Great Western Hospitals NHS Foundation Trust

RN3

Community health inpatient services

Quality Report

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Date of inspection visit: 29 September - 2 October 2015
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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)
RN313	Savernake Hospital	In patient wards	SN8 3HL
RN333	Chippenham Community Hospital	In patient wards	SN15 2AT
RN3C5	Warminster Community Hospital	In patient wards	BA12 8QS

This report describes our judgement of the quality of care provided within this core service by Great Western Hospitals NHS Foundation 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 Great Western Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of Great Western Hospitals NHS Foundation Trust

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

Overall rating for this core service Good

We rated Great Western Hospitals NHS Foundation Trust as good overall for community inpatient services. This trust provided inpatient care and support at three community hospitals. There were 37 beds on two wards at Chippenham Community Hospital, 26 beds on one ward at Savernake Hospital in Marlborough and 25 beds on one ward at Warminster Community Hospital. Care and support were provided by nurses, healthcare assistants and therapy services including physiotherapists and occupational therapists. Medical cover was provided by visiting consultants and local general practitioners.

Summary of findings

Background to the service

Information about the service

Great Western Hospitals NHS Foundation Trust provided inpatient care and support at three community hospitals. There are 37 beds on two wards at Chippenham Community Hospital (Mulberry ward 20 beds specialising in stroke care and Cedar ward specialising in rehabilitation). There are 26 beds on Ailesbury ward at Savernake Hospital in Marlborough and 25 beds on Longleat ward at Warminster Community Hospital, also specialising in rehabilitation.

Care and support were provided by nurses, health care assistants and allied health professionals such as occupational therapists and physiotherapists. Medical support was provided by visiting consultants and local general practitioners.

During our inspection we visited all three community hospitals where inpatient beds were provided. Our inspection team included a Care Quality Commission inspector and two specialist advisors who had backgrounds in physiotherapy and speech and language therapy. We spoke with 37 staff, ten patients and three relatives. Staff included managers, trained nurses, healthcare assistants, other healthcare professionals, ancillary staff and volunteers.

The community services provided by the Great Western Hospitals NHS Foundation Trust were managed within the Integrated Community Health Division.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop, Professional Advisor, Care Quality Commission

Head of Hospital Inspections: Mary Cridge, Care Quality Commission

The team included of 58 people included 17 CQC inspectors and a variety of specialists: A retired chief executive, a director of nursing, a safeguarding specialist, a paramedic, a senior sister in emergency medicine, a consultant surgeon, a consultant in anaesthesia, a consultant neonatologist, a consultant in paediatric palliative care, a consultant haematologist, four community matrons, a health visitor, a speech and language therapist, two physiotherapists, an occupational therapist, specialist nurses in end of life care, medicine and maternity, a junior doctor, a student nurse and an expert by experience.

Why we carried out this inspection

We conducted this inspection as part of our in-depth hospital inspection programme. The trust was identified as a low risk trust according to our Intelligent Monitoring model. This model looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations.

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?

Summary of findings

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Great Western Hospital NHS Foundation trust and the Great Western Hospital. These included the local commissioning groups, Monitor, the local council, Healthwatch Swindon and Healthwatch Wiltshire, the General Medical Council, the Nursing and Midwifery Council and the royal colleges. We also talked to the provider of community services in Swindon, and the company who own, run and manage the hospital building, providing domestic and portering staff, meals and facilities management.

We held one listening event in Malborough on 24 September 2015, at which people shared their views and experiences. In addition we ran a 'share your experience' stall in a shopping centre in Swindon on 22 August 2015. In total more than 50 people attended the events. People who were unable to attend either shared their experiences by email and telephone as well as on our website.

We talked with patients and staff from across most of the trust. We observed how people were being cared for, talked with carers and family members, and reviewed patients' records of their care and treatment.

What people who use the provider say

Completed comment cards returned to CQC included nine positive comments relating to community hospitals. Themes included: caring staff, hardworking nurses and dignity/respect/listening. There were only two mixed comments which related to food and service. There were no negative comments received about the community hospitals.

Prior to the inspection positive comments were received about Savernake Hospital in Marlborough – "Very happy with the service provided, excellent support from a variety of healthcare professionals, particularly OT (occupational therapist) who we nominated for a peoples award. Very supporting of individualised needs"

Good practice

The Governance Database developed and used by the Integrated Community Health Division (ICHD) was a spreadsheet used by staff to record audit information and outcomes, serious incidents and investigations that took place and training records. There was also information about staffing levels, complaints and safeguarding issues. Staff at all levels were aware of and used the database regularly.

The division had recently developed a four day community induction programme. Once staff had completed the GWH trust induction they were expected to undertake the community induction. This applied to new staff, staff who had a new role within the trust and staff employed in the last year that had not had a chance when they started to attend the specific community induction. The programme was very detailed and staff told us they had really appreciated the induction as it gave them an insight into the services offered and lone working, fire safety and medical cover for example.

We heard that two consultants provided bespoke training on some of the community hospital wards. This was well received and attended by staff. They felt this enhanced the feeling of working in partnership to ensure the best care and support is provided for the patients.

Great Western Hospitals NHS Foundation Trust

Community health inpatient services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We rated safety in the community inpatients services as good overall. We found there were good systems in place for reporting, investigating incidents and subsequent shared learning. We saw that there had been a high number of falls reported on some wards and staff had been proactive in looking for solutions.

We saw medicines management was robust and any incidents were reported. However there was not a trust wide policy for the self-administration of medicines.

The ward environments across all three community hospitals were clean and tidy. There was some signage and pictures to help people with a form of dementia find their way to the toilets and bathrooms.

Patient records were very personalised and detailed and generally fully completed.

Staffing levels were good with support from bank and agency staff. However agency therapy staff could not always be booked when required meaning occasionally patients did not have the required amount of physiotherapy.

