tewkesbury Hospitals the ward's bathroom had been used as storage for equipment and supplies. When asked why, we were told this was because adequate storage has not been considered during the development of the sites. Patients who wanted to have a bath (which was only occasionally) could have one, but the equipment had to be moved. At North Cotswolds Hospital an arrangement had been made with the portering staff to use one of their cupboards for storage. At Tewkesbury Hospital no

storage facility was available so it had to be placed in the corridor. This had been added to the risk register and further storage outside the hospital was being acquired to house the equipment.

- Dignity and privacy was maintained during intimate care as green lights illuminated outside of bedrooms to indicate when a nurse was providing care. This acted as a warning to prevent other staff from entering the room.
- Staff had visited other hospitals outside of the county to capture ideas for the design of their 'dementia friendly' wards and reminiscence rooms. These facilities had been developed in several of the community hospitals and stff told us they had had an impact on falls. Dementia friendly wards contained minimal contrast in colour, removal of clutter, non-shiny floors (which may look like water or wet patches) and took into account visuo-spacial disabilities to reduced the likelihood of a patient with dementia getting confused and reduced the risk of a fall.
- The trust's Patient Led Assessment of the Care Environment (PLACE) score for food was 91.2%, which was higher than the England average for similar trusts. The highest score was achieved by Vale Community Hospital (92.4%) and the lowest score was at Dilke Memorial Hospital (87.4%). This showed that a large majority were satisfied with the quality of the food provided.
- It had been raised to staff several months prior to inspection in a comment from a patient that there were not enough activities for patients. 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.
- At Dilke Hospital we saw an activity room being ran by volunteers. This was open to all patients and visitors and gave them an opportunity either to sit and talk or play games.
- Matrons in some of the hospitals had concerns over the design of the newer hospitals. One matron mentioned in North Cotswolds that they would like to see the windows lowered so patients could see more out of them without straining themselves, and that the mirror on the back of the bathroom doors should be moved as when they are open people in the corridor can see into them compromising privacy and dignity.

Equality and diversity

- Staff at Cirencester Hospital from Windrush ward told us the trust could cater for patients who required an alternative diet due to their religious or cultural needs, for example, Halal. No patients at the time of our inspection were receiving an alternative diet because of their cultural or religious beliefs.
- We 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 inaccessible because of a mobile screening van. This meant that patients were having to park further away from the hospital which also meant going up a hill.
- We saw at Stroud Hospital one of the accessible toilets was being used as a store room. In a second toilet the toilet paper was out of reach.
- Staff at Cirencester Hospital told us they had access to translation services via their switchboard.

Meeting the needs of people in vulnerable circumstances

- At North Cotswolds Hospital drama therapy had been introduced as a way to bring patients together and to encourage them to take part in activities. Staff had found that through this activity patients living with dementia were less agitated during and after therapy.
- At Tewkesbury Hospital charitable funding had been used to train staff to perform hand massage, aromatherapy and reflexology. There is evidence that these techniques can reduce agitation for people living with dementia.
- At Stroud and Dilke Hospitals they had devised a sitting room that was set up as it would have been in the 1940's. This was for all patients to use but especially those living with dementia. It had memorabilia from this

era and patients were able to sit and touch the furniture and look at the books and pictures from this period. We observed patients sitting in this room with staff or their relatives/representatives.

