Care Quality Commission

Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Royal Hospital

Quality Report

Gloucestershire Royal Hospital
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Outstanding
Maternity and gynaecology	Good
Services for children and young people	Good
End of life care	Requires improvement
Outpatients and diagnostic imaging	Requires improvement

Summary of findings

Letter from the Chief Inspector of Hospitals

Gloucestershire Royal Hospital is one of two district general hospitals run by Gloucestershire Hospitals NHS Foundation Trust. It is an acute hospital with 683 beds. It provides urgent and emergency services, medical care, surgical care, critical care, maternity and gynaecology, services for children and young people, end of life care and outpatient and diagnostic imaging services. It provides specialist cancer care to patients from Gloucestershire, Worcestershire and Herefordshire as the hub for the three Counties' Cancer Network

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a low risk trust according to our new Intelligent Monitoring model. The inspection took place with an announced inspection 10–13 and an unannounced 20 March 2015.

Overall, Gloucestershire Royal Hospital was rated as requiring improvement. We rated it as good for caring and as requiring improvements in safety, effectiveness, being responsive to patients' needs and being well-led. Overall, critical care was rated as outstanding. Maternity and gynaecology and services for children and young people were rated as good with the remaining core services rated as requiring improvement.

The trust's services are managed through a divisional structure that covers all the hospitals within the trust, with some staff rotating between the three sites of Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital; therefore there are significant similarities between the content of the three location reports.

Our key findings were as follows:

Safe

- Safety was judged as good in critical care and surgery, but in all other areas it required improvement.
- The emergency department was frequently overcrowded; this was associated with a lack of patient flow, which in turn led to the risk that patients might not be promptly assessed, diagnosed and treated. Patients were not always cared for in the appropriate part of the department, with particular concerns about the safety of patients being cared for in the corridor when the department was so busy that it could not accommodate patients in clinical areas.
- Staff were aware of how to report incidents and felt encouraged to do so. However, overall the trust was reporting fewer incidents than the national average (6.8 per 100 admissions compared with 9.3 per 100 admissions for the NHS England average in the period from November 2013 to October 2014).
- The majority to staff stated they received feedback after reporting incidents. In all areas there were examples of learning from incidents.
- Overall, the hospital was visibly clean; however some areas, such as the room for patients with mental health needs and areas in the medical wards, were found to be dusty, dirty and, or to contain litter. We also found a number of hand gel dispensers that were empty.
- The number of cases of Clostridium difficile was significantly lower than in previous years, and at 34 cases up to February 2015 was well below the trust's target of a maximum of 55 for the year ending April 2015. There had been just one case of methicillin-resistant Staphylococcus aureus (MRSA) in the year to date.
- Throughout the hospital we found medication stored in resuscitation trolleys was not secured to demonstrate it had not been tampered with between checks.
  - In some areas, records were not stored securely.
  - Review of 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms showed that the forms did not consistently demonstrate or link to a reference of patients' mental capacity, and this information was not obvious or easily accessible in other records. Explanations for the reason for the decision to withhold resuscitation were not always clear, and records of discussions with patients and their next of kin, or of reasons why decisions to withhold resuscitation were not discussed, were always not documented.

Summary of findings

- The majority of staff had attended safeguarding training in order to keep people safe from abuse. The exception to this was staff in urgent and emergency services, where for level 2 child protection training, particularly for junior doctors, completion rates were low, at 68% compared with the trust's target of 90%.
- Staff had access to a range of mandatory training, and attendance was monitored. Records showed that the majority of staff had attended the required mandatory training, and the trust's target of 90% was exceeded. However, in the unscheduled care division, medical staff were performing less well at accessing such training.
- Systems were in place to assess and respond to patient risk; these included risk assessments relevant to patients' needs and early warning scoring systems to determine whether patients were at risk of deteriorating.
- The trust's target for completion of venous thromboembolism (VTE) risk assessment had not being met since the first quarter of 2013/14.
- Nurse staffing levels had been reviewed and assessed, with oversees recruitment having taken place in order to meet the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidance. Some areas, such as the flexible capacity wards, relied heavily on the use of bank and agency staff.
- Medical staffing was at safe levels in many services. However, there were some exceptions; these included consultants in acute medicine, general and old age medicine and radiology, and junior doctors in medicine and emergency care.
- The trust had a major incident and business continuity plan in place. The majority of staff were aware of their roles and responsibilities should the plan be activated.

Effective

- Services were found to be effective in surgery, maternity and gynaecology, children and young people, end of life care and critical care. The latter we judged as outstanding. Improvements were required in urgent and emergency services and medicine.
- In most services, people's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance.
- Mortality rates were in line with those of other trusts, as measured by the Hospital Standardised Mortality Ratio.
- Information about patient outcomes was routinely collected and monitored, with the trust participating in a number of national audits so it could benchmark its practice and performance against that of other trusts. In a number of these audits, the trust was performing less well than other trusts, for example the College of Emergency Medicine (CEM) audits, the National Sentinel Stroke Audits, The National Heart Failure Audit, and the Royal College of Physicians National Care of the Dying Audit 2104. Overall in surgery and critical care, the trust was performing better than the England average in most of the national audits it took part in.
- Patient pain was assessed and well managed; the exception to this was in the emergency department, where not all patients had a pain score recorded and not all patients consistently received prompt pain relief.
- In the ward areas, we found that patients had access to adequate food and fluids, observing that drinks were left within their reach.
- Staff had access to training to develop their skills, knowledge and experience to deliver effective care and treatment. The trust's target for the percentage of staff who had an annual appraisal was 90%, with the actual figure standing at 85%.
- Multidisciplinary working was evident in all areas we inspected.
- Overall patients were assessed in line with the Mental Capacity Act 2005 and care and treatment for patients unable to consent was undertaken in line with their best interest. However we did find one example where we were unable to find a documented assessment of a patient's capacity to make decisions despite evidence that this person was confused.
- The hospital was working towards providing services seven days a week. The pharmacy service was open for limited hours on a Saturday and Sunday. Some on-call cover was provided at weekends by allied health care professionals. The palliative care team was available from 9am to 5pm Monday to Friday, with the specialist palliative care nurses providing an out-of-hours telephone advice service for clinicians.

Summary of findings

- Weekend ward rounds did not take place in some areas such as stroke, gastroenterology or the diabetes and endocrinology wards. In cardiology, a ward round took place on both days of the weekend.
- Weekend discharges were problematic, with significantly fewer patients being discharged at this time.

Caring

- Staff were providing kind and compassionate care with dignity and respect. Caring in critical care was outstanding, with all other areas rated as good.
- In some areas such as the surgical admissions unit and outpatients, at times privacy could be compromised when personal conversations could be overheard and procedures seen.
- Prior to the inspection we received a number of concerns from patients and relatives about a lack of clear communication; however, during the inspection we found that patients and, when appropriate, those close to them, were involved in decisions about patients' care and treatment.
- Patients generally received the support they needed to help them cope emotionally with their care, treatment and condition.
- Spiritual support was available from within the hospital through the chaplaincy service, which provided a 24-hour on-call service.

Responsive

- Urgent and emergency care and medicine required improvement; all other services were rated as good.
- Bed occupancy at Gloucestershire Royal Hospital was constantly over 91%, which was above both the England average of 88% and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital. The hospital had been operating at near 100% occupancy in the months leading up to the inspection.
- There were issues with the flow of patients into, through and out of the hospital. The emergency department frequently became overcrowded when demand for services exceeded capacity. This was a hospital- and community-wide issue. In December 2014 and January 2015, the trust had declared an internal major incident when the situation became unmanageable.
- The standard that requires 95% of patients to be discharged, admitted or transferred with four hours of arrival in A&E was consistently not being met. Trust wide performance was 82.86% with Gloucestershire Royal Hospital achieving 80.59%.
- There were numerous examples of initiatives to reduce inappropriate emergency department attendances, to ensure patients were directed to the appropriate services to prevent admission and to shorten length of stay. Some of these were in their infancy and not yet fully developed to enable an effective and comprehensive service to be provided seven days a week.
- The average length of stay for patients admitted as elective cases fell to its lowest level in February 2015; however this masked a performance that was better than the national average in surgery and worse than the national average in medicine. For non-elective patients, the average length of stay had risen to 6.7 days, which was above the trust's target of 5.8 days for the third month in a row.
- The number of emergency admissions within 30 days of discharge for both elective and emergency patients was above the trust's target and had been for the last year.
- The 18-week referral to treatment targets were being met in almost all surgical specialities. Urology and ophthalmology were just behind the 90% target at 85% and 87% respectively. The trust was below (that is worse than) the NHS England average 62-day cancer waiting time target.
- The number of elective patients cancelled on the day of admission for a non-medical reason had not met the target in over a year, reaching its peak over the three months from December 2014 to February 2015, which matched the time during which the trust had been facing significant increased demand. This was also reflected in the number of patients who were cancelled and not rebooked within 28 days, which saw a significant rise in January 2015.

Summary of findings

- There was an agreement with partners in the local health economy that the daily number of patients who were medically fit for discharge would not be more than 35 a day; this number had reached 74 in February 2015.
- The two-week wait target for urgent GP referrals for cancer and the 62-day wait from GP referral to treatment were not consistently being met. However, other targets such as the 31 days for surgery and radiotherapy were constantly met, as was the 31-day period from diagnosis to treatment.
- Systems were in place to identify patients who were living with dementia or who had a learning disability and might need additional support.
- Patients knew how to make a complaint if they wanted to, and information was available around the hospital outlining how to make a complaint and how it would be dealt with. There were examples of learning from complaints to improve care.

Well led

- Leadership in critical care was rated as outstanding; surgery, maternity and gynaecology, children and young people, and outpatients were also well-led. Urgent and emergency care, medicine and end of life care all required improvement.
- Most services had a five-year strategy in place. The exception to this was end of life care. Whilst the team demonstrated understanding of the national policy and priorities, there were no defined work plan priorities for Gloucestershire Royal Hospital for the present and future.
- Staff were generally aware of the trust's values of listening, helping, excelling, improving and uniting.
- The trust was organised into four clinical divisions which operated across all trust sites; each was led by a chief of service, a divisional nursing director and a divisional operations director. This team was supported by a clinical director, a matron and a general manager in each specialty. Staff in all areas stated they felt supported by these lead staff. Of the executive directors, the director of nursing was singled out by many staff as visible and approachable.
- Generally appropriate governance systems were in place; each specialty had governance meetings, and these were reported to the divisional governance meetings, with significant issues reported on to the trust's quality governance meetings. Shortcomings were identified in two main areas. Monitoring of mortality and morbidity meetings in medicine was poor. We were informed these meetings took place, but we were not able to view any minutes of these meetings. In end of life care, governance and quality measurement were inconsistent. Whilst governance meetings were held, the minutes lacked details on information relating to actions planned or taken.
- In the 2014 staff survey, the trust was performing less well than other trusts on staff engagement; however, there had been an improvement from the previous year. Many staff told us about the executive walk-arounds and the top 100 leaders' information meetings.

We saw several areas of outstanding practice including:

- Patients living with dementia on Ward 9b were able to take part in an activity group, which had been organised by one of the healthcare assistants. The activity group enabled the patients to become involved in activities and encouraged them to maintain their skills and independence. The group was held weekly, and patients were able to play bingo, watch films, take part in reminiscence, paint, sing and eat lunch together. Activities were tailored to individual preferences, and relatives were encouraged to be involved.
- The trust had a mobile chemotherapy unit which enabled patients to receive chemotherapy treatment closer to their homes, to prevent frequent travel to hospital.
- Patient record keeping in critical care was outstanding. All the patients' records we saw were completed with high levels of detail. The records contained all the essential details to keep patients safe and ensure all staff working with them had the right information to provide safe care and treatment at all times.