Safety performance

- Safety thermometer information was displayed on all the wards we visited. The safety thermometer is a national tool that allows trusts to measure and compare their performance in four key areas of safety: falls with harm, pressure ulcers, venous thromboembolism (VTE) and urinary tract infections (UTI's) in patients with catheters. The data is collected on one day a month and then analysed, allowing trusts to see where they can improve their performance. Data for the community inpatient wards showed an average of 80 patients a month were surveyed. Results showed incidents of both new pressure ulcers (June 2014 to June 2015 – 1.13%) and falls with harm (December 2014 to April 2015 - 2.3%)

were both low. Although there was a higher prevalence of new UTI's in December 2014 the numbers regularly reported were still low with nine months out of 13 months reporting no new UTI's.

- The safety thermometer data showed that falls with harm were low in number across the community hospitals peaking at four in April 2015. There had been no falls with harm recorded in May and June 2015. The deputy head of inpatient services told us they had recognised the number of falls on Longleat ward at Warminster Community hospital was higher than other wards. As a result they had introduced specialised equipment to help reduce falls such as alarm mats. The deputy head of inpatient services and the inpatient wards will be actively part of the Patient Safety falls Collaborative to understand how they could continue to help reduce falls of any kind. We saw that each ward manager could monitor their wards individual performance via the electronic tracker so they were able to tell how many falls had occurred on their ward over a period of time and if there were any themes developing.
- We saw on the governance framework spreadsheet that all category two and above pressure ulcers were reported via the trusts electronic incident reporting system. There was a system in place to then assess and review the pressure ulcers to help understand if there were any areas the division could work on to prevent new pressure ulcers developing.
- We saw information displayed on white boards on the wards we visited. On Ailesbury ward at Savernake Community Hospital information displayed showed there had been no complaints reported in September 2015. Across the community division 106 complaints had been made with the themes of staffing levels, falls and challenging behaviour. Recruitment was ongoing and ward staff said they were aware some new staff had been recruited for the community hospital wards. There was ongoing work across the three community hospitals around falls management and how falls could be reduced in the hospital setting. Attendance at slips, trips and falls training was 85.9%, which exceeded the trusts 85% target.

Incident reporting, learning and improvement

- There had been five serious incidents requiring investigation (SI) between July 2014 and April 2015. They had all been investigated and actions put in place where necessary.The August 2015 board of director's minutes stated that there were no overdue serious incident action plans.
- We heard there was a positive culture around incident reporting with staff telling us they were encouraged to report incidents. Staff said they found the electronic reporting system easy to use and reported they could ask the patient safety team for advice if they did not know how much detail they needed to put into the system. All staff we spoke with across the community hospitals told us they received feedback when they had reported an incident and felt learning was shared amongst the relevant staff groups.
- Staff told us learning was shared with staff on an individual basis (if necessary), during team meetings and through the minutes of the meetings for staff who were not able to attend. The patient safety lead and ward sisters told us Harm Free Care Focus Groups were held monthly to discuss any patient safety issues. They felt this helped to ensure learning was shared and improvements were implemented across all three community hospitals.

Duty of Candour

- Senior staff were aware of the term Duty of Candour (making an apology to patients and/or relatives when patients suffered moderate or severe harm). They had received some training and were able to describe how the principle was used in practice. On the divisional governance database serious incidents tab we were able to see how duty of candour had been applied following investigations. We were told the Duty of Candour (DoC) policy was linked to the trusts safeguarding system available online and therefore the information about DoC was easy to find if staff needed any advice on the subject.

Safeguarding

- All staff we spoke with in the hospitals were able to describe how to recognise and report safeguarding concerns. There was a divisional safeguarding team available for staff to ask for advice and support when considering safeguarding matters.

Good

Are services safe?

- Staff were able to show us how to access a safeguarding referral form,the information about how to complete the form and where to send it.
- Overall compliance for community hospital staff attending Safeguarding Vulnerable Adults including Learning Disability Awareness was 97.1%. With Warminster Hospital achieving 100% compliance.
- At one hospital we saw that Deprivation of Liberty Safeguard requests had been submitted to the local authority. The condition and reasons why the request had been made were discussed at handover each day to ensure staff were up to date with the patients' condition.
- We heard that any safeguarding concerns were discussed at handovers to ensure staff remained fully informed.

Medicines

- We saw that oxygen cylinders were not stored in designated rooms, with relevant signage, whilst not in use. When we asked about this we were shown the risk assessments carried out by the patient safety and health and safety team. The teams had ensured the cylinders had been reduced in size and had suitable securing tapes to ensure the cylinders could not fall out of their storage trolleys. They were stored away from patient areas. We were assured all steps had been taken to ensure the way the cylinders were stored was safe and that the situation continued to be under review.
- The community hospitals ordered their medicines from their local acute hospitals. Pharmacists from the local acute trusts visited the sites to check stocks and order medications and out of hours advice was available. Staff said they also had local arrangements in place with pharmacies who could supply medications prescribed by the GP quickly to prevent patients having to wait to be discharged.
- We checked some controlled medications when visiting one ward. The medications had been checked correctly and the amount of medication stored tallied with what was detailed in the controlled drug register. The controlled drugs were stored correctly.
- We saw that drug storage fridge temperatures were checked daily on all the wards. The readings were recorded. On our visit to Warminster Community Hospital we saw a faulty drug storage fridge had been reported and was being repaired during our visit. We were told of the alternative storage in use for drugs that required refrigeration.
- There was no trust wide policy for self-administration of medication. There were also no lockable facilities by patient's bed to enable medicines to be kept with the patient. One of the advanced nurse practitioners said there were some patients were self-administration would be useful in the patient's ongoing rehabilitation. They added they were new in post that week but would be looking into the possibility of introducing self-medication for relevant patients. Patients own drugs were used on the wards but there was not a process to assess the safety of these medicines.
- The ordering, receipt, storage, administration and disposal of controlled drugs were in accordance with current legislation however liquids did not always have the date of opening on them. . Arrangement were in place to ensure medicines required urgently outside of normal delivery times could be accessed
- Medicines were stored in locked treatment rooms in all of the hospitals. The rooms were all clean and tidy.
- Medicine charts from the acute hospitals could be used for up to 72 hours from admission to support continuity of care. An out of hours GP would be called to admit the patient if they were admitted from another care setting to ensure they would have the appropriate medications when required.
- We spoke to three patients about their medicines. One patient was very knowledgeable about their medicines (e.g. knew how to adjust dose of codeine to pain requirements). Two patients said that they had not been given information about their medicines. One patient said that they were taking three medicines at admission and was now taking 12 medicines. Another patient told us they had been started on warfarin but had not been given any information about the medicine and was not sure if they should continue warfarin when they went home. This meant the patient was not being being involved in discussions about their condition and plan of care.