- Also 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.
- On Windrush Ward at Cirencester Hospital they had devised a picture menu to help assist some patients to choose their meals, for example those living with dementia or patients who had limited eye sight and could not read the paper menu.
- In North Cotswolds Hospital charitable funding had been used to purchase a collapsible bed so patients could have relatives staying in their room if appropriate. This was not available in all hospitals. However, in Tewkesbury Hospital reclining chairs and mattresses were available to place on the floor.
- There was continual input from volunteers at North Cotswold Hospital. They regularly deployed up to two volunteers a day who attended and helped staff by delivering newspapers, talking to patients, going around each bed with food trollies and offering a library service.
- A patient said that the night staff were "lovely and always accommodate my needs overnight".
- During our inspection we looked at six sets of patient notes. They were mostly complete and legible and staff had signed and dated their entries. We saw evidence of goals and objectives being set for patients which was confirmed by staff we spoke with. We saw evidence of clear up-to-date care plans and consenting decisions. We saw that carers and relatives were considered when producing care plans with information clearly visible in the patient notes. Daily records of care were completed and up- to-date. We also saw examples of living assessment plans and tools for recoding confusion.
- At Lydney hospital armchairs had been placed next to the nurse's station. We were told that patients often sat in those chairs and had conversations with nurses and other staff. There was also a less public area where nurses could have conversations without being overheard.
- We received very few negative comments about staff not responding to patients needs. One patient said that one of the night staff did not know how to help them with going to the bathroom. The patient said "they upset me and I wet the top sheet".
- We received some negative comments via comment cards concerning the delays in answering the call bell. However, during our inspection the longest time a call bell went unanswered for was one minute.

Access to the right care at the right time

- Patients had access to doctors at each community hospital but the cover arrangements varied. The medical cover for Tewkesbury community Hospital was provided by the local GP surgery seven days a week during the day. A consultant from the local acute trust visited each Wednesday to review all patients. Outside of these times medical cover was provided by the out of hours service.
- At Cirencester Hospital each ward had senior doctor cover Monday to Friday during the day and they provided out of hours cover at nights and weekends as part of team. Staff told us this was due to be changed in the future. A consultant from the acute trust visited two days a week to review patients.
- On Jubilee Ward at Stroud General Hospital the medical cover was five hours a day Monday to Friday provided by the local GP consortium. At weekends during the day time they also provided medical cover. Outside of these hours the ward contacted the out of hours medical service. A consultant from the local acute trust visited each Wednesday to review all patients. Staff told us they were also able to contact them at other times for advice and guidance by telephone.
- Staff at Stroud General Hospital told us that out of hours doctors could take a long time to respond to calls or refuse to attend entirely. Staff at other hospitals said that sometimes a doctor did not turn up at all. Staff also

told us about concerns that out of hours doctors were interpreting blood results differently than GPs during the day. This had been raised with matrons and was being managed though an action plan.

- Patients had access to an X-ray department which provided plain X-rays in each of the community hospitals. If they required any further diagnostic investigation they had to go to the local acute hospital. If this was the case, patients were offered a packed lunch. If a patient required diagnostic procedures during a weekend or overnight they were transferred to the acute hospital although this was not often required.
- If it was known that a patient was about to be transferred from an acute hospital community hospital staff would contact the relevant departments in the acute hospital to ensure that all diagnostic imaging and tests were conducted prior to the transfer.
- Blood specimens were collected daily (during the week) at 1pm from all wards. If urgent blood tests were required specimens were couriered by the porters to the acute hospital for analysis.
- We saw patients had been referred to other health care professionals, for example, tissue viability nurses. Records were maintained of these visits and any action they required the ward staff to take before their next review of the patient.
- However, we did receive several pieces of negative feedback. One patient's relative said that they had been waiting all day for a physiotherapist with little communication between them and the nurses as to when they would arrive.