Summary of findings

- There was an outstanding holistic and multidisciplinary approach to assessing and planning care in the department of critical care. All the staff involved with the patients worked with one another to ensure the care given to the patient followed an agreed treatment plan and team approach. Each aspect of the care and treatment had the patient at its centre.
- In critical care, there was an outstanding commitment to education and training by both nurses and trainee doctors. Nurses and trainee doctors followed comprehensive induction programmes that were designed by experienced clinical staff over many years. All the staff we met who discussed their training and development spoke very highly of the programmes on offer and there being no barriers to continuous learning.
- There was outstanding care for bereavement in critical care. All staff spoke highly of how they were enabled to care for and support patients and relatives at this time. Bereavement care had been created with input from patients, carers, relatives and friends, and staff were particularly proud of the positive impact it had on bereaved people and patients nearing or reaching the end of their life.
- The outstanding arrangements for governance and performance management in critical care drove continuous improvement and reflected best practice. There was a serious commitment to leadership, governance and driving improvements through audits, reviews, and staff honesty and openness. All staff had a role to play in this area and understood and respected the importance of their work.
- Mobility in labour was promoted with the Mums Up and Mobile (MUM) programme, which included wireless cardiotocography (CTG) monitoring across the whole of the delivery suite.

Importantly, the trust must:

- Improve its performance in relation to the time patients spend in the emergency department to ensure that patients are assessed and treated within appropriate timescales.
- Continue to take steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced consultants and middle grade doctors to provide senior medical presence in the emergency department 24 hours a day, seven days a week, and to reduce reliance on locum medical staff.
- Continue to reduce ambulance handover delays and take steps to ensure that patients arriving at the emergency department by ambulance do not have to queue in the corridor because there is no capacity to accommodate them in clinical areas.
- Develop clear protocols with regard to the care of patients queuing in the corridor. This should include risk assessment and the identification of safe levels of staffing and competence of staff deployed to undertake this care.
- Work with healthcare partners to ensure that patients with mental health needs who attend the emergency department out of hours receive prompt and effective support from appropriately trained mental health practitioners.
- Take immediate steps to address infection control risks in the ambulatory emergency care unit.
- Ensure that systems to safeguard children from abuse are strengthened by ensuring that children's safeguarding assessments are consistently carried out, and safeguarding referral rates are audited to ensure they are appropriate.
- Ensure that senior medical staff in the emergency department are trained in level 3 safeguarding.
- Ensure that patients in the emergency department have an assessment of their pain and prompt pain relief administered when necessary.
- Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.

Summary of findings

- Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.
- Ensure that patients' records across the hospital are stored securely to prevent unauthorised access.
- Ensure that the premises for the medical day unit are suitable to protect patients' privacy, dignity and safety.
- Ensure an effective system is in place in the medical wards to detect and control the spread of healthcare-associated infection.
- Ensure patients' mental capacity is clearly documented in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) and 'unwell/potentially deteriorating patient plan' (UP) forms. Improvements in record keeping must include documented explanations of the reasoning behind decisions to withhold resuscitation, and documented discussions with patients and their next of kin, or reasons why decisions to withhold resuscitation were not discussed.
- Ensure that where emergency equipment in the form of resuscitation trolleys is not available, the decision to not supply is based on a thorough risk assessment. Where emergency equipment is available, this should be ready to use at all times.
- Review communication methods within maternity services to ensure sensitive and confidential information is appropriately stored and handled whilst being available to all appropriate staff providing care for the patient concerned.
- Ensure that systems are in place to ensure that medication available in departments is in date and therefore safe to use.

In addition the trust should:

- Review how staff perceive the feedback they get from incident reporting and the level of detail received.
- Ensure that patients, including children, are adequately monitored in the emergency department waiting room to ensure that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Take steps to improve the experience for patients and visitors in the emergency department waiting room. This should include the provision of drinking water, a TV, and appropriate reading material and information about waiting times.
- Review the emergency department nursing staff mix and training to ensure adequate numbers of staff are trained to identify, care for and treat seriously ill children.
- Continue to improve hospital-wide ownership of the emergency department four-hour target, to ensure that delays in admission are minimised.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.
- Ensure all staff in surgery services are able to demonstrate and understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty Safeguards, so patients are not put at unnecessary risk of staff not acting legally in their best interests. Ensure there is appropriate documentation in place to support decisions.
- Ensure that the ambulatory emergency care unit is sited in an appropriately equipped area that is conducive to ensuring patients' comfort and dignity.
- Consider displaying feedback from patients and relatives for each individual medical ward.
- Consider a system to identify when patient equipment has been cleaned.

Summary of findings

- Ensure all areas are clean and free from litter.
- Store all medicines in critical care in a way that meets requirements for their security.
- For safety of the medicines and equipment inside, ensure resuscitation trolleys are secured in such a way so there is clear evidence if they have been opened between checks.
- Capture and report safety thermometer data in the department of critical care alongside the other data on patient harm that the department collects.
- Ensure all items are within their expiry date.
- Maintain continuity of care for patients on the day surgical unit to ensure they have their needs met 24 hours a day, seven days a week.
- Review the medical and surgical cover at weekends for the day surgery unit to make sure patients are reviewed and discharges not held up.
- Ensure patients who are admitted to the surgical day surgery unit can have their needs met by the staff team.
- Reduce the number of times patients are moved between wards, for continuity of care.
- Review the staffing levels of physiotherapists against the requirements of the Faculty of Intensive Care Medicine Core Standards.
- Ensure the specialist palliative care team can be sustained and are able to remain responsive to the evidenced increased demands of complex referrals, provide a face-to-face seven-day service, provide ongoing staff training in line with national policy, and make improvements to inconsistent governance, risk management and quality measures.
- Ensure that a strategy for end of life care is developed.
- Ensure all patients who are referred by their GP with suspected cancer are seen with two weeks of referral, and treatment is started within 62 days of referral.
- Ensure the cleaning arrangements for all outpatient areas are appropriate to maintain a high standard at all times.
- Ensure that where medication is required to be stored at refrigeration temperatures, systems are in place to monitor the correct temperature.
- Ensure that systems are in place in outpatients to identify in a timely manner and replace medication that is approaching its expiry date, to prevent potential harm to patients.
- Ensure patients' privacy and dignity is consistently respected in the outpatient department and medical unit.
- Ensure patients in outpatients have access to information on the trust's complaints procedure, and that this is readily available in all areas.
- Ensure staffing levels and the skill mix of staff in the diagnostic and imaging teams meet the needs of patients at all times and support staff to deliver a quality service.
- Review, in the maternity services, the midwifery and support staffing to ensure there are sufficient staff to meet patients' needs at all times in all areas.
- Ensure that in maternity services, both service risk registers detail actions underway to mitigate risks.
- Review cleaning schedules in maternity services and devise systems to ensure staff know when equipment has been cleaned and is ready for use.

Summary of findings

- Within gynaecology, review recalibration schedules for weighing scales.
- Within maternity services, review the provision of oxygen and air on resuscitaires to ensure that the correct gases are administered during resuscitation, in line with the Resuscitation Council guidelines.
- Review the location of the maternity services' registrar clinic and early pregnancy assessment clinic (at weekends) to ensure facilities are appropriate to provide care, assessment and treatment.
- Review the processes to ensure early screening (pre 10 weeks' gestation) can occur where the need for such screening is indicated.
- Within maternity services, work with the wider organisation to ensure overall patient flow is effective to prevent the need for cancellation of gynaecology patients because of the need to accommodate other patients on Ward 2a.
- Review the timeliness of access to patient information in alternative languages.
- Ensure staff in all areas of maternity services are aware of the procedures to follow in the event of early discharge ahead of the completion of all bereavement processes.
- Ensure all patients' referral-to-treatment times do not exceed national targets, and that services are delivered in a way that focuses on patients' holistic needs and does not mean patients experience long delays in receiving their first outpatient appointment.

Professor Sir Mike Richards, Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Patient feedback about the service was mostly positive. All the patients we met praised the service and its staff. In the CQC's national A&E survey (2014), eight out of 10 patients (trust wide) rated their overall experience of A&E to be good. The service received few complaints and reported few serious incidents. However, the department was regularly overcrowded when demand for services exceeded capacity. This was a hospital- and health-community-wide issue, but it impacted significantly on the 'front door' of Gloucestershire Royal Hospital. The trust declared a major incident on two occasions, in December 2014 and January 2015, when this situation became unmanageable. The service was consistently failing to meet the national standard which requires that patients are discharged, admitted or transferred within four hours of arrival. A significant contributing factor in this was unavailability of beds. This system-wide capacity and patient flow issue was the medicine division's and the trust's number one priority, and there was significant focus on and engagement with health and social care partners to address the issues that impacted on emergency department performance. There were numerous examples of initiatives to reduce inappropriate emergency department attendances, to ensure patients were directed to the appropriate clinical services, to prevent admission and to shorten length of stay. Some of these initiatives were in their infancy and were not fully developed to provide an effective and comprehensive service seven days a week. Funding, staffing and accommodation issues had all impacted on progress in these areas, but there was a clear commitment and strategy to achieve the vision that would provide the whole range of urgent and emergency services under one roof. Patient safety was seen as a priority. Risks were understood and systems were in place to ensure that learning resulted from mistakes. However, a significant number of staff felt the service was unsafe when the department was overcrowded. The

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department's philosophy of 'consuming its own smoke' meant that sometimes the department was overwhelmed. We judged there was a lack of a clear protocol around the staffing of the department when it was at full capacity.
We had some concerns around the care and treatment of children. Insufficient children's nurses were employed to ensure there was always a children's nurse on duty, although most adult-trained staff had also been trained in paediatric life support. Arrangements to ensure children were safeguarded from abuse were not robust.
Patients' needs were not always appropriately or promptly met. Ambulance handover delays, although reducing, still occurred too often. Patients frequently queued in the corridor because no cubicles were available. This compromised their comfort, privacy and dignity, and at times, when staffing was inadequate, had the potential to be unsafe. When queues occurred, other patients were moved around the department in order to free up cubicles, which impacted on their patient experience.
The department had not performed well in national audits that measured performance against best practice and good clinical outcomes. Pain relief, in particular, was an area of concern, and we could see no clear plan of action to address this poor performance; indeed our scrutiny of patients' records showed similar poor performance.
There was a strong, cohesive and supportive management team and a committed workforce. Staff felt well supported and had good access to ongoing education. Multi-disciplinary team working was good, although there was a lack of ownership of the four-hour target within the wider Gloucestershire Royal Hospital. There were excellent working relationships with external partners, including the local clinical commissioning group (CCG), the community care trust and the ambulance service.

Medical care **Requires improvement**

We have judged medical care services as requiring improvement overall. This was in relation to the hospital's safety, effectiveness, responsiveness and leadership. Caring was judged as good.

Summary of findings

Although the majority of staff we observed were following the trust's infection control procedures, we found some ward staff were not consistently following infection control policies. The hospital was not visibly clean in all areas. There had been a marked decrease in cases of hospital-acquired Clostridium difficile, although cases had recently begun to increase in number.

There was no evidence to show how patient mortality and morbidity was reviewed and actions taken to address any practice that could be improved.

Medicines were safely stored in the majority of areas, although the resuscitation trolleys were not secured in such as a way to show they had not been tampered with. Mandatory training was meeting trust targets. Nursing staffing levels were mostly safe, but there were times when not all shifts were able to be fully staffed.

Staff were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable people from abuse.

The service responded to incidents reported and demonstrated change where it was needed. Data was collected to analyse and address patient harm. Patient risks were assessed and care plans developed to keep patients safe. These included assessments for mobility, falls, pressure ulcers, nutrition and hydration. Patient records were completed well, although there were some that were not supervised or locked away at all times.

The trust's overall score for the Sentinel Stroke National Audit Programme (SSNAP) had steadily declined; data for April to June 2014 showed a score of E on a scale of A to E, with A being the best.