Environment and equipment

Good

Are services safe?

- Chippenham Community Hospital had two wards. Warminster Community Hospitals and Savernake Hospital had one ward each. There was a mix of single rooms and four or six bedded bays. Some single rooms had en-suite facilities whilst others were near to male and female designated toilets and bathrooms. All the wards were light and bright. Each ward had large day rooms used for dining and activities. Chippenham and Warminster Community Hospitals had plans to introduce dementia friendly areas, in their day rooms, with reminiscence items and period décor. Some staff had visited community hospitals in nearby trusts, who had already provided such areas, to get ideas. Each day room had access to secure outside space.
- There was signage and pictures on some, though not all doors to indicate to patients who had a form of dementia the room was a toilet or bathroom.
- Patient-led assessments of the care environment (PLACE) assessments August 2015 (a national annual assessment of the quality of the patient environment) showed the average score for the condition, appearance and maintenance was 92.5% better than the England average of 90.3%.
- Mulberry Ward at Chippenham Hospital that cared for people who had had a stroke, had a mix of single rooms and four bedded bays. The single rooms had ceiling track hoists which were considered good practice when lifting and handling patients. They were not present in the bays. We saw a comprehensive risk assessment carried out around provision of ceiling track hoists in the bays on Mulberry ward updated in September 2015. It detailed the advantages to staff and patients of having overhead hoists instead of traditional hoists. The actions stated that a decision was awaited regarding the source of the hoists and available funding.
- All of the resuscitation trollies and grab bags (small bags with resuscitation equipment that could be used in areas not easily accessed by a trolley, such as outdoor spaces) were regularly checked and equipment was seen to be in date.
- One syringe driver we checked had a label that said next due for calibration in January 2015. We bought this to the attention of the deputy head of inpatient services who immediately checked with the team (contracted from a local acute trust) if they had records that showed the item had been checked in January 2015. Records showed it had been checked and the label should have been dated to read the next calibration date due January 2016. Although the situation was resolved the deputy head of inpatient services said they would put in an incident report to ensure the issue was captured in the incident report monitoring system. This would ensure if the same had happened elsewhere this would be picked up and resolved trust wide. All other equipment we checked was within its service dates.
- On the stroke ward (Mulberry) we saw an equipment log with the most up to date maintenance dates recorded. There was also a list of maintenance requests and new equipment requests.

Quality of records

- We saw a selection of patient records at each hospital we visited. They were very personalised to each patient and were fully completed. In one case we were not able to establish if a referral had been made to a dietician following a nutritional assessment score that required a referral to be made. We saw concerns had been escalated appropriately to either a GP or specialist nurse or therapist. Daily records recorded patients daily progress. They were detailed and relevant. Care plans were kept securely in ward offices.
- Records were subject to regular audits to ensure they were consistently completed. Areas of non compliance were discussed with individual teams during team meetings or one to one meetings.
- Records kept at the patient's bedside included observation charts and food and fluid charts.
- Medication administration sheets, that included blood clots (VTE) risk assessments, were kept in folders in locked treatment rooms. The ones we saw had been fully completed and detailed reasons why medicines had not been given if relevant.

Cleanliness, infection control and hygiene

- Patient-led assessments of the care environment (PLACE) assessments January to June 2014 showed the average score for cleanliness in the three community hospitals, was 92.4% which was below the England average of 97.0% (across all community sites). Ward managers were monitoring the cleanliness of their wards. They bought any concerns to the attention of the

hotel services teams. Any barriers to improvement were discussed and if there was an environmental issue for example due to the lay out of the ward/room/corridor the estate team would be involved in any discussions to help resolve the issue.

- All of the hospitals we visited were clean and tidy. There were paper towels, liquid soap and pedal bins at each hand-washing basin. There were antibacterial hand gel dispensers at the entrances to the hospitals and wards.
- We saw staff using personal protective equipment (PPE) such as gloves and aprons. This was readily available on all of the wards.
- All of the wards had single rooms that could be used for looking after people who had infections. We saw one case of a person who was being barrier nursed. All relevant equipment was available outside the room. Information for staff and visitors was clearly displayed outside the room and we observed staff used antibacterial hand gels and wearing gloves and aprons when entering and leaving the room.
- Training records showed that staff on all the wards apart from Longleat ward at Warminster Community Hospital had achieved above the 80% trust target for infection control training. 42.4% of staff on Longleat ward had attended infection control training. Staff had been booked onto training to ensure this percentage increased.
- Members of the community infection control team visited one of the wards during our visit. They were known to staff who told us the team were available for advice and support if required.
- Hoist slings were single patient use and remained with the patient at their bedside. This helped to reduce the risk of cross infection by sharing equipment.

Mandatory training

- The trust had set a target of 80% compliance with mandatory training. Staff on both wards at Chippenham Community Hospital had not achieved the trusts 80% target in the following areas: consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. None of the wards had achieved over 80% for their information governance and record keeping refresher. However staff on all the wards had achieved over 80% for training in moving patients equipment and manual handling, safe practice of medicine management and venous thrombotic embolism. The ward sisters and the deputy head of inpatient services told us and showed us evidence that staff were booked onto mandatory training to ensure they were up to date. They said and ward staff agreed that training was very rarely cancelled due to staffing issues.
- Staff were all very positive about the Great Western Hospital NHS Foundation Trust (GWH) training Academy. It was described as easy to access and could provide role specific training if it was identified as part of a staff members appraisal and continuing professional development. Staff gave us examples of training that had also been part or wholly funded for them such as nurse training. Staff also said the trusts electronic 'training tracker' where they accessed on-line training was easy to use and meant you did not always have to go to the acute hospital to receive training. The system also showed them what training they were due to undertake and could link them to available dates for specific training.
- Training was also held at the community hospitals which was often easier for staff to access instead of travelling to GWH.