Learning from complaints and concerns

- A senior manager told us that very few complaints were escalated to the trust complaints team and were mostly managed between the local matrons and the complaints team. We saw evidence that all complaints were dealt with formally and records were available at the community hospitals. All patients were given choice as to who they complained to and had access to the trust wide managers if they felt it necessary.
- Information about the complaints process was available to patients. There was guidance on how to make a formal complaint and how to contact support organisations such as the local Healthwatch. Patients we spoke with were aware of how to complain and said they were comfortable to raise concerns.
- All complaints were discussed at Patient Safety Group meetings which were attended by the matrons from all of the community hospitals and the learning and development team. At these meetings training needs were identified and programmes of work developed. We saw how learning from a complaint had affected training for pressure ulcer assessment.
- All formal complaints were investigated by a member of staff from a different community hospital and if a complaint was shared across multiple sites it was managed by the risk team. Complaints received from NHS choices (a website for giving feedback to services the public have used) were managed in the same way.
- All patients who complained received a letter to explain the outcome of the complaint, any learning points, and changes in practice that had occurred as a result
- Compliment data was also collected by individual hospitals and monitored as a performance measure. This information was also used as supporting evidence for themes and trends with the main performance dashboard. When a compliment was received it was shared with the wider team and the hospital.

Good

Are services well-led?

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

We found that the service vision and strategy was measurable and realistic and that projects for improvement were making progress. We found a positive culture of risk management with management having good oversight. Risk assessments and registers were comprehensive and information was shared appropriately.

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 hospitals.

We saw very good local leadership in all of the community hospitals and this was reflected in the culture of the staff. Matrons led by example and were supportive of all their staff. However, we found that there was a disconnection between the hospitals and the executive team.

Detailed findings

Service vision and strategy

- There was a service vision and strategy for the inpatients service was based on the outcome goals and actions from the Transforming Community Hospitals group; a group of staff from the hospital, the executive team, volunteers and people from the local authority who manage innovation and change in the community hospitals. We received a service strategy for the introduction of ambulatory care (advanced medical diagnosis and treatment provided in an outpatient setting) in the trust. This was developed by the Transforming Community Hospitals group and highlighted the milestone, the risks, and the mitigating actions. We also received the community hospitals development group projects plan. This summarised activities since the last update and objectives for the next period. It was clear that progress was being made in this project group for example changes to discharge were being established. This resulted in multi disciplinary discussions both in and outside of the trust to develop a project plan.
- The trust quality accounts identified priorities to reduce the number of pressure ulcers acquired in community hospitals, to reduce the number of patient falls, to improve the experiences of service users, carers and families within the community hospitals, and to improve active two-way engagement with service users, carers and families. We saw in this report that strategies to fulfil these priorities were measurable and realistic. We also saw evidence on wards where these priorities were being implemented appropriately.
- Senior staff at Stroud General Hospital told us about their vision for service. They told us they were well supported by the League of Friends who had supported them with the development of the vintage 1940 lounge on Jubilee Ward. Further plans includes the re-decoration of side rooms on both Jubilee and Cashes Green wards to become specific for people at end of life.

Governance, risk management and quality measurement

- The lead for the inpatient service had good oversight of the key risks to the inpatient service. They were able to identify and describe the highest risks and actions in place to mitigates these risks. These were identified as recruitment in community hospitals, incidence of falls, and estates issues in Lydney and District and Dilke Memorial Hospitals.
- Recruitment days had been planned to increase nursing workforce numbers in community hospitals. However a matron recognised that recruiting to a rural community hospital was more difficult than in an acute hospital.
- Each matron maintained their own risk register for the services they managed based on risk assessments which fed into the community hospitals risk register. Risks were escalated to the unscheduled care risk register and the corporate risk register as appropriate. This was based on a risk and likelihood score.
- We saw evidence of risk assessments being carried out at each hospital. Each were of good quality and used

appropriate scoring methods for escalation. All had mitigating actions and had a responsible individual identified as accountable for overseeing and managing the risks.