Gloucestershire Royal Hospital performed worse in the heart failure audit 2012/13 compared with other trusts. The endoscopy service required further improvements to attain JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation.

Access to seven-day services was variable throughout Gloucestershire Royal Hospital. Most services were working towards providing a seven-day service, and this had been identified on the medical division's risk register. Staff reported a lack of staffing resources to achieve this.

Summary of findings

The trust consistently had a high bed occupancy rate, and we were told that flexible capacity wards were not always open in a planned way.
The directors of the medical division were passionate about providing a high quality service. The service was clinically led; however they felt they lacked sufficient autonomy to enable them to drive improvements and instigate change.
Patients were positive about the care and treatment they received at Gloucestershire Royal Hospital. We observed that patients were treated with compassion and kindness by dedicated, professional staff.

Surgery

Good

We have judged surgery services in Gloucester Royal Hospital as good in relation to safety, effectiveness, caring and leadership. Improvements are required to make surgery services responsive to patient needs.
Staff were encouraged to report any incidents on the trust's computer system. Learning from incidents that had been investigated at ward level was shared at meetings and included in the minutes so staff could refer to it at a later date.
The trust was working on its compliance with the World Health Organization (WHO) surgical safety checklist following the results of its audits. Use of the checklist was also being monitored for compliance to improve patient safety. A safety briefing and recording document had been introduced in theatres.
Due to the increased demands on its services and beds, the day surgery unit was open out of hours and at weekends. The unit was staffed by bank and agency staff at these times, which meant continuity of care might have been affected and patients' needs might not always have been met. Patients from other specialties were placed on this unit, and staff felt they didn't always have the skills and knowledge to meet the unit's needs.
Storage on some wards and units for patients' notes was not secure, which meant visitors to the hospital could have had access to these confidential records.
The trust participated in national and local audits. These included the national bowel cancer audit, in which the trust was above, better than, the England average.

Summary of findings

There was good multidisciplinary working within the units and wards to make sure there was coordination of patient care. Patients we spoke with felt the care they received was very good and that staff respected their privacy and dignity. Information was provided for patients about their operations, and patients were able to ask questions and were kept up to date on their progress. Relatives were able to be part of this process with the consent of the patient, and other arrangements were in place for patients who were not able to consent although documentary evidence to support this was not consistent.

The trust had not met it target for the year for the number of patients cancelled on the day of their operation for non-medical reasons and had only met the national targets for rebooking patients within the 28-day timescale in one month.

The 18-week referral to treatment targets were being met in almost all surgical specialities. Urology and ophthalmology were just behind the 90% target at 85% and 87% respectively. The trust was below (that is worse than) the NHS England average 62-day cancer waiting time target. The trust was treating 74.7% of cancer patients within the 62-day target against the NHS England average of 81.2%.

Staff told us they were aware of the trust's visions and values. Staff on the wards and units told us they felt supported and listened to by their management team, divisional management and executive board.

Critical care

Outstanding ☆

The effectiveness, caring and leadership of the service were outstanding, and safety and responsiveness were good. Treatment, care and rehabilitation by all staff were delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Innovation, high performance and the highest quality care were encouraged and acknowledged. All staff were

Summary of findings

engaged in monitoring and improving outcomes for patients. They achieved consistently good results for patients who were critically ill and with complex problems and multiple needs.

Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Staff went above and beyond their usual duties to ensure that patients experienced compassionate care and that care promoted dignity. People's cultural, religious, social and personal needs were respected. Innovative caring for patients, such as the development of patient diaries, was encouraged and valued.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. All the senior staff were committed to their patients, their staff and their unit, with an inspiring shared purpose. There was strong evidence and data to base decisions upon and drive the service forwards from a clear, approved and accountable programme of audits. There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and consistently high levels of constructive engagement. Innovation and improvement was celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

There was a strong track record on safety, and lessons were learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and by a desire to get things right. Staff responded appropriately to changes in risks to patients. There was high quality equipment and a safe environment. The unit was clean and well organised. Staff adhered to infection prevention and control policies and protocols. There were good levels of nursing and medical staff meeting the Core Standards for Intensive Care Units to keep patients safe. There was a daily presence of experienced consultant intensivists and doctors, and rarely any

agency nursing staff or locum cover used. Patients' records were excellent, clear, legible and contemporaneous, although their security needed to be improved.
Some improvement was needed to ensure stocks of medicines and other consumables were stored safely, were in date, and details were recorded accurately. The patient harm data was low, but the internal and external recording and display of some information could be improved.
The critical care service responded well to patients' needs. There were bed pressures in the rest of Gloucestershire Royal Hospital that sometimes meant patients were delayed on discharge from the unit, but the number of incidences was only just above the NHS national average for similar units. Some patients were discharged onto wards at night, when this was recognised as less than optimal for patient wellbeing, but the rate was the same as the NHS national average. There was a very low rate of elective surgical operations being cancelled because a critical care bed was not available.
The facilities in critical care were excellent for patients, visitors and staff, and met all the modern critical care building standards. The trust had responded to the need to improve patient flow by opening a new surgical high dependency unit with four new beds (and expansion capability to six beds) in January 2015.
Patients were treated as individuals and there were strong link nurse roles for all aspects of patient need, including learning disabilities, dementia and mental health. There were no barriers to people who wanted to complain. There were, however, few complaints made to the department. Those that had been made were fully investigated and responded to with compassion and in a timely way. Improvements and learning were evident from any complaints or incidents.

Maternity and gynaecology — **Good**

We found maternity and gynaecology service at the Gloucestershire Royal Hospital to be effective, caring, responsive and well-led; however, in order for safety to be good, improvements were required. There were insufficient medical and midwifery staff to meet the needs of the service. Infection control

Summary of findings

and emergency risks were not adequately managed, and confidential information was not appropriately stored. Medicines were not managed safely.
There were some organisational challenges to meet referral-to-treatment times in gynaecology. This was under regular review at board level. Outcomes were monitored and benchmarked against national standards, and care given in line with national guidance and delivered with kindness and compassion. Understanding and involvement promoted high levels of patient satisfaction. The services were delivered in a way that met the needs of the local population as well as individual patients and were led by a team of committed and visible individuals. Services were looking at innovative ways to move forward and develop.

Services for children and young people

Good

Overall, services for children and young people were found to be good. Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families. Children, young people and their families were involved in the children's and young people's care, and the comments we received were all very positive.
The arrangements for safeguarding were good and improving, although we had some concerns about the numbers of referrals being received and the lack of staff to deal with those referrals in a timely way. We also had concerns about the medical cover for middle grade doctors on both the neonatal and children's units.

End of life care

Requires improvement

We found end of life care was caring and responsive to individual patients' needs, particularly in the last days and hours of life. Patients were prescribed appropriate medicines to manage end of life symptoms and pain. The relatives of patients we spoke with told us they had been involved in decisions, that care was good and staff were respectful and kind. It was, however, unclear how patients' mental capacity had been assessed, particularly in relation to documentation in the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms.

Summary of findings

Staff throughout the trust demonstrated an understanding that the end of life pathway was for use with patients diagnosed with any life-threatening condition approaching the last few days of life.
Improvements were needed to identify patients who were potentially in their last year of life in order to plan care better. Discharge procedures needed to be evaluated to identify whether patients achieved their preferred place of care. Specialist face to face palliative care was not available seven days a week; due to the demands on the service the team were not able to provider a wider service.
There was no end of life strategy, and governance processes were inconsistent. The priorities for the service were not fully understood or articulated at trust board level. The continuing rise in referrals was threatening the sustainability of the service and it ability to innovate and improve as it was only able to react and focus upon short term issues.
The specialist palliative care team were highly valued and respected by colleagues, and they worked collaboratively and effectively with other palliative services in the community and with the local clinical commissioning group.

Outpatients and diagnostic imaging

Requires improvement

During our inspection we found concerns and a lack of assurance that people were safe and protected from harm.
Staff had raised concerns about the cleanliness of the general and orthopaedic outpatient departments, because of the busy departments and insufficient cleaning time. Systems were not in place in all departments to check that medication was in date and safe to use. This had resulted in out-of-date medication being stored in the medication cupboard in the computerised tomography (CT) department. Patients' confidential and personal information was not securely stored at all times.
Patients were protected from the risk of infection by the practice of the staff, who demonstrated understanding of and compliance with the trust's policies and procedures.

Summary of findings

We found patients' care, treatment and support achieved good outcomes and were based on national guidance and legislation. Staff were trained and competent to carry out their roles effectively and in line with best practice.
Records inspected showed patients had consented to care and treatment. Staff demonstrated a good understanding of the Mental Capacity Act 2005 and their responsibilities within this legislation.
Systems were in place for staff to request and track and trace notes for individual patients' appointments at clinics. Action was taken when notes did not arrive at the clinic in time, to ensure the patient was seen with as much prior history and information as possible.
Staff involved patients and treated them with compassion, kindness, dignity and respect, providing them with a caring service.
We observed that staff were polite and respectful in all interactions with patients. Feedback from patients who used the service and their relatives/ representatives was positive about the way staff treated them.
We had concerns regarding the privacy and dignity of patients in two clinical areas, where opportunities arose for other people to observe patients during their care and treatment.
Outpatient services were not organised in a manner that ensured patients' needs were met promptly or responsively.
We found that referral-to-treatment times exceeded national targets, with services not delivered in a way that focused on patients' holistic needs. Some patients experienced long delays in receiving their first outpatient appointment. The booking team was taking action to address waiting times and monitored patients who did not attend for appointments.
Patients did not always know how to make a complaint, there was no consistency within clinics regarding the complaints process. When patients had made a complaint, the hospital had responded promptly and thoroughly, with staff being informed of the outcomes to enable learning to be taken forward.
The leadership and management of the outpatient and diagnostic services ensured the provision of

Summary of findings

person-centred care and supported the staff to deliver the care. Staff found their local management teams were approachable, but not all staff were aware of senior management, for example the trust's board of directors.
Potential risks within the delivery of the service were assessed, and the action taken to mitigate the risk was recorded. In some instances the action was not in accordance with other guidance.

Gloucestershire Royal Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to Gloucestershire Royal Hospital

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services to a population of around 612,000 people in Gloucestershire and the surrounding areas.

The trust has three main locations that are registered with the Care Quality Commission (CQC), which are Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital. There are 1,087 beds across these three hospitals. The trust has six further locations registered at which it runs outpatient clinics and provides imaging services. There are 683 beds at Gloucestershire Royal Hospital.

The trust was formed in 2002 with the merger of Gloucestershire Royal and East Gloucestershire NHS Trusts, and became an NHS foundation trust in July 2004.

Deprivation in Gloucestershire is lower than average. Gloucester is ranked 142 out of 326 local authority districts across England in the Index of Multiple Deprivation. The other districts are less deprived, with the Forest of Dean at 164, Cheltenham 214, Stroud 255, Cotswold 263, and Tewkesbury least deprived at 275. Life expectancy for both men and women is higher than the England average.

According to the last census, in all the districts in Gloucestershire the proportion of black, Asian and minority ethnic residents was less than the England average, ranging from 11% in Gloucester to 1.6% in the Forest of Dean. The percentage of residents aged 65 years and over was higher than the England average of 17.3% in the Forest of Dean (22.3%), Stroud (20.9%), Tewkesbury (21.4%) and Cotswold (23.9%).

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it was an example of a low risk trust according to our new 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.

The inspection team inspected the following eight core services at Gloucestershire Royal Hospital:

- Urgent and emergency services
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children's and young people
- End of life care
- Outpatients and diagnostic imaging

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Specialist clinical advisor

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

The team included CQC inspectors and a variety of specialists: chief executives, consultants from medicine, anaesthetics, surgery, emergency services, paediatrics, obstetrics and intensive care; a junior doctor; a newly qualified nurse; a nurse consultant in paediatrics and an emergency nurse practitioner; the head of outpatients; a theatre specialist; a midwife; and nurses from medicine, care of the elderly and critical care. The team also included two experts by experience, analysts and an inspection planner.