Assessing and responding to patient risk

- There were systems in place to assess and monitor patient risks. We reviewed a total of 14 records. All had completed risk assessments including falls risk assessment, nutrition assessments and skin assessments. Patients' conditions were monitored by the use of an early warning system that tracked changes in a patient's condition and those at risk of deterioration. They were kept at the patient's bedside. We saw that as a result of rising scores patients had been appropriately referred to the GP. Allergy information recorded on patient records including their medication administration sheet.
- We observed a number of handovers and multidisciplinary team meetings. At these meetings the staff team discussed patients in great detail including current or perceived risks, safe discharge planning and patients and relatives understanding of their risks.
- A patient had been able to leave the ward at Warminster Community Hospital and fallen resulting in a fracture. A risk assessment had taken place and a decision had

been made to fit a keypad on the door. This would mean patients were still able to leave the ward but a member of staff would know and able to accompany them if they felt they were at risk of falling or hurting themselves. During the inspection we were told the keypad had been ordered and would be fitted as soon as it arrived. Staff in the meantime were being extra vigilant to ensure they knew the wheabouts of all patients who were able to mobilise independently. The risk with these pateints was also discussed at each handover meeting.We did see one patient let a member of staff know they were leaving the ward to go for a walk along the corridor. The member of staff ensured they were alright and not intending to go down the stairs. The patient came back to the ward a few minutes later with a member of the therapy team who they had met along the corridor.

Staffing levels and caseload

- Staff and managers told us they had vacancies for nursing staff and some therapy staff. Data showedat Chippenham Community Hospital Mulberry Ward had a trained nurses vacancy rate of 23.5% and 23.5% for allied health professionals (AHPs). Cedar ward (Chippenham Communtiy Hospital) had a 24.9% trained nurse vacancy rate and a 27.8% for AHPs. Ailsbury ward at Savernake Hospital had a 17.3% trained nurse vacancy rate and 5.6% for AHPs. Longleat ward had no vacancies for AHPs and 26.3% vacancy rate for trained nurses. Recruitment was ongoing and a number of nurse vacancies had recently been filled. The duty rotas showed that some shifts were covered by bank or agency staff. The deputy head of inpatient services told us she was able to carry out clinical shifts sometimes to help. She said this was usually when a shift could not be covered by bank or agency staff. Staff were prepared to cover shifts and be flexible around their working hours to try to cover vacant shifts. Staff told us the bank and agency staff, they used, were familiar with the respective hospitals and worked as part of the team. During the inspection staff had time to attend to patients needs and we did not see patients waiting too long for attention when they needed it.
- Agency or bank therapy staff were not easy to access and this resulted in some patients not getting the recommended amount of physiotherapy per day following a stroke. In one case staff had tried to access an agency physiotherapist for a patient who felt they were not having the amount of physiotherapy they had expected. At the time of the inspection they had not been successful in getting any physiotherapy agency staff. This was escalated to the locality manager during the inspection.
- Staff told us they were always able to get additional nursing staff for patients assessed as needing one to one care.
- The ward sister on Mulberry ward, which looked after people who had had a stroke, told us they had demonstrated the high work load on the ward meant that more staff were needed on each shift. This was agreed by the divisional leaders and levels increased on each shift. Staff told us this had reduced sickness levels and stress among the staff group. Mulberry ward sickness rates had reduced from 5.21% in March 2015 and 3.61% in April 2015 to 2.75% in May 2015. An acuity tool had been used to demonstrate the need for more staff. The patient safety team would ensure the acuity tool was used regularly to ensure staffing levels were maintained at the right level to meet pateints needs.
- Speech and language therapy was available on Mulberry ward each day and dieticians could be contacted when needed. They were employed to work across the community services and told us they were often able to follow patients when once discharged home. There were two part time band six and one part time band five physiotherapists with a full time band three physiotherapy assistant on Mulberry ward. There were three part time band six and one fulltime occupational therapist on the ward supported by one assistant occupational therapist. This level of therapy staff was able to meet the needs of the patients on the ward during the inspection.
- During the day medical cover on the wards was provided by the local GP surgeries. Out of hours and at weekends staff had to call the out of hours service and a GP would visit the ward. This may or may not be one of the local GPs. Staff we spoke with told us the system worked well as good GP coverage during the day and regular ward rounds meant that routine work was attended to in a timely way.

Managing anticipated risks

- We heard from staff that fluctuations in demand were planned for such as holiday season or when bad

Good

Are services safe?

weather was forecast. Staff told us they worked with their community colleagues to ensure that during bad weather staff worked at their nearest hospital if they could get to it and/or offer to see patients in the community if they lived nearby.

Major incident awareness and training

- There was a major incident plan available to all staff on the trust intranet. Local evacuation and fire risk assessments were available on each ward. Staff we spoke to were able to describe the role of the community hospitals in the divisional major incident plan. Staff were also able to describe the business continuity plan for example during severe weather.

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 judged effectiveness within community hospitals as good. Evidence based practice was in use and the divisional governance database had links to the most recent National Institute for Health and Care Excellence (NICE) guidance. Audits and learning from incidents and sharing of information across the community hospitals ensured patients were having care and support, including pain relief and nutritional assessments, relevant to their needs. Staff spoke very highly of the Academy and practice educators who provided relevant and accessible training for the staff. Staff had a good awareness of the Metal Capacity Act 2005 and the impact capacity had on patient's abilities to make decisions and consent to treatments. There was effective multidisciplinary working across all three community hospitals.

Some patients waited for packages of care to be arranged before they could go home. As a result, step up beds that were funded by the local commissioning group were not able to be used effectively.