- The risk register was discussed on a monthly basis at the governance meeting and assessments and mitigating actions were updated. Information was then disseminated through the matrons to sisters and ward staff via staff meetings or newsletters, if no meeting was possible. Senior staff at Stroud General and Vale Community Hospitals spoke of monthly clinical governance meetings where all disciplines of staff were represented. They discussed all incidents, complaints and any safeguarding alerts. Learning from incidents or complaints were shared at this meeting and with staff on wards and unit. When a meeting did not take place a clinical governance newsletter was produced. We were shown a copy of this for June 2015.
- The incidence of falls was considered a high risk to the inpatient service so a 'deep dive' investigation was conducted. This investigation was carried out by matrons and sisters in all of the community hospitals, the director of nursing and quality, head of community inpatients, head of estates and the quality and safety manager. Background information was obtained, data was analysed in detail and best practice considered. An action plan had been developed as a result. Examples of actions included embedding the National Institute of Clinical Excellence falls care pathway, the introduction of a senior nurse-led review of falls to perform a case review of the fall to identify the causes, the introduction of 'safety huddles', introduction of alternative therapies to relieve anxieties, and the introduction of 'cluttered rooms'. Patients would be assessed individually for their appropriateness to be in a 'cluttered room' and would use the additional furniture (for them to hold onto) to enable them to move more securely. This was based on research produced on dementia awareness by the Kings Fund.
- The trust employed two pharmacists who provided professional support for medicines management across the trust. Since 1 May 2015 the clinical pharmacy service and stock supply had been provided by a community pharmacy provider. Systems were in place to monitor these arrangements.
- Following the change in pharmacy contract the clinical pharmacists were not able to use the trust reporting system to report medicines errors themselves. They had to ask trust staff to do this for them. The head of medicines management told us they were looking at how this could be addressed, so the pharmacists would be able to make reports directly. A pharmacist providing clinical services told us that any interventions they made were recorded in the patient's notes. There was no standardised format in place for pharmacists to record the interventions they made on the ward, to enable the trust to review the service provided or the level of interventions necessary.

Leadership of this service

- All staff we spoke with spoke highly of the matrons. It was clear they led by example and always put the patient first. They way they conducted themselves while talking to patients and staff was exemplary. Staff at Stroud General Hospital told us they felt well supported by their line managers and hospital managers.
- Some staff described a disconnection between the community hospitals and the trust executive and described the trust's headquarters as "Ivory Tower". They felt that emails sent to staff had little meaning and were often ignored as a result. However, other staff said they regularly saw some members of the executive team. For example, one member of staff told us that the director of nursing visited their hospital often and another member of staff said that the director of transformation regularly worked shifts as a healthcare assistant.
- One matron said that they felt valued by the team in the hospitals and their immediate line manager but not by the trust team overall. They said that they rarely saw the executive team. However, they were appreciative of a pre inspection audit carried out buy the trust which identified areas of improvement to act on.
- There were rotas on the walls of the ward to enable staff to know where their managers were as some matrons worked across multiple sites. This meant nurses were aware of where senior nurses were and of how to contact them.
- Several senior staff were concerned that there was a disconnection between themselves and the human resources department. They described no consultation

for a MARS (mutually agreed retirement scheme) which would have left the hospital severely understaffed had it gone ahead. Matrons also told us they did not receive updates when vacancies were to be filled. For example, a senior sister was retiring and there had been delays in recruitment to their position which had not been communicated to the hospital. We were told that delays in recruitment had also had an effect on the housekeeping workforce.

- Staff felt the 'open door' sessions with the chief executive were a good way to get in touch with staff and they told us they would like to see more of these. Staff told us they felt comfortable raising issues with the executive team and that the introduction of staff awards had enhanced their self-value and team value within the hospitals.
- The head of medicines management sent out regular newsletters to inform staff about current medicines issues. These included feedback from recent medicines incidents and changes in medicines policies and procedures. These were available to staff on the organisation's intranet. Staff we spoke with were aware of these.