How we carried out this inspection

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about Gloucestershire Royal Hospital. These included the local commissioning group, Monitor, the local council, Gloucestershire Healthwatch, the General Medical Council, the Nursing and Midwifery Council and the royal colleges.

We held two listening events, one in Gloucester and one in Cheltenham, on 25 February 2015, at which people shared their views and experiences. More than 35 people attended the events. People who were unable to attend the event shared their experiences by email and telephone and on our website.

We carried out an announced inspection on 10–13 March 2015 and an unannounced inspection at Gloucestershire Royal and Cheltenham General Hospitals on 20 March 2015. We held focus groups and drop-in sessions with a range of staff in Gloucestershire Royal Hospital, including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

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.

Facts and data about Gloucestershire Royal Hospital

Overall, Gloucestershire Hospitals NHS Foundation Trust has 1,072 beds, about 7,400 staff and provides acute healthcare services to a population of around 612,000 people in Gloucestershire and the surrounding areas. There are 683 beds at Gloucestershire Royal Hospital.

In 2013/14 the trust had more than 108,000 inpatient admissions including day cases. From December 2103 to November 2014, there had been 773,447 outpatients' attendances (both new and follow-up) and 124,904 attendances at urgent and emergency care.

At the end of 2013/14 the trust had a financial surplus of £3.59 million.

Bed occupancy was constantly over 91% in 2013/14. It was above England average (85.9%) all year and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

Gloucestershire Hospitals NHS Foundation Trust has a stable executive team, with the chief executive, nursing director, medical director, director of clinical strategy and director of human resources and organisational development all having been in post for over six years. The non-executive team is also stable, with the chair having been in post since 2011.

CQC inspection history

Detailed findings

Gloucestershire Hospitals NHS Foundation Trust has had a total of nine inspections since registration. Four of these inspections have been undertaken at Gloucestershire Royal Hospital.

In March 2011 an unannounced inspection was undertaken in response to concerns. Concerns were found relating to: care and welfare of people using services, nutrition, working with other providers, safeguarding, cleanliness and the environment. An inspection was undertaken in August 2011 to review these standards; four were found to have been met, and improvements had been made relating to the other two – care and welfare of people using services, and working with providers – but minor concerns remained. A further two inspections were undertaken in February 2103 and May 2013, at which all standards inspected were met.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Requires improvement	Good	Good
Critical care	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Requires improvement	Not rated	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

Urgent and emergency care and treatment is provided at Gloucestershire Royal Hospital by the unscheduled care service, which forms part of the medical division. An emergency department, otherwise known as the accident and emergency department, operates 24 hours a day, seven days a week. The emergency department sees approximately 80,000 patients a year, of which approximately 15,000 are children.

The emergency department is designated a trauma unit and provides care for all but the most severely injured trauma patients, who are usually taken by ambulance to the major trauma centre in Bristol if their condition allows them to travel directly. If not, they may be stabilised at Gloucestershire Royal Hospital and either treated or transferred as their condition dictates. The department is served by a helipad.

Emergency department patients receive care and treatment in two main areas: 'minors' and 'majors'. Self-presenting patients with minor illnesses or injuries are assessed and treated in the minors' area. A GP is present in the department on some weekdays and sees people with minor illness. There are two waiting areas, one for adults and a second smaller area for children. Patients with a serious injury or illness who arrive by ambulance are seen and treated in the majors' area, which includes a four-bay resuscitation room. The majors' area is accessed through a dedicated ambulance entrance, and the resuscitation room is located just inside this entrance.

An ambulatory emergency care unit operates from 10am to 6.30pm, Monday to Friday. This service provides same-day emergency care for patients who are able to be assessed and treated without the need for an overnight admission.

The unscheduled care service also manages an acute care unit and a short stay ward. These services are reported on separately under 'medical care'.

We visited the department over one and a half weekdays, and conducted a further unannounced visit during the evening. We spoke with approximately 32 patients and relatives. We spoke with staff, including nurses, doctors, managers, therapists, support staff and ambulance staff. We observed care and treatment and looked at care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

Emergency and urgent services provided by the trust are located on two hospital sites, the other being Cheltenham General Hospital. Services at Cheltenham General Hospital are reported on in a separate report. However, services on both hospital sites are run by one management team, and within the trust are largely regarded as one service, with some staff rotating between the two sites. For this reason, it is inevitable that there is some duplication in the two reports.

Urgent and emergency services

Summary of findings

Patient feedback about the service was mostly positive. All the patients we met praised the service and its staff. In the CQC's national A&E survey (2014), eight out of 10 patients (trust wide) rated their overall experience of A&E to be good. The service received few complaints and reported few serious incidents. However, the department was regularly overcrowded when demand for services exceeded capacity. This was a hospital- and health-community-wide issue, but it impacted significantly on the 'front door' of Gloucestershire Royal Hospital. The trust declared a major incident on two occasions, in December 2014 and January 2015, when this situation became unmanageable.

The service was consistently failing to meet the national standard which requires that patients are discharged, admitted or transferred within four hours of arrival. A significant contributing factor in this was unavailability of beds. This system-wide capacity and patient flow issue was the medicine division's and the trust's number one priority, and there was significant focus on and engagement with health and social care partners to address the issues that impacted on emergency department performance.

There were numerous examples of initiatives to reduce inappropriate emergency department attendances, to ensure patients were directed to the appropriate clinical services, to prevent admission and to shorten length of stay. Some of these initiatives were in their infancy and were not fully developed to provide an effective and comprehensive service seven days a week. Funding, staffing and accommodation issues had all impacted on progress in these areas, but there was a clear commitment and strategy to achieve the vision that would provide the whole range of urgent and emergency services under one roof.

Patient safety was seen as a priority. Risks were understood and systems were in place to ensure that learning resulted from mistakes. However, a significant number of staff felt the service was unsafe when the department was overcrowded. The department's philosophy of 'consuming its own smoke' meant that sometimes the department was overwhelmed. We judged there was a lack of a clear protocol around the staffing of the department when it was at full capacity.

We had some concerns around the care and treatment of children. Insufficient children's nurses were employed to ensure there was always a children's nurse on duty, although most adult-trained staff had also been trained in paediatric life support. Arrangements to ensure children were safeguarded from abuse were not robust.

Patients' needs were not always appropriately or promptly met. Ambulance handover delays, although reducing, still occurred too often. Patients frequently queued in the corridor because no cubicles were available. This compromised their comfort, privacy and dignity, and at times, when staffing was inadequate, had the potential to be unsafe. When queues occurred, other patients were moved around the department in order to free up cubicles, which impacted on their patient experience.

The department had not performed well in national audits that measured performance against best practice and good clinical outcomes. Pain relief, in particular, was an area of concern, and we could see no clear plan of action to address this poor performance; indeed our scrutiny of patients' records showed similar poor performance.

There was a strong, cohesive and supportive management team and a committed workforce. Staff felt well supported and had good access to ongoing education. Multi-disciplinary team working was good, although there was a lack of ownership of the four-hour target within the wider Gloucestershire Royal Hospital. There were excellent working relationships with external partners, including the local clinical commissioning group (CCG), the community care trust and the ambulance service.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

The biggest risk faced by emergency and urgent services was overcrowding in the emergency department, associated with a lack of patient flow, which in turn led to the risk that patients might not be promptly assessed, diagnosed and treated. There were particular concerns about the safety of patients being cared for in the corridor when the department was so busy that it could not accommodate patients in clinical areas.

There were concerns with regard to staffing. There was insufficient clarity around safe levels of staffing to manage overcrowding and patients queuing in the corridor. Although there was an acute shortage of middle grade doctors and a high reliance on locum staff, these staff were used in a planned manner and worked in the department regularly. There were insufficient children's nurses employed in the ED, and those who were employed were not allocated to care solely for children. Systems to protect children from abuse were not robust.

The service was not achieving the trust's target compliance rate (90%) for mandatory training for medical staff, and in some subjects, compliance was significantly below this level.

The service was safety aware; there was a strong emphasis on patient safety and improvement. Staff were encouraged to report concerns, and did so. Not all staff felt they received adequate feedback when they reported concerns, but we saw evidence that learning from identified themes and significant incidents was regularly discussed and disseminated.

There were concerns about infection control in the ambulatory emergency care unit, which was housed in temporary accommodation that was not fit for purpose.

Incidents

- There was a strong safety culture in the emergency department. Risks were well understood and safety issues were regularly discussed. The department had a designated clinical governance lead who led regular reviews of incidents.
- Staff were encouraged to report incidents, and most staff told us they did so. The clinical governance lead told us that between 80 and 100 incidents were reported each month. Most nursing staff we spoke with said they did not receive individual feedback, although medical staff expressed a contrary view that feedback was good. We saw that identified themes and serious incidents were discussed to ensure learning.
- Some nursing staff told us they preferred to report concerns to the nurse coordinator, who might then report concerns via an incident form. A communication log book was held at the nurses' station, in which any events or issues that affected the smooth running of the shift were recorded. At night, an electronic log was maintained and emailed to managers the next morning.
- There was evidence that lessons were learned when things went wrong:
- Bimonthly meetings were held to review incidents and discuss outcomes and learning. Safety bulletins were circulated to share learning following incidents. Incidents included needle-stick injuries, incidents during blood transfusion, and those relating to pump settings, missed antibiotics and record keeping. There were regular emergency department safety meetings. Two case studies of suboptimal care were discussed in February 2015 to ensure learning within the team.
- Mortality and morbidity meetings were held every two months to review the care of patients who had complications or an unexpected outcome. Learning points were shared with staff, and real incidents were used in simulation training. Mortality and morbidity trends were reported in monthly emergency pathway performance reports.
- An incident was reported involving a patient being moved between the emergency department and radiology while being ventilated, during which time the ventilator was accidentally switched off. Following an investigation, the ventilator was taken out of service because of a design fault. Another incident occurred involving a patient who required oxygen, and the oxygen tubing was attached to the air port. A training schedule had been put in place to ensure that all staff were competent in using high risk medical devices. It was reported in the divisional incident report for the period

August to November 2014 that, following these incidents, a review of all equipment within the emergency department had taken place and a five-year replacement plan been developed.

- There was a safeguarding and domestic homicide educational programme that incorporated issues raised during incident reviews. Two university-accredited courses, 'Caring for the unwell patient' and 'Caring for the unwell child', were included in this programme and were run in April and September each year.
- There had been a high level of incidents and negligence claims in relation to failure to detect abnormal radiology results. A review by the trust identified the system in the emergency department required improvements. As a result an improvement plan had been produced by a consultant in emergency medicine, and a bid for resources to make the necessary improvements had been submitted and accepted. In the meantime, there was a protocol whereby each day a middle grade doctor took responsibility for X-ray reporting and acting on any missed radiology findings.
- Staff told us their main safety concern was overcrowding, and that they regularly reported concerns. One staff member told us the department was "more often than not unsafe" because of overcrowding. Another nurse told us, "We are just keeping our head above water… just waiting for someone to die in the corridor; it is going to happen."
- There was a lack of clarity with regard to escalation procedures. One member of nursing staff told us that they escalated concerns when they thought the department was unsafe, but acknowledged that their safety threshold might be different to that of their colleagues.
- The risk register identified high levels of violence and aggression incidents. Staff were provided with conflict resolution training and other bespoke training. The division was sending letters to patients who had behaved inappropriately in the department.
- The department had a good track record on safety. Four serious incidents were reported in the emergency department (trust wide) in 2014. Three related to delayed or missed diagnosis, and one related to equipment failure (see details of ventilator incident above).
- The department had a system in place to ensure that patients were informed when something went wrong, given an apology and informed of any actions taken as a result. This is known as the duty of candour. The governance lead shared with us an example of a patient who had suffered a poor outcome, where the service had been proactive in explaining what had gone wrong and had apologised.