Evidence based care and treatment

- Staff had access to the intranet containing a divisional governance database which contained a link to all the latest National Institute for Health and Care Excellence (NICE) guidance**.** We were told when policies and procedures were reviewed the staff member looked at the link to determine if there was any more up to date information that needed to be added or amended in the document. We were shown how this was done on the trusts intranet system.The patient safety nurse told us when staff investigated reported incidents they reviewed the NICE guidance referred to in the relevant policies and procedures to ensure the documents were up to date and also reflected the most up to date guidance.
- The divisional governance database included sections on clinical audits where staff could input data for local and national audits. We saw one staff member inputting data into the Sentinel Stroke National Audit Programme (SSNAP). This is the single source of stroke data in England, Wales and Northern Ireland.
- There was an audit department who were available to provide assistance to any staff having difficulty completing their audits. We were told that many of the audits were based on the Commissioning Quality and Innovation framework (**CQUINs)** requirement from the clinical commissioning group (designed to improve quality and therefore secure better outcomes for patients).
- Best practice was shared amongst the three community hospitals via ward sister meetings and meetings with divisional managers.The deputy head of inpatient services visited each hospital at least weekly and had an oversight of how they implemented any required changes and ensured they were embedded in practice.
- Patients with long term conditions or complex needs who were having rehabilitation had clear care plans with goals set taking into account relevant good practice guidelines. Some staff reported that due to patients sometimes having to wait for discharge, whilst a package of care was being put in place, they needed continuing rehabilitation. This meant that although they had successfully completed their rehabilitation programme in order that they did not lose their skills they had to continue with some form of rehabilitation to remain fit for discharge. Staff were concerned they did not always have sufficient time to spend with patients to maintain their skills.

Pain relief

- Patient records we reviewed had care plans detailing patients pain management plans. The early warning score charts, kept at the bedside had a pain assessment section which were all completed on the documents we reviewed.
- Medication administration records reviewed contained records detailing that patients had pain relief between drug rounds when required

- During observation of a medication round we saw the nurse asked patients if they were in pain and would like pain relief medicine.

Nutrition and hydration

- There were safe swallowing instructions, written by the speech and language therapist, at the bedside of all but one patient who was having difficulty with swallowing following a stroke. Food and fluid charts were in place where required and were up to date meaning patients were being regular assessed in terms of their intake and output.
- Care plans reviewed included a nutritional screening and assessment tool. They were up to date and used by nursing and therapy staff to assess a patient's nutritional status. Supplemental drinks were available to patients for whom they had been prescribed.
- Staff were available to assist patients at mealtimes. We were told visitors and doctors were discouraged from visiting at mealtimes to allow staff more time to help people. There were signs displayed exaplining the concept of protected mealtimes and asking for visitors to avoid being on the wards at mealtimes.
- Patients had access to fresh water whether they were by their bed or in a day room. We saw hot and cold drinks being offered to patients regularly.
- Patient-led assessments of the care environment (PLACE) assessments January to June 2014 showed that the average score for food overall was an average of 89.7% slightly worse than the England average of 90.5%. Patients we spoke with said the food was good and that there were choices.

Technology and telemedicine

- Telehealth services were carried out by a privately contracted company. Staff we spoke to had never encountered any problems with the service provided.

Patient outcomes

- The Sentinel Stroke National Audit Programme (SSNAP) data for the stroke unit (Mulberry ward) at Chippenham Community Hospital for the period January 2014 to December 2014 showed overall scores were at level D (the levels are achieved by comparing a variety of data received against a set of relevant questions about care provided post stroke). This was an improvement from level E in the previous report. This compares to an overall SSNAP rating of E for the trust. There was a working group in place to ensure ongoing improvement in the management of people who had had a stroke. Other trusts locally had ratings that ranged from B to D. We observed therapy staff inputting information in the SSNAP template during our visit.
- Quality and audit information collected at each community hospital demonstrated local audits were ongoing. For example monitoring of falls and length of stay in hospital. This led to initiatives to help improve outcomes for patients such as alarm mats to alert staff when patients were trying to get put of bed unaided. Multidisciplinary team work had been strengthened over a period of time to ensure clear plans for discharge were made in a timely way to help reduce the length of stay on a ward.
- It was clear that information that improved patient outcomes was shared between the three community hospitals meaning patients across the hopsitals would benefit from improved practices.
- It was felt the outcomes for some patients who required extra support with their long term conditions would improve once the step up beds could be used as planned.
- Speech and Language therapy staff at Chippenham Community Hospital told us about their involvement in the local audit relating to dysphagia (difficulty swallowing) and food textures. They had met with ward staff and discussed concerns and their current knowledge base. Following that an action plan had been put in place to help inform staff about dysphagia. This included a training session to be attended. The plan was to reaudit in December 2015 after all staff had attended the training to assess if staff had improved their skills in mamaging pateints with dysphagia.

Competent staff

- Staff told us they had regular appraisals and one to one sessions with their line managers. They said they could request a meeting at any time if they had concerns or issues to discuss. Data showed that annual appraisals were 81% completed across the trust. At Chippenham Community Hospital completed appraisals ranged from 63.3% for unregistered nursing staff to 100% for administration and clerical staff. At Warminster the

completed appraisals ranged from 60% for allied health professionals to 100% for administrative and clerical staff. On Ailesbury ward at Savernake Hospital the only available data showed only 58.8% of registered nurses had received an appraisal. Following the appointment of some senior nursing staff and a period of stability ward sisters told us they had prioritised appraisals. They were able to show us dates booked for staff to have their appraisal meetings.

- Staff told us they valued the four day community induction programme they were expected to complete once they had finished their corporate Great Western Hospital NHS Foundation Trust induction training. Staff who had started a few months before it had been introduced had also been asked to attend the community induction as well as staff whose roles had changed.
- Access to mandatory and role specific training was good. Staff spoke very highly of the trusts training Academy, based at Great Western Hospital. They said they could access training via the Academy and also at the community hospital. In addition, the Academy was felt to be a good resource for role specific training. The Integrated Community Health Division had a practice educator who linked into the Academy and was able to help ensure community staff had access locally to relevant training.
- There was a trust wide leadership programme for senior staff. Staff who had attended this told us it had been very useful and they felt supported and encouraged to do the course.
- We heard that two Consultants provided bespoke training on some of the community hospital wards. This was well received and attended by staff. They felt this enhanced the feeling of working in partnership to ensure the best care and support is provided for the patients.
- There were link staff for a range of areas including dementia, infection control and tissue viability. These staff attended meetings to ensure they had the most up to date information about best practice. They were then able to share what they had learnt with staff on the ward at ward meetings for example.