Culture within this service

- The trust's values were to be caring, open, responsible, and effective. The trust's values statement summarised the key behaviours they expected from all staff. We observed staff demonstrate these values through their working day.
- In order too encourage staff to raise concerns, a dedicated telephone line had been set up for staff to raise concerns anonymously. There was also a whistle-blower email address which allowed staff to communicate directly with the board chair.
- Staff said that they "worked as a team" and were "there for each other". They told us the culture of multidisciplinary teamwork between all levels of staff had a positive impact on the care and wellbeing of patients. Administration staff described the organisation as "an excellent place to work" and there was a focus on "putting the patients first".
- Administration staff felt they were well supported by clinical teams and their direct line managers. However, there had recently been a reorganisation of administration roles, leading to redundancies which had affected the morale of the team. Some administration staff said there was a disconnect between the trust and the local teams.
- Some staff felt more valued than others. We were told that there were "pockets of excellence" recognised within the trust but that other teams felt less appreciated.
- We saw evidence of analysis of exit interviews. In a five month period 34 members of staff left the trust. 63% of healthcare assistants left the trust after less than six months. 33% of registered nurses left the trust after more than six years of service. Half of registered nurses and 26% of healthcare assistants left as a result of not achieving a work life balance. They commented that there was an increased workload and that nurses were being stretched. During our inspection staff we spoke with were happy with the workload and said that if demand increased, so did the use of bank and agency staff.
- Staff at Stroud General Hospital spoke passionately about their job roles and felt valued as part of the team. Staff felt they worked well as a team.
- We received comments from staff which stated that there had been a negative culture eighteen months prior to inspection between staff at Cirencester Hospital. We were told that January 2015 two leadership consultants were hired to manage this identified problems. Improvements had been achieved through encouraging change. Staff had attended 'away days' and training sessions. During our inspection we saw a positive and open culture.

Public engagement

- Volunteers were being considered to inform governance in the organisation. One volunteer was part of a patient environmental action group and sat on governance meetings representing "the patient's perspective". This volunteer was given specific issues to investigate and to report back to the governance meetings. Techniques involved talking to patients, carers and relatives and sitting and observing practice. Examples of where this role had changed practice included the removal of posters and changes to accessing information in the day

room. Staff thought that access to information was important, but after discussions with volunteers found that patients thought there was too much information available.

- Staff at North Cotswolds Hospital had engaged with patients, relatives and carers, staff, volunteer groups and the local brownies to design artwork in the hospital.
- A poet had been commissioned to write a poem for staff at Tewkesbury Hospital. This poem was in remembrance of several staff members who had recently passed away. The poet was due to visit the hospital to present his poem and explain how the hospital had been the inspiration for this work.

Staff engagement

- A senior manager felt that issues on the staff's 'worry list' were similar to concerns recorded on the risk register. All staff we spoke with felt confident to raise concerns with their line managers and more senior managers if necessary and felt that their concerns would be listened to and actioned. However, it was raised that if a concern would take a long period of time to address not all staff received updates on its progress.
- The trust received feedback through staff surveys and found that 48.6% of staff were either extremely likely or likely to recommend the trust as a place to work and that 77.8% would recommend it as place to receive treatment. During our inspection we found no evidence of staff not wanting to work at the trust which is different to the survey results.
- Staff we spoke with in the community hospitals were confident about raising concerns to managers and felt like they were listened too and actions taken appropriately.
- At Stroud General Hospital a suggestions board had been implemented to encourage staff to raise ideas. We were told that this has influenced change in some practices on the ward.

Innovation, improvement and sustainability

- Staff described multiple examples where staff had won awards for their achievements. These included an award for the integrated care notes, another for the transition between old and new hospital buildings, and another for the quality of the 'dementia friendly' wards,. The administration team had also won an award for changing processes in patient transport.
- A senior manager told us that innovation was clearly demonstrated through the "you said we did" programme. Examples described included the lights being changed in the car park of one of the hospitals as the light was preventing a patient from sleeping well at night. However, some staff said it could take a long time for change to happen and there were few updates from managers. One staff member said this was a lengthy process which delayed positive change.

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 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 15 (1) (e) All premesis and equipment used by the service provider must be properly maintained. 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
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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.

This section is primarily information for the provider

Requirement notices

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