Cleanliness, infection control and hygiene

- In the CQC's 2014 A&E survey, 8.7 out of 10 patients described the A&E departments (trust wide) as clean.
- The emergency department was mostly tidy and visibly clean, and we saw cleaning in progress throughout our visits. However, on the first day of our visit a side room used for assessing patients with mental health issues had litter strewn across the floor, including discarded tissues and a vomit bowl.
- Emergency department staff frequently washed their hands and observed the 'bare below the elbows' policy. However, on the first day of our visit we noted that four hand gel dispensers in the emergency department were empty. We drew this to the attention of the matron, and this was rectified promptly. However, during our evening visit two out of three hand gel dispensers in the waiting room were empty. There were no hand gel dispensers in the paediatric waiting area. We noted also that there was no cleaning agent available to wipe the nappy changing mat in the children's area. Hand hygiene was audited on a monthly basis. Results showed room for improvement.
- The department used evidence-based care bundles (a series of actions/care elements) to prevent healthcare-associated infections when undertaking invasive procedures such as inserting cannulas and catheters. Compliance with these safe systems was monitored on a monthly basis. Performance for cannula insertion was poor (30% in November and 60% in December 2015). Performance in relation to catheter insertion for the same period was 100%. The ambulatory emergency care service, trust wide, consistently scored well in audits of hand hygiene and cannula and catheter insertion.
- Protective clothing and equipment such as gloves and aprons was available and used by staff.

- There were two assessment/treatment rooms in majors where infected patients could be isolated and barrier-nursed to prevent the spread of infection.
- Infection control measures were inadequate in ambulatory emergency care. The department had recently been relocated to temporary accommodation. The clinical assessment room was not fit for purpose. We counted 26 holes in the walls, some with protruding screws where things had been taken down from the walls and the holes not filled. The room was carpeted, and the carpet was badly stained. Paper had been taped across the glass pane in the door. These issues meant that this clinical area was difficult to keep clean. We noted dusty surfaces. There was no hand wash sink in the room, although there was a kitchen sink in the adjacent room, where hand gel was also located. Staff and managers acknowledged that this room was not fit for purpose. Infection control concerns had been reported. There were plans for the service to be provided from a portacabin in the short term. In the longer term, there were plans for the service to be provided from the area currently occupied by the fracture clinic in a reconfigured unscheduled care department.

Environment and equipment

- The emergency department was generally laid out and equipped to protect people from avoidable harm. However, at busy times overcrowding was an issue. Staff told us that majors' patients were sometimes seen in inappropriate parts of the department, including the corridor, the eye room, sub waiting room and in the minors' area. One member of nursing staff told us they felt the department was "no longer fit for purpose".
- There were poor lines of sight in both the adults' and children's waiting areas, which meant that waiting patients were not adequately observed. This meant that a deteriorating patient or inappropriate behaviour might go unnoticed. The height of the reception desk meant that reception staff had a limited view of the main waiting area. Reception staff and a triage nurse expressed their concern about this lack of observation.
- The children's waiting area had appropriate restricted access, and the area was not overlooked by the adults' waiting area. However, the area was not observed by staff to ensure that parents and children could summon attention.
- Security arrangements were adequate. In the CQC's 2014 A&E survey, 9.6 out of 10 patients said they did not feel threatened in the A&E department.
- We checked a range of equipment, including resuscitation equipment in the emergency department. Resuscitation trolleys were all in order and appropriately stocked at the time of the inspection. Regular checks were documented; however, we noted that trolleys were not sealed following these checks to ensure they were tamper evident.
- We checked four defibrillators. These were supposed to be checked every day. Two had been checked on the day of our visit, one the day before, and one had no checks recorded. We could not be assured, therefore, that this equipment was safe.
- There were appropriate arrangements for the segregation, storage and disposal of waste, and we saw that emergency department staff complied with guidance in this respect.
- It was reported in the divisional incident report for the period August to November 2014 that, following a number of incidents (see incidents above), a review of all equipment within the emergency department had taken place and a five-year replacement plan had been developed. This showed that the department took appropriate action to mitigate risks. The report to the capital planning group (undated) identified priorities for 2014/15. These included:
- Replacement of otoscope and ophthalmoscope replacement heads.
- Replacement of the ultrasound scanner, because this equipment was out of action regularly because of its frequent use. This posed the risk that critically ill patients might not receive timely and safe care. The clinical lead confirmed that the equipment was sometimes out of action, but was not aware of any incidents arising from this. They said that equipment could be borrowed from another department if necessary. We noted, however, in the missed radiological pathology improvement plan (see above)

produced by an emergency department consultant, that it was recorded "At present we have one machine on each site. Both of these are aged with significant barriers to use such as long turn on time, poor battery life and low image resolution and definition. …. These machines are often borrowed by other teams in the hospital and not available when required."

- A replacement ventilator, because it was identified that having just one ventilator after the other one had been decommissioned (see above incident) posed a risk to critically ill patients. On 9 March 2015, it was recorded in the emergency department's communication log that the remaining ventilator had been contaminated and was taken out of use. A ventilator had been borrowed from the intensive therapy unit.
- Replacement portable screens in the resuscitation area, because of the age and condition of current equipment. Damaged equipment compromised patient privacy and dignity and infection control. New screens were currently being trialled.
- Replacement of the Bier's block machine. This equipment was reported to be nearing the end of its life and needed urgent replacement. The equipment was used for reducing certain types of fracture. Failure of this equipment could result in serious consequences to patient safety, including the risk of cardiac arrest.

Medicines (includes medical gases and contrast media)

- Medicines were appropriately stored in locked cupboards or fridges. On the ambulatory emergency care unit we saw that fridge temperatures were regularly checked; they were correct at the time of our visit. In the emergency department, no checks of the medicine fridge temperatures had been undertaken. This was not in accordance with the trust's medicines management policy. We could not be assured, therefore, that medicines stored there were safe to use.
- Controlled drugs were stored appropriately, and suitable records were kept. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.
- In the CQC's 2014 A&E survey, 8.8 out of 10 patients said that the purpose of new medicines was explained before they left A&E. However, only 4.3 out of 10 patients said they were told about possible side effects of those prescribed new medicines while in A&E.
- We checked 50 patients' records dated 10 March 2015. Fifteen of these records had no allergy status recorded. This increased the risk that patients might be given inappropriate medicines that might have a harmful effect.

Records

- Patients' records were in paper and electronic format. Paper records were scanned onto the electronic system when patients were discharged or transferred. A receptionist had recently been employed in the majors' area and was able to assist with this to ensure there was no delay in transferring patients with their records.
- We looked at a total of 52 patient records and found that, on the whole, they were not well completed. The time that care, treatment or assessment took place was often not documented, and staff did not always sign or initial their entries. In one patient's notes (24 February 2015), we saw no written evidence that the patient had been offered food or drink between 3.30am and 12pm the next day. A documentation audit that looked at the records of 20 patients who attended the emergency department between October 2014 and January 2015 found:
  - four had a nurse assign code completed,
  - nine had a safeguarding assessment completed,
  - three had a Waterlow score recorded or details recorded regarding pressure areas,
  - two had property signed for,
  - seventeen had early warning scores and neurological observations documented
  - nine had appropriate documentation in relation to cannula insertion or venepuncture.
- Staff told us that inpatients' records were easily accessed 24 hours a day.
- There was no system-held data on patient allergies, so this had to be recorded at each attendance. In the sample of records we looked at, allergy status was not consistently completed.

Safeguarding

- Processes were in place for the identification and management of adults and children at risk of abuse (including domestic violence). Staff understood their responsibilities and were aware of safeguarding policies and procedures. There was a safeguarding lead nurse in

the emergency department. However, we looked at a sample of 50 patients' records dated 10 March 2015 and found only 18 patients had a safeguarding assessment recorded.

- The department was meeting most of the safeguarding children standards produced by the College of Emergency Medicine's (CEM's) clinical effectiveness committee:
- Training records showed that as at 31January 2015, 83% of all staff in unscheduled care (trust wide) had received a minimum of level 2 child protection training. All middle grade doctors had received training, but only 68% of junior doctors had.
- The trust told us that all senior emergency medicine doctors (ST4 or equivalent and above) had received level 3 child protection training, although five out of 23 doctors required updating.
- The department had access to a senior paediatric and senior emergency medicine opinion 24 hours a day for child welfare issues.
- The patient record system identified previous child attendances in the last 12 months so that staff would be alerted to possible safeguarding issues.
- Frequent attenders (more than three attendances in last year with different conditions) were notified to the local safeguarding children services.
- Child attendances were notified to GPs, health visitors and school nurses.
- We were told that all skull or long bone fractures in children under one year were discussed with a senior paediatric or emergency department doctor during the child's emergency department attendance.
- We were concerned that there was a lack of any system to ensure that child safeguarding referral rates were appropriate. A health visitor liaison team attended the emergency department every few days to check referrals, but did not check all child attendances to see whether any had been missed. Two children's records out of our sample of 50 dated 10 March 2015 contained no safeguarding assessment. A further three children's records dated 13 March 2015 were checked. Two out of three had safeguarding assessments completed, although one was not signed.

Mandatory training

- Staff completed most mandatory training using e-learning. They were able to negotiate a study day in order to complete this.
- Compliance with mandatory training for the unscheduled care division as a whole was as follows:
  - Additional clinical services: most staff were up to date with mandatory training, although only 79% had completed conflict resolution training and 81% had completed basic adult resuscitation training.
  - Administrative and clerical staff: staff were up to date in most mandatory subjects.
  - Medical staff: this group of staff performed less well with regard to mandatory training, with few subjects achieving the trust's target completion rate of 90%. Only 51% of staff had completed conflict resolution training, 73% had received training in prescribing, and 77% had received training in fire safety and infection control.
  - Nursing staff: most nursing staff were up to date with mandatory training, although only 81% had received basic adult resuscitation training.

Assessing and responding to patient risk

- The trust used a recognised triage system (Manchester) in the emergency department for the initial assessment of all patients. Guidance issued by the College of Emergency Medicine (CEM) (triage position statement dated April 2011) states that a rapid assessment should be made to identify or rule out life-/limb-threatening conditions to ensure patient safety. This should be a face-to-face encounter within 15 minutes of arrival or registration, and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the department and the appropriate clinician. It also ensures that serious or life-threatening conditions are identified or ruled out so that the appropriate care pathway is selected.
- During our visits we saw triage mostly took place promptly, although during our evening visit a child waited 40 minutes to be assessed. We were told that all patients who arrived by ambulance were assessed on arrival. The time from arrival to initial assessment for self-presenting patients was separately measured. Median performance against the 15-minutes standard ranged from 10 to 15 minutes between March 2014 and February 2015.