Multi-disciplinary working and coordinated care pathways

- We observed two multidisciplinary team (MDT) meetings. They were organised, well led and each member of the team was listened to and respected. All staff were aware of who was responsible for each patient. They worked with other community teams within the community division to ensure the most appropriate support was organised for patients whilst an inpatient and for when they were fit to go home. Staff showed a real understanding of patients' needs and described issues in detail during the meetings. The social workers we spoke with said it was invaluable being included in the MDT meetings as it allowed them to make immediate referrals for services that would be needed following discharge. Joint visits with the patient, social workers and relevant therapists were also set up during the MDT meetings. Formal minutes were made of the meetings so they could be referred to if there were any points of clarification needed.
- Local GPs who provided medical cover on the wards and visiting consultants conducted ward rounds which involved ward staff and the patient, where possible.

Referral, transfer, discharge and transition

- Trust board meeting minutes from September 2015 reported the average length of stay in the community hospitals as 28.3 days against a trust target of 20 days. This was an improvement from 34.9 days stated in the August 2015 board minutes.
- Data showed there were high readmission rates following discharge from community hospitals. We discussed this with the deputy head of inpatient services who told us the divisional team had reviewed the readmissions and most of them related to patients who visited the wards for ambulatory care (day care for blood transfusions or intravenous medication for example) more than once in a short period of time. They were effectively discharged and readmitted every time they attended the hospital even though they were not inpatients.
- There were comprehensive discharge plans in the patients' care records. They included details of who to inform when discharge was confirmed. We heard ward staff talking to community nurse teams and passing on relevant information that would allow effective care and treatement to continue at home.

Good

Are services effective?

- Patient records contained detailed discharge plans. Patients we spoke to generally were aware of the plans for discharge and the expected date of discharge. There were systems in place for informing the patients GP and any other health care professionals involved with the patient prior to admission of expected discharge dates. This included information about their current assessed needs.
- There were some patients ready for discharge during our inspection, all of whom were waiting for a package of care to be arranged. There were daily teleconference discussions with the acute hospitals and social services to ensure patients ready for discharge were being prioritised.
- Additional beds had been commissioned on Longleat and Ailesbury wards for step up care, Longleat ward had 15 beds and Ailesbury ward had 6. These patients were admitted from home rather than being admitted into the acute system. The beds were available until 3.00pm, after which they were made available to acute services to aid patient flow. However although extra staffing had been agreed and advanced nurse practitioners (who could prescribe some medications) had been employed on a trial basis the step up beds were not able to be used due to beds being full of people ready to go home but waiting for packages of care to be arranged.
- A private contractor collected information about people ready to be discharged to community hospitals from the local acute trusts. These were then discussed during regular teleconferences, that included ward managers, to ensure they were receiving appropriate referrals to vacant beds.

Access to information

- Access to a bed management system was in place across the community services, including the community hospitals. Staff described really good communication between community services and accessed information about patients via telephone calls and the email system. We saw this information was added into the current patient records in use in the hospital setting.We saw ward staff, including medical staff and allied health professionals, writing in the patient records or medical notes. The medcal notes included information about test results and care plans included information about care needs and risk assessments.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Staff showed a good awareness of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DOLS). They were able to explain how they had recently had to complete a DOLS application. Staff were able to find the documentation required and knew they could ask the safeguarding team if they were unsure about how to complete the forms.
- Staff were aware of issues relating to lawful and unlawful restraint and if in doubt would not hesitate to contact the trusts safeguarding team for advice.
- Care records had risk assessments relating to the use of bed rails and alarm mats. The rationale for their use and discussions with the patient and/or relatives had been documented.
- We saw how consent for procedures had been obtained or discussed with the patient or their relatives. When patients did not have capacity to make decisions or give consent we saw conversations with the patient and their relative had been documented to show how a decision had been reached as to whether or not to carry out a procedure. The reasons for the procedure being needed were also documented. The governance database had details of document audits that included if consent had been appropriately gained.
- Records reviewed showed individual capacity had been assessed and how that impacted on the discussions about care and support required for patients.
- Training records from June 2015 showed that 78.9% of community hospital staff had completed the Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. However staff at Chippenham Hospital had not reached the trusts 80% target for training attendance at the time of the inspection. Mulberry ward was 68.6% and Cedar ward was 77.8%. We saw some staff had been booked onto upcoming training courses.

Good

Are services caring?

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

Summary

We judged the caring to be good. Patients and relatives across all three community hospitals provided positive feedback . We were told by patients and their relatives that they felt involved in their care. They felt they had emotional support in what were often difficult circumstances. Patients and relatives were complimentary about care staff, therapy and medical staff. Interactions we observed between patients and staff were discreet, appropriate and not rushed. Call bells were answered quickly.

Compassionate care

- Patient-led assessments of the care environment (PLACE) assessments January to June 2014 showed that the average score for privacy, dignity and wellbeing across all three community hospitals was an average of 85% which was below the England average of 93.6%.
- Patients spoke positively of the way staff managed their privacy and dignity. We saw staff speaking with patients discreetly, in a caring and supportive manner. Curtains were drawn around patients when personal care was taking place. Staff were seen ensuring engaged signs were used and knocking on doors before entering single rooms or toilets.
- We saw examples of thank you cards and letters displayed on all the wards we visited. They all had positive comments about how caring and supportive the staff were.
- We were told about and met with volunteers who told us they were able to spend time with patients doing activities or simply talking.
- Call bells were answered quickly. We heard one patient was telling a nurse they had to wait a long time to have their bell answered. The electronic records were checked and it was found the patient did not ever use the call bell. This showed staff were concerned about responding to patients quickly.
- We saw that most patients with a form of dementia had a 'forget me knot' flower symbol against their name to identify them to staff. This indicated to staff at a glance which patients had a form of dementia and therefore may need specific help in some areas. This was seen as good practice.