- Receptionists in the minors' area told us they used their judgement and experience to recognise a seriously unwell/injured patient who needed immediate clinical attention. There was no written guidance about 'red flag' conditions, although receptionists were able to name some of these, such as chest pain and profuse bleeding. They told us they summoned help either in person or by phone.
- There was insufficient observation and monitoring of patients in the waiting room. The height of the reception desk meant that receptionists could not see patients in the waiting room, and the triage nurse did not enter the waiting room when calling patients in for assessment. Children were not supervised as recommended in Health Building Note 15-01, which states "the waiting area should be provided to maintain observation by staff."
- There was a multidisciplinary handover at 1pm every day, attended by all clinician grades, where patients' risks and management plans were discussed.
- Staff in the emergency department used recognised early warning tools for adults and children. Observations were recorded as indicated by the early warning score. We saw evidence that observations were regularly recorded.
- Risk assessments were carried out to ensure that risks were identified and appropriately managed. Patients with mental health problems were risk-assessed and prioritised using a mental health assessment pro forma. Patients were assessed for the risk of developing pressure damage, and we saw some evidence of this. Staff told us patients identified as at risk would be provided with pressure mattresses.
- Overcrowding in the emergency department was a serious and ongoing risk. There was a trust-wide escalation policy which set out a range of triggers that would enable the trust to mitigate risks associated with capacity and overcrowding. Within this policy, the emergency department had a separate internal escalation plan and a series of triggers which were linked to its ability to achieve the following key performance measures:
- Assessment within 15 minutes
- Senior review within one hour
- Management plan within three hours
- Admission/discharge within four hours.
- Other trigger factors included the number of patients in the department, the space available in majors and resuscitation, and the number of ambulances queuing. The nurse coordinator in the emergency department was responsible for reviewing the status of the department every hour.
- There were a series of action cards for medical and nursing staff to follow in the event of escalation. Actions included reallocating staff, requesting additional staff and diverting patients to other emergency departments. At times of increased pressure patients waiting for entry to ED were held in the 'secure corridor' in 'Majors 2'.The practices described to us by staff, and which we observed during our evening visit – such as caring for patients in the corridor, in minors and in the sub waiting room – appeared to be pragmatic and not guided by protocol or risk assessment.

Nursing staffing

- Senior nursing staff told us that nurse staffing levels in the emergency department were appropriate, although additional senior nurses were needed in order to extend the floor manager role, which was currently only available on the late shift. A detailed piece of work had been undertaken to align staffing levels with anticipated demand. A number of nurse vacancies had arisen recently, and recruitment was ongoing to fill these. Some concerns were expressed about the proportion of inexperienced and overseas nurses who needed more support. This limited the number of nurses who were able to perform triage. A senior nurse told us that junior (inexperienced) nurses were often deployed as triage nurses, as there were insufficient senior staff to allocate to this role. It was reported at the emergency care board on 5 March 2015 that there was a need for additional emergency nurse practitioners to cover at night, and there was a commitment to fast-track this recruitment.
- Nurse staffing levels were not consistently achieved. Between 5 and 11 March 2015, it was recorded in the communications log that three night shifts were understaffed. During our evening visit, the department was understaffed by two trained nurses and two healthcare assistants. A floor manager (senior nurse) was assisting by covering staff breaks. The night shift was fully staffed, albeit supplemented by two agency

nurses. Staff told us that every effort was made to cover short--notice sickness with bank or agency staff, but this was not always possible. Between December 2014 and March 2015, approximately 20% of shifts were unfilled. There was a staff texting system whereby all staff, including regular bank staff, were advised of any shifts that needed to be filled. Bank/agency usage ranged between 13.7% and 14.6% from September to November 2014.

- Floor managers had been employed in the emergency department to support the shift coordinators. Currently they were only deployed on the late shifts (2pm to 10pm), although we were told that the department hoped to extend this to other shifts. Part of their role was to ensure that there was adequate staff cover in all areas of the department and to redeploy staff as required. For example, when patients queued in the corridor because there were no cubicles available, the nurse-to-staff ratio in majors would be reduced from 1:3 to 1:4 to enable the release of a nurse to care for patients in the corridor.
- The matron told us that patients in the corridor would be observed by a 'corridor nurse', and that a ratio of one trained nurse to three patients would be provided where possible, although one to four might be acceptable, depending on the acuity of patients and the experience of the nurse. Two healthcare assistants told us they were regularly deployed as corridor nurses, sometimes with a registered nurse, sometimes not.
- There was no protocol with regard to the staffing of the corridor and the management of patients there. At a staff meeting held on 9 March 2015, a healthcare assistant had sought clarification with regard to attending patients in the corridor, as there was "some disagreement" regarding this. It was recorded that the senior sister would clarify and feedback. The local management team told us that a maximum of four patients would be cared for in the corridor, but emergency department staff and ambulance staff told us that sometimes there were more. It was recorded in the communications log on the Saturday night prior to our visit that six ambulance patients were queuing at 9.54pm and five at 11.30pm. One member of ambulance crew told us they had witnessed up to seven patients queuing. During our evening visit, an agency nurse had been deployed as corridor nurse. They told us they were experienced and had worked in the department many times before, although seldom in the corridor. They were responsible for observing three to five patients at any one time. We asked them how many they might be expected to care for, and they told us "as many as come through the doors".
- There was not a dedicated paediatric-trained workforce in the emergency department. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identifies that there should always be registered children's nurses in the emergency department, or trusts should be working towards this. Staff should, as a minimum, be trained in paediatric life support. The department had two trained children's nurses, which would not enable the department to ensure a children's nurse was always on duty. We were assured, however, that all nurses were trained in paediatric life skills as training records confirmed all but three of 60 staff were appropriately trained. All nursing staff had received trained during their induction to recognise and respond to unwell children. Further extended training was available after one year in post, but we were not provided with information that showed what proportion of staff had completed the training. Should a child attend the department acutely unwell, in the event of there being no paediatric nurse on duty, where possible a paediatric nurse attended from the paediatric assessment unit.
- The trust told us that a registered children's nurse was always available in the hospital and could be summoned by bleep if required.
- The A&E risk register highlighted there was inadequate nursing cover for children and the paediatric area was being covered by minors' staff.

Medical staffing

- The department was able to achieve the target of providing a minimum of an ST4 (specialist registrar year 3) or above in the department 24 hours a day, seven days a week. However, this was challenging, due a shortage of middle grade doctors. The monthly emergency pathway performance report presented to the February 2015 board meeting recorded that, "Despite recruiting additional consultants, gaps in the emergency department doctors' rotas, especially at

middle and junior grades, continue to remain the biggest risk to delivering emergency department performance." The A&E risk register identified a "chronic lack of middle grade doctors in ED [the emergency department] GRH [Gloucestershire Royal Hospital]", which meant that the department was "unable to consistently provide safe clinical cover". Nursing staff told us they felt that medical cover was not adequate at weekends, which were the busiest times.

- The department had only 1.6 whole-time-equivalent substantive specialist registrars and relied heavily on locum staff. Locum usage in unscheduled care ranged between 10.7% and 12.4% from September to November 2014. The clinical lead told us the service (trust wide) spent approximately £1 million on locum medical staff in the last year. A dedicated staffing manager was employed to ensure that gaps in the rota were consistently filled with appropriately skilled and experienced clinicians. There was a checklist which locum staff had to read, follow and sign before starting work.
- Overseas recruitment had recently taken place, and the department had successfully recruited a further two middle grade doctors.
- Consultants had been filling some of the middle grade gaps at night, but one consultant told us, "This takes its toll on consultants."
- There was good consultant presence in the department. A fifteenth consultant was appointed in October 2014, bringing the total to 14.8 whole-time equivalents. Consultant cover was currently provided until 10pm, but a further three consultants were being recruited, which would enable cover to be extended until midnight.

Other staffing

- Porters were employed in the emergency department on two overlapping shifts from 10am to 6pm and from 2pm to 10pm. Staff reported that sometimes there were insufficient porters available to transfer patients to wards and other departments. On the night shift report to senior managers on 11 March 2015, it was recorded, "At one point we had five transfers and one porter – this included an urgent CT scan." A log was being maintained to demonstrate how frequently nursing staff had to undertake portering duties. Twelve examples had been recorded between 17 March and 20 March 2015.

Major incident awareness and training

- There was a major incident plan, which had been reviewed and was up to date. We were unable to access the major incident equipment cupboard because, according to the nurse in charge, the keys were held "maybe by the site team". They told us the last major incident exercise had taken place in November 2014 and was a "phone exercise". They were unable to recall the last time a practical exercise had taken place. The trust told us that staff received training during their induction. They told us there had not been a full practice for many years, although a walk-through simulation of a patient with Ebola had been undertaken recently.
- A receptionist told us they had recently received training in the arrangements to deal with casualties contaminated with chemical, biological or radiological materials, but were still unaware of what to do in the event of an incident. They told us they would be guided by the nurse in charge.
- Staff in the department told us they felt safe; however the risk register identified high levels of violence and aggression incidents. There were 86 reported incidents of violence and aggression from April 2014 to January 2015. There was a bid to the trust management team for a security service. Staff were provided with conflict resolution training. The department was sending letters to patients who had behaved inappropriately in the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Staff, teams and services mostly worked well together to deliver effective care and treatment. In particular, there was a very effective relationship with the acute physicians, and care pathways had been jointly developed. However, there was a lack of ownership of emergency department targets within the wider Gloucestershire Royal Hospital.

Staff were well supported, with good access to training, supervision and development. The department had

developed evidence-based guidance on the management of a range of conditions, but provided little evidence to demonstrate that it consistently followed good practice. The department participated in national audits of clinical practice and patient outcomes. Performance was worse than the England average, and most standards were not met. The service performed particularly poorly in relation to pain relief, and we saw little evidence that there were clear action plans to improve performance.

Evidence-based care and treatment

- There were a range of care pathways that complied with National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine's (CEM's) clinical standards for emergency departments. We saw evidence that the sepsis management pathway (sepsis 6) was being followed during our visit, and staff we spoke with were familiar with sepsis 6. Compliance was being audited on a monthly basis (see patient outcomes below), but we saw little evidence that other clinical pathways were regularly audited.

Pain relief

- Patients in the emergency department did not consistently receive prompt pain relief. We looked at 50 patients' records dated 10 March 2015. These included adults and children and were a mixture of minors and majors patients. Ten out of 50 patients did not have a pain score recorded, and none of the 50 patients had a repeat pain score recorded. Five patients with a moderate pain score received no pain relief while in the department. Two patients waited over two hours and one patient waited four hours for pain relief.
- The emergency department performed poorly in the College of Emergency Medicine's (CEM's) renal colic audit 2012 and did not meet the required standard in respect of the provision of prompt pain relief. Only 25% of patients in severe pain received analgesia within 30 minutes (the standard is 75%), and only 57% of patients received pain relief within an hour (the standard is 98%).
- The emergency department performed poorly in the CEM's fractured neck of femur audit 2012/13. Hip fractures are painful, and the administration of pain relief should be a priority in the emergency department. The department performed poorly in relation to pain relief for those patients in moderate pain.
- In the CQC's 2014 A&E survey, 7.8 out of 10 patients said staff did everything they could to control their pain.
- Of the 76 complaints received about the emergency department between April 2014 and February 2015, five complaints related or partly related to lack of pain relief.

Nutrition and hydration

- We noted in patients' records that staff rarely recorded that food and drink had been offered to patients who had been in the department for more than two hours. We asked staff how they ensured that people's nutrition and hydration needs were met. They told us there was no formal system of 'comfort rounds' in place because this was not practical in a high turnover area; however, they offered food and drink "as often as possible" and "as and when we remember and we have time". Visual reminders about nutrition and hydration were displayed on the walls. During our evening visit, when the department was short of healthcare assistants the nurse coordinator acknowledged that this was one aspect of care that might suffer.
- In the CQC's 2014 A&E survey, 7.3 out of 10 patients said they were able to get suitable food or drinks when they were in the A&E department.

Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The trust participated in national College of Emergency Medicine (CEM) audits so it could benchmark its practice and performance against best practice and against other emergency departments. Overall, its performance was below average. The department was unable to provide us with clear action plans to show how improvements were to be made. There was a designated consultant audit lead for the department, although this responsibility had very recently changed.
- In the CEM's 2013/14 audit of severe sepsis and septic shock, a number of indicators scored in the lower national quartile, including administration of fluids, blood culture sampling and administration of antibiotics. The results were published in September 2014. We spoke with the outgoing audit lead, who was not able to provide us with an action plan to show how performance was to be improved. Compliance with the sepsis 6 bundle (a set of interventions to be undertaken

within the first hour of sepsis presentation) was monitored on a monthly basis. Between January 2014 and January 2015, performance had been steadily decreasing, with compliance trust-wide and at Gloucestershire Royal Hospital at its lowest (74% and 71% respectively). The sepsis protocol had been introduced in 2013, but the outgoing audit lead told us "it is difficult to keep it at the top of the agenda."

- The department was meeting the standard that requires the percentage of patients re-attending (unplanned) the emergency department within seven days to be less than 5%. Performance between March 2014 and February 2015 ranged from 0.8% to 1.5%.
- The department performed better than the England average in six out of the eight indicators in the 2013 audit of consultant sign-off. This measured the percentage of patients presenting at the emergency department in certain high risk patient groups (adults with non-traumatic chest pain, febrile children less than one year old, and patients making an unscheduled return visit with the same condition within 72 hours of discharge) who are reviewed by an emergency department consultant (or, in exceptional circumstances, by an appropriately experienced middle grade doctor) before discharge.
- The department performed below CEM standards in respect of the measurement and recording of vital signs. In the 2010/11 audit, the department scored in the lower England quartile for the measurement and recording of pulse, blood pressure and oxygen saturation. The trust provided no evidence to show that effective action had been taken to improve this performance.
- There was a programme of local audit, but the trust was unable to demonstrate the effectiveness of this programme or its impact on patient outcomes.

Competent staff

- The department had two practice development nurses who were responsible for planning, coordinating and delivering in-house training.
- There was a programme of emergency department competency-based training and professional development training for each grade of nursing staff. Each staff member maintained their own training record, which was overseen by their manager.
- Junior medical staff told us they were well supported and supervised. They received regular teaching sessions. One junior doctor told us, "I love working here."
- Appraisal rates for the unscheduled care division trust-wide were as follows:
  - Additional clinical services staff: 85%
  - Administrative and clerical staff: 92%
  - Medical staff: 79%
  - Nursing staff: 87%
- The General Medical Council (GMC) reported in October 2014 that feedback from trainee doctors in the emergency department had significantly improved since the development of an emergency department education group to oversee training in the department. They reported that junior doctors were always supervised by an emergency department consultant or middle grade doctor. There was positive feedback about departmental teaching and one-to-one teaching sessions with consultants. They reported that the emergency department consistently released trainees for teaching. Work intensity and rotas had received negative feedback from higher level trainees, but not at a more junior level.

Multidisciplinary working

- Staff, teams and services mostly worked well together to deliver effective care and treatment. There was an effective and cooperative relationship with the acute physicians who managed ambulatory emergency care and the ambulatory care unit, and these staff had jointly developed care pathways.
- An assisted discharge service was provided by the British Red Cross. This had been very recently introduced and was currently providing a limited but valued service from Monday to Friday, from 1pm to 10pm. It was planned to extend the service to run from midday to midnight once the service was established and emergency department staff were more familiar with it. The team, based in the emergency department and ambulatory care unit, provided a transport and resettlement service for people in vulnerable circumstances to ensure that their discharge from the emergency department was safe. Patients were offered

two hours' support, which might include making sure their home was warm and safe and that they had food in the house. There were plans to introduce a night sitting service in the future.

- Emergency department staff reported that they were well supported by some specialties; however, there was a lack of ownership of the four-hour emergency department target in the rest of Gloucestershire Royal Hospital. There were frequent difficulties in transferring patients from the emergency department to appropriate beds once the decision to admit had been made. A senior clinician told us that only 23% of agreed admissions were transferred within an acceptable time frame to ensure that breaches did not occur. A performance measure had recently been implemented whereby specialties were required to accept admissions from the emergency department within 30 minutes of the decision to admit. This was monitored by daily analysis of breaches. It was hoped that this would enable more cooperative working and ownership of the target by the medical division. However, in the December minutes of the joint emergency department/ acute care operational meeting, it was recorded, "General physicians are paid for on-calls but attend infrequently. Weekend specialties few and far between. There doesn't appear to be any focus on discharging patients." Several nursing staff also reported that at times there were strained relationships with some ward staff in relation to the transfer of emergency department patients to wards.

Seven-day services

- Senior medical staff were present in the emergency department seven days a week.
- Staff reported a less responsive service from specialists at weekends and during bank holidays.
- Radiology was available seven days a week.
- Mental health liaison was available seven days a week; however, specialist support for patients presenting with drug or alcohol misuse was not available at weekends.
- The assisted discharge service provided by the British Red Cross was currently only available from Monday to Friday.
- Attendance-/admission-avoidance initiatives, including the primary care service in the emergency department, older people's assessment and liaison and ambulatory emergency care were currently only provided from Monday to Friday.

Access to information

- There was a bespoke IT system, which was real time and allowed tracking of patients through the department. The status of both of the trust's emergency departments could be viewed on either site, thus enabling an overview of the workload. The system also allowed for statistical analysis and reporting of activity.
- A discharge summary was sent to GPs when patients were discharged from the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent. We heard doctors and nurses explaining things to patients simply, checking their understanding, and asking permission to undertake examinations or perform tests.
- Most nursing staff (92%) and consultants (96%) in unscheduled care (trust wide) had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, although only 75% of middle grade doctors and 73% of trainee doctors had received this training. Staff we spoke with, however, were clear about their responsibilities in relation to gaining consent from people, including those who lacked capacity to provide valid informed consent to care and treatment.

Are urgent and emergency services caring?

Good

Feedback from patients, relatives and carers was generally positive. All the patients and relatives we spoke with during our visits spoke highly of their care and the staff.

Urgent and emergency services

Although the Friends and Family Test in the emergency department yielded a low response rate (which is not uncommon in an emergency department), the majority of respondents provided positive feedback as were the results of CQCs 2014 A&E survey.

The service received few complaints and more compliments than complaints.

Compassionate care

- Patients' privacy and dignity were mostly respected. In the CQC's 2014 A&E survey, seven out of 10 patients said they had enough privacy when discussing their health problem with the receptionist. Regarding privacy, 9.2 out of 10 patients said they were given enough privacy during examinations and treatment.
- Patients received respectful and considerate care. In the CQC's 2014 A&E survey, 8.9 out of 10 patients said they were acknowledged by staff, and staff did not talk in front of them as if they weren't there. We observed staff interacting with patients in a friendly, caring and respectful manner.
- In the CQC's 2014 A&E survey, 7.3 out of 10 patients felt reassured by staff if they were distressed while in A&E.
- However, a relative reported via the NHS Choices website in April 2014 that reception staff in the emergency department at Gloucestershire Royal Hospital showed no empathy or concern and treated them with disdain. In October 2014, another relative reported that staff in the emergency department appeared "disinterested" and failed to provide prompt assistance when a distressed patient needed help to go to the lavatory. In January 2015, a relative wrote, "receptionists were rude and unhelpful, preferring to finish their conversation as opposed to seeing those that were arriving in front of them". However, they described medical staff as "helpful and friendly". A further post in November 2014 described "staff as pleasant, empathetic and helpful".
- Of the 76 complaints received about the emergency department between April 2014 and February 2015, 11 related to or partly related to staff attitude.
- The trust used the Friends and Family Test to capture patient feedback. In common with those of many emergency departments, response rates were low; however, the majority of respondents said they would recommend the service to friends and family. Response rates ranged between 5% and 13% (November 2014 to January 2015). Between 92.2% and 94.6% of responses were positive.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. In the CQC's 2014 A&E survey:
  - 7.8 out of 10 patients said they were involved as much as they wanted to be in decisions about their care and treatment.
  - 8.1 out of 10 patients felt the doctor or nurse explained their condition and treatment in a way they could understand.
  - 8.8 out of 10 patients felt the doctor or nurse listened to what they said.
  - 7.7 out of 10 patients said they had enough opportunity to talk to a doctor if they wanted to.
- We spoke to a relative who had accompanied a family member to the emergency department. They told us they had been kept well informed of their family member's condition and what was happening at all times.
- Self-presenting patients did not know how long they would have to wait to be seen. An electronic sign in the waiting room informed people of the time and advised that the department aimed to see patients within four hours. Patients were not informed of current waiting times. Reception staff told us this information was not displayed because it raised expectations and led people to complain if they were not seen at the expected time.

Emotional support

- Patients and those close to them received the support they needed to cope emotionally with their care, treatment or condition. In the CQC's 2014 A&E survey, 7.3 out of 10 patients said the doctor or nurse discussed any anxieties or fears they had about their condition or treatment.
- The department had recently employed a bereavement counsellor, whose role was to support bereaved relatives and to support staff who had experienced

traumatic events at work. The counsellor told us that they usually contacted bereaved relatives approximately four to six weeks after their loss to offer support.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Patients did not always receive timely care and treatment. The emergency department was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival. Patients arriving by ambulance waited too long to be handed over to emergency department staff. Although ambulance handover delays were reducing, they still occurred too often. Patients frequently queued in the corridor at the entrance to the emergency department, because there were insufficient cubicles in the department. This impacted on patient comfort, privacy and dignity.

The service and Gloucestershire Royal Hospital were taking steps to improve patient flow; these included admission avoidance schemes, for example, the development of ambulatory emergency care and frail elderly pathways, the establishment of a short stay ward and the improving the discharge process. There were also initiatives to make the 'front door' of the hospital more efficient by preventing unnecessary emergency department attendance and ensuring that those who did attend were directed and seen by appropriate clinicians, for example GPs and the integrated discharge team.

Some of these schemes were in their infancy and their effects were not yet fully apparent. The anticipated impact of the ambulatory emergency care service and the potential of the older people's assessment and liaison service had not yet been realised, because of funding and staffing issues. The ambulatory emergency care unit, in particular, had suffered because it was located in premises that were not fit for purpose. The number of patient pathways had been curtailed because of lack of space and shortage of staff. The current premises were not conducive to a comfortable and dignified patient experience. Nevertheless, these initiatives were commendable, and there was a clear plan to develop them further to achieve a more significant impact on patient flow.

Service planning and delivery to meet the needs of local people

- Services had been adapted to meet the needs of the local population. In July 2013, the trust made changes to emergency care provision across the county. The changes meant that at night patients with critical illness or injury who required treatment from emergency medicine doctors were taken by ambulance to Gloucestershire Royal Hospital not Cheltenham General Hospital. In the event that a critically ill patient self-presented at Cheltenham General Hospital, they would be assessed and receive initial treatment and a decision would be made to either admit them under the care of the acute physician or transfer them by ambulance to Gloucestershire Royal Hospital. These changes were made primarily because the trust was unable to provide sufficient medical cover to provide a full service on both the Gloucestershire Royal Hospital and Cheltenham General Hospital sites.
- Emergency department facilities and premises were largely appropriate for the services that were delivered. There were plans to extend and reconfigure premises to accommodate a new model of unscheduled care.
- The emergency department had created a second majors area (majors 2) to increase its capacity and reduce ambulance handover delays.
- The emergency department was accessible. Parking was available close to the department, and there was a covered drop-off zone. The helipad was directly opposite the emergency department, with quick and easy access to the ambulance entrance.
- The main waiting area was adequate, and staff told us that at most times it was large enough to accommodate patients and visitors. However, during our evening visit, the children's waiting area was at times overcrowded. Some parents had to stand, as there was insufficient room or seating available.
- Patients in the ambulatory emergency care had little privacy or comfort. This had also been identified by the emergency care intensive support team when it visited

in September 2014. Although there was an assessment/ treatment room where private conversations, examinations and tests were carried out, patients spent most of their time in a large open space which was essentially a waiting room. There were a mixture of upright waiting room chairs and some reclining chairs. There were no screens and no facility for a patient to lie down should they feel unwell. Despite this, the service received positive feedback from patients; 60 compliments and no complaints were received in February 2015. Because of the low numbers seen in the department during our visit, we were not able to speak with any patients.