Understanding and involvement of patients and those close to them

- Relatives and the patient (where possible) were involved in detailed discussions around patient care and ongoing support. Relatives were involved in multidisciplinary team meetings if this was felt to be in the patients best interests.
- Patients and relatives told us they were aware of discharge plans. Some expected to go home with support from community services, whilst others were going to alternative care settings to continue their rehabilitation.
- There were information leaflets about national and local help and support groups displayed on all the wards. There were phone numbers and addresses for people to contact.
- Patients we spoke with said of Chippenham Community Hospital the "food good, choice and quality is there", I've had "top quality care, like private care" and "privacy and dignity - very good" and "staff are friendly and competent". Feedback we received about Savernake Community Hospital included "Very happy with the service provided, excellent support from a variety of healthcare professionals, particularly OT who we nominated for a peoples award. Very supporting of individualised needs".

Emotional support

- We saw staff of all grades and roles assisting and supporting patients. Therapists walked with patients to help them gain confidence and asked them how it felt using a mobility aid. We saw staff taking time to chat to patients who were disorientated or upset.
- There were close links with the local integrated community teams and as a result a member of the team that would be looking after a patient after discharge

Good

Are services caring?

visited the ward to introduce themselves to the patient and relatives. Ward staff said this was a great opportunity to talk about the patients and relatives anxieties and concerns about going home.

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 community inpatient services were responsive to patient's needs. Staff had regular meetings with the commissioners of community services to ensure the division was able to provide services that met local people's needs. Community hospital staff worked closely with community specialist and integrated community teams to ensure patients had their rehabilitation and that the right care and support was available at home prior to discharge. Some patients were having to wait for available capacity within external providers to before they could be discharged.

Community hospitals were accessible to people who used mobility aids or were wheelchair users. There disabled parking spaces near the main entrance of each hospital.

Dementia friendly environments had been considered with signage and pictures to help patients find the toilet and bathroom facilities. Staff recognised more work was needed to provide better dementia friendly environments and as a result some staff had visited another local hospital to see how they had developed their dementia friendly ward.

The wards responded positively to complaints and tried to resolve the issues locally. When a complaint investigation was carried out any learning points to improve the service were shared across all three community hospitals.

Planning and delivering services which meet people's needs

- Regular meetings were held with the commissioners of the services to ensure the division was able to provide the services that met the needs of the local population. This included supporting people in hospital and at home with long term conditions and complex needs.
- Community hospital staff worked with community specialist nurses, for example respiratory specialist nurses and integrated community teams, to ensure most comprehensive packages of care were in place for patients returning home or to another care setting.
- Some patients waiting for discharge home needed care packages arranged before they could be discharged. Whilst arranging the care packages was not the responsibility of the trust the community division were working hard to ensure their internal processes were in place to complete discharges smoothly and consistently. This meant that Longleat ward at Warminster Community Hospital could not maximise the use of their 15 step up beds to support effective patient flow.
- All three community hospitals had facilities and premises appropriate for patient's needs. Staff told us they were always looking at ways to improve the way they ran their services and facilities provided.
- Treatment by therapists often took place at the bedside. Therapists who worked at Chippenham Hospital on Cedar ward told us although they could book the muscular skeletal gym at the hospital it was very busy. They said it would be more helpful to patients to have a rehabilitation gym available.
- We spoke to one nurse who identified that, as part of their rehabilitation, a patient might benefit from managing their own medication whilst in hospital as they did prior to admission and would be after discharge. They were going to consider how this could be managed for patients in the future.
- One patient told us they had expected to be able to use wireless communication whilst they were in hospital. They had found this difficult to achieve but had received no satisfactory explanation from staff as to why they could not access the 'wi-fi' connection. We told the deputy head of inpatient services who made sure staff explained to the patient what was available and provided assistance if required.

Equality and diversity

- Staff had access to telephone translation services. Leaflets were available in all of the hospitals community and could be printed in large print or other languages as required.
- The hospitals all had level access at the front entrances, with lifts available to facilities on other floors as well as disabled parking places near to the main entrances.

Good

Are services responsive to people's needs?

Meeting the needs of people in vulnerable circumstances

- All of the community hospital wards had 'dementia champions' who were care and /or therapy staff. They had extra training and attended link meetings to ensure they were up to date with best practice recommendations and could help to inform the other staff on the wards. All of the community hospitals had dementia friendly environments. Some areas had signage and pictures indicating bathrooms and toilets on doors. Staff had visited another community hospital locally to see how they had developed their dementia friendly ward in order to gain further ideas.
- Staff had a good awareness of how to manage patients with a form of dementia. They were able to respond to their needs appropriately.
- Care was planned and delivered by joint working with community services including learning disability services and dementia services. Staff had access to the learning disability team , who worked for the same community division.

Access to the right care at the right time

- Local GPs provided medical cover for the wards, with visiting consultants providing specialist advice. Patients with the most urgent needs were seen quickly and had relevant medications prescribed and tests arranged.
- If patients deteriorated and needed to see a GP staff called the 111 service to request a visit. If a patient needed urgent treatment staff called 999 for an emergency ambulance who could transfer the patient to an acute hospital.

Learning from complaints and concerns

- A formal record was kept of all complaints at each community hospital. Each ward also had a white board that displayed information for patients and their visitors which also detailed complaints and compliments. An example was Mulberry ward at Chippenham Community Hospital where information displayed showed there had been no complaints and 12 compliments made in August 2015.
- Staff we spoke with told us they would refer any complaints made to them by patients or relatives to the ward sister or direct the person with the complaint to the patient advice and liaison service (PALs). We saw PALs information in leaflet and poster form for the Great Western Hospital NHS Foundation Trust and the other neighbvouring acute trust as patients had often been admitted from the acute hospital to the community hospital.
- Complaint investigation recordsreviewed were detailed and looked at a wide range of information during the investigation. A complaint had been made at Savernake Community Hospital in October 2015. The complaint, relating to a discharge, had been investigated and the family had been given an apology. The ward sister told us an email would be sent to all relevant staff about improving communication in relation to discharges.
- Staff told us that any complaints about their ward were discussed at team meetings. Any shared learning points were discussed and minutes were made to document decisions about how to implement the learning and the improvements that would be expected. Staff added that they knew the improvements were monitored by means of regular audits and the results would be shared with them.
- Staff attempted to address problems informally and resolve issues for people quickly. These were discussed at shift handover or team meetings to ensure people knew the concerns had been addressed.
- Relatives described knowing how to make to complaints and who to approach. We spoke with one family who had raised some concerns and although their issues were not yet resolved they said the staff were working hard to improve the situation.

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 judged the community adult services as being good when looking at the well led domain. Leadership was good at local and divisional level. Staff felt supported and informed. They were aware of the values of the trust and were clear services were designed with the patient at the centre.

Staff at all levels were engaged in the governance processes and systems. This was achieved by the use of a Governance database spreadsheet to that was used to 'monitor aspects of governance and patient safety issues within the division along with any actions arising'. Staff were familiar with the document and found it a useful to manage audits and governance at a local level.

We found a very positive culture within the Integrated Community Health Division (ICHD). Staff felt that since community services had joined together this had led to more integrated working which benefitted patients and staff.

All of the community hospitals had active League of Friends, whose opinion of their local services, with that of the local general public was valued. Staff felt their ideas and opinions were listened to and as a result felt valued within the division.

Service vision and strategy

- Staff were clear there was a five year trust vision and were all aware of the STAR (service, teamwork, ambition, respect) values. Staff told us they felt engaged with the trusts values which were echoed in the Integrated Community Health Division (ICHD).
- The values were displayed around the hospital sites and references to putting the patient first were also seen displayed.
- Staff knew community services as a whole were developing nationally and locally but felt there were being kept informed of any proposed changes.

Governance, risk management and quality measurement

- The Divisional Quality Governance facilitator for the ICHD had developed a 'Governance Database' spreadsheet. It was managed along with the divisional Patient Safety and Quality Lead. The document states 'this database is used to monitor aspects of governance and patient safety issues within the division along with any actions arising'. The spreadsheet had information stored under the 5 domains used by CQC (effective, safe, caring, responsive and well led and included a tab for meetings that related to governance and patient safety and quality. The document also included links to the ICHD quality reports, performance dashboard, quality dashboard and organisational structure chart. The reports were regularly discussed at the monthly patient safety and quality meetings. The head of locality also attended performance and quality meetings with the local commissioning group (CCG) to ensure there was continual dialogue about the services the community hospitals provided and the challenges they faced.
- There were no items relating to community hospitals that had reached the threshold to be on the trusts risk register. Risks concerning the community hospitals were held on the governance database. These were discussed at monthly divisional meetings that included the Director of Community Services, Head of Locality and the Patient Safety Lead. The Director of Community services, who was a non voting executive director on the trust board, was able to discuss specific concerns at board level.
- Staff were clear about their roles in relation to governance and their accountability. There was a robust system for reporting concerns and monitoring quality.
- There were definite lines of accountability with staff being aware of how to cascade information upwards to the management team and downwards to staff on the front line. Staff at all levels were clear about how information travelled in the division.

Leadership of this service

Good

Are services well-led?

- There was very good leadership in the ICHD. Ward sisters told us they had good support from the deputy head of community inpatients and the head of locality. They found them approachable and accessible and had regular meetings with them,
- Ward sisters were described as approachable and supportive. Therapists also had access to senior therapists from their own specialities if they had any professional issues to discuss.
- The Director of Community services was fully engaged with the community hospitals and had 'walked in the shoes' of the hotel services by performing tea rounds on the wards. We were told this had been successful and they intended to carry this out across the wards on a routine basis.
- The deputy head of community inpatients spent time each week at the community hospitals. Staff felt thissupported the sharing of good practice and helped to prevent staff from feeling disconnected from the other community hospitals.

Culture within this service

- Staff described feeling valued, respected and supported by their colleagues and the ICHD.
- Staff told us the divisional lead and head of the locality were very visible and approachable if they had any queries or suggestions.
- Sickness levels had fluctuated between January 2014 and May 2015 (range 0% to 17%). The trust target for sickness was below 3.5%. There had been a period of change of senior ward staff during this period. Data showed that where the leadership had become more settled the sickness rates had reduced
- Senior staff told us action had been taken to address performance when it did not meet with the trust and divisional expectations. This sometimes took the form of bespoke support for staff members or staff being redeployed to a role more suitable to their skills.
- Staff said they asked patients and their relatives for feedback. This was on an informal basis and by encouraging patients and relatives to complete the national Friends and Family Test feedback questionnaire.They also felt their ideas as a staff group were listened to both informally and during team meetings.
- Each hospital had an active league of friends who fund raised to support improvements in the facilities such as improved outdoor spaces, entertainment equipment.

Public engagement

- Each community hospital had an active League of Friends who were able to help fund specific pieces of equipment, for example garden furniture
- Each community hospital also had a number of volunteers who helped to improve outside spaces, talked with patients and sometimes helped with activities.
- Feedback from patients and the public in the form of compliments sent to the wards or completed Friends and Family tests was discussed at divisional meetings. The information was stored on the Governance Database and updated regularly.
- On Ailesbury ward at Savernake Hospital a Carers Café was regularly held. This helped to support local carers and get their input about the quality of the service their relative may have received as an inpatient.

Staff engagement

- Staff we spoke with at all levels felt informed about their own particular ward and community hospital.Divisional updates were received via email or the intranet in the form of newsletters and notices, some of which had been printed out and displayed in ward offices.

Innovation, improvement and sustainability

- Staff told us they were aware that the trust overall had financial pressures. They said they had not felt an impact around this in the community hospitals.
- We were shown how information from audits and complaint investigations was used to improve care. We saw examples on the governance database of repeated audits to ensure improvements had been made and embedded in practice.