- The trust was working with health and social care partners to ensure there was a system-wide approach to managing demand and the impact that fluctuating and increasing demand had on the emergency department. A local health resilience partnership was examining all aspects of the urgent care system and agreeing plans to address identified areas of pressure.
- There was a county-wide, centrally held information system which all partners contributed to. The data was collated and analysed to help health and social care teams understand performance trends and the causes and effects of key measures.
- Following detailed analysis of data, the local health resilience partnership identified four main priorities:
  - Ensuring sufficient capacity to support discharges; this included ensuring that sufficient reablement and domiciliary care were available for patients
  - Increasing weekend discharges
  - Increasing patient flow by ensuring patient discharges took place earlier in the day and understanding how sufficient beds could be made available at times of surge in demand or of infection outbreak
  - Management of emergency department demand: ensuring that staff capacity matched anticipated peaks in demand. This included the appropriate diversion of patients to other services, including a new primary care service in the emergency department (currently working "most weekdays"), ambulatory emergency care and community-based services such as minor injury units (MIUs) and rapid response services.
- All health and social care partners, including Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Care Services NHS Trust, South Western Ambulance Service NHS Foundation Trust, the council and the clinical commissioning group (CCG), participated in a daily teleconference call to monitor patient flow and pressures and agree necessary actions and escalation plans for the day ahead. At times of pressure, meetings took place several times a day. Prior to the call, a dashboard of information was prepared. Gloucestershire Hospitals NHS Foundation Trust submitted performance information for the previous day, including the number of emergency department attendances, performance against the four-hour standard, the number of emergency admissions and discharges, bed availability and the number of medically stable patients who were ready for discharge.

Meeting people's individual needs

- The service took account of the individual needs of different patient groups.
- The department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available in the department, and staff could access wheelchairs and trolleys which could accommodate bariatric patients.
- The reception desk was too high for people of short stature to see the reception staff. We saw several people standing on tip-toes at the desk. A lower section was provided for people in wheelchairs. Staff told us that many people commented that the height of the reception desk had the effect of creating a barrier between people attending the department and the staff. The department had not taken any steps to ensure patient confidentiality at the reception desk.
- There were vending machines in the waiting area so that patients and visitors could access food and drink, although we noticed that drinking water was not available. There was no television in the main waiting area, although some reading material had been provided.
- Toilets suitable for adults and children and nappy changing facilities were available in the children's area. An area was designated breastfeeding mothers.

- There was a separate waiting area for children, which was not overlooked by the adults' waiting area. It was suitably furnished, decorated and equipped with toys and a television.
- A mental health liaison team supported the emergency department and ambulatory care unit from 8am to 10pm, seven days a week. The team was employed by the local mental health trust, 2gether NHS Foundation Trust, although commissioned by Gloucestershire Hospitals NHS Foundation Trust. The team aimed to respond verbally to all crisis and urgent referrals for mental health advice or assessment, and provide assessment according to the urgency of the referral. Between April and September 2014, all urgently referred patients were seen within two hours. Most non-urgent referrals were seen within 24 hours. Outside these hours, staff could contact the crisis home treatment service (2gether NHS Foundation Trust) or the on-call psychiatrist. Staff told us that this service was not responsive, as only two mental health practitioners covered the whole county. They told us that at night patients were likely to be admitted and assessed the next morning. Although this resulted in a more comfortable experience for patients, it was accepted that the use of a medical bed for someone who did not require medical treatment was not appropriate. However, funding had been secured to extend the mental health liaison team to provide night-time cover, and recruitment was underway.
- A patient who attended the emergency department in January 2015 after taking an overdose told us (via HealthWatch) they waited seven hours for a Mental Health Act assessment, and eventually discharged themselves. They reported that staff did not have the correct telephone number for the crisis team at the mental health trust.
- There was a specialist alcohol liaison service which supported the emergency department. Patients attending the emergency department who were identified as having harmful and dependent drinking behaviours were offered assessment, brief intervention and signposting to relevant services. Emergency department staff assessed patients and, where appropriate, provided them with a leaflet and an appointment to see the alcohol liaison worker at the next available clinic slot or within 48 hours. People attending the emergency department on Friday or Saturday would be given an appointment for the following Monday. Clinics were held from Monday to Friday, between 9am to 5pm, and services were split between the two sites (Gloucestershire Royal Hospital and Cheltenham General Hospital). The alcohol liaison service was supported by the Independence Trust Alcohol Liaison Worker; however, concerns were expressed by a member of the team that referrals to this service could take six to eight weeks.
- Guidance was available for emergency department staff to assist them to identify and manage patients with a learning disability. A team of learning disability liaison nurses could be called upon to support staff.
- The department did not have a dementia champion, but staff told us they could access support from the learning disability liaison nurses. All staff were required to complete e-learning in dementia care. Patients identified as having dementia or some form of cognitive impairment were identified by displaying a purple butterfly indicator on their notes. There were similar visual alerts for patients who were at risk of falling, patients who were deaf or hard of hearing, and visually impaired patients.
- Staff recognised the importance of supporting bereaved relatives. Deceased patients were moved to a side room, where family members could spend time with them.

Access and flow

- People did not always receive care and treatment in a timely way. The trust was consistently failing to meet key national performance standards for emergency departments:
- The trust was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. In January 2015, neither of the trust's emergency departments met the 95% target, for the fourth consecutive month. Trust-wide performance was 82.86%, with Gloucestershire Royal Hospital achieving 80.59%.
- While waiting no more than four hours from arrival to departure is a key measure of A&E performance, there are other important indicators such as how long patients wait for their treatment to begin. A short wait

will reduce patient risk and discomfort. The national target is a median wait of below 60 minutes. The department regularly failed to meet this target. From March 2014 to February 2015, the average wait was 65 minutes.

- Another important indicator for patients who require admission to a hospital ward is the time it takes for their transfer to take place from the time of decision to admit. In January 2015, 18% of emergency admissions via the emergency department waited four to 12 hours. Fifty-nine per cent of breaches of the four-hour target trust-wide were because of patients waiting for a bed. It was reported in November 2014 by the director of service delivery that it was a regular occurrence for patients to spend the night in the emergency department waiting for a bed. In October 2014, a relative complained that their elderly family member waited overnight in the emergency department because no beds were available. It was reported that, during this time, the patient sat in a wheelchair with no head support.
- The department consistently achieved the national target which requires that the percentage of patients who leave the department before being seen by a clinical decision-maker (which is recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they have to wait) should be less than 5%. Between March 2014 and February 2015, the proportion of patients leaving before being seen ranged from 0.7% to 2.2%.
- Some patients brought into the emergency department by ambulance waited too long to be handed into the care of emergency department staff. There were 167 ambulance delays of over 30 minutes in February 2015. Joint work with the ambulance service aimed to reduce these delays. A new handover trial started at the end of November 2014, with the emergency department floor coordinator taking the lead. A receptionist had also been employed within majors between 3pm and 11pm to make the handover process more efficient. Despite this, 'black breaches' (patients waiting over an hour to be offloaded from an ambulance) occurred nine times (trust wide) in January 2015.
- The department aimed to have no ambulance handover delays. When the department was busy and there were no available cubicles, patients queued in the corridor, but, where possible, they would be transferred to a hospital trolley and cared for by the designated 'corridor nurse'.
- We did not witness any queues on the two days we visited; however, staff told us that delays were a regular occurrence. During our evening visit, we saw that between 8pm and 11pm, patients queued almost continuously. There was very little space, and patients were moved around this confined space to make room for more incoming patients. A nurse was taking patients' histories and undertaking observations such as blood pressure and temperature, all in full view of other patients and visitors. A patient contacted us to tell us that in February 2015 they spent three and a half hours on a trolley in the corridor. They told us that the queue stretched back to the entrance door. Staff told us they did all they could to ensure that patients in the corridor were comfortable, but acknowledged that sometimes it was cold and there was little privacy, although mobile screens could be used.
- The trust recognised that overcrowding in the emergency department presented a risk to patient safety, the patient experience and performance against key waiting time targets. There was a trust escalation policy (reviewed in June 2013) which set out steps to mitigate these risks by ensuring that patient flow throughout the two hospitals was managed.
- The escalation policy described and 'RAG rated' the escalation level of each hospital, ranging from green (low risk) to black (very high risk). The escalation level was triggered by bed capacity, emergency department capacity or both and was reviewed regularly. In the emergency department, escalation status was reviewed hourly by the nurse coordinator who monitored the department's performance against key indicators: time to initial assessment, senior review, management plan and discharge or admission.
- A series of action plans were in place for each escalation status. Actions included opening additional beds, providing additional staff, cancelling training and diverting patients to other hospital sites. When escalation status was black, an internal major incident would be declared.

Urgent and emergency services

- During the winter months, the trust declared an internal incident on two separate occasions (December 2014 and January 2015). This was because more patients requiring admission attended the two emergency departments than Gloucestershire Royal Hospital and Cheltenham General Hospital had beds for, resulting in overcrowding in the emergency department. The trust also experienced sudden peaks in demand following the festive season. In declaring this heightened level of alert, the trust was able to mobilise extra resources (specialist discharge team, additional staff, equipment and facilities).
- The emergency care board had discussed and agreed a resilience plan for the forthcoming Easter holiday.
- The trust had developed a number of initiatives to prevent unnecessary emergency department attendance and/or admission to hospital and thereby improve patient flow (see below).
- Since September 2014, all GP calls for an ambulance had been handled by the Gloucestershire single point of clinical access, run by Gloucestershire Care Services NHS Trust, which would consider alternatives to emergency department attendance.
- The trust was working with partner healthcare organisations to encourage members of the public to choose the most appropriate service when they needed urgent healthcare advice or treatment. The trust's website directed people to a range of local services, including primary care (including out of hours), NHS 111, pharmacies and local minor injury units. Live information was also posted on the website showing how busy each minor injury unit and emergency department in the county was and what services were offered by each of the locations.
- Media campaigns encouraged the public to think carefully before coming to the emergency department and to consider other sources of care and support.
- The emergency pathway report to the board in February 2015 reported that January 2015 saw the lowest number of total emergency department attendances and the lowest average daily attendance since before April 2011. It was believed that the reason for this decrease was primarily because of the regional and national media coverage the NHS received in January 2015, resulting in low acuity patients choosing not to go to the emergency department.
- Staff completed 'inappropriate attendance' forms to provide data that could be used to inform health and social care partners and commissioners of services and help to provide an understanding of patient behaviour and referral patterns.
- The trust had commissioned the integrated discharge team provided by Gloucestershire Care Services NHS Trust to work in the emergency department and on the acute care unit. The team, made up of health and social care professionals, assessed appropriate patients and, where possible, directed them to other services in the community. It also supported patients (inpatients and emergency department patients) who needed ongoing health or social care services after they were discharged, and helped to facilitate their early discharge. The service operated from 8am to 8pm, Monday to Friday, and from 9am to 5pm at weekends and over bank holidays.
- The integrated discharge team was highly regarded and valued by the emergency department team because of its proactive approach to admission avoidance. The emergency care intensive support team had praised this service following its visit in September 2014. There were plans to formally audit the effectiveness of the service, but early indications were positive. The integrated discharge team saw 1,410 patients in the emergency department or ambulatory care unit between September and November 2014, of which approximately half were not admitted to a ward.
- The integrated discharge team often liaised with the older people's assessment and liaison service, which had been developed with the aim of reducing the need for admission or reducing the length of stay. The service was established approximately 12 months previously and was run by two consultants in elderly care, who were being backfilled by locums because the service had not been able to appoint consultants in elderly care.
- The older people's assessment and liaison service was valued by the emergency department. A list of patients over 80 years of age was passed to the service each weekday morning, and appropriate patients were

selected and assessed. Gloucestershire Clinical Commissioning Group (CCG) reported in January 2015 that 58% of patients reviewed were able to go home the same day. A GP had also been recruited to work with the service. It was recorded on the medical/unscheduled care division's risk register (December 2014) that this service was not fully staffed and there had been recruitment difficulties. One of the two consultants told us that they had successfully recruited a third consultant, who was due to commence in September 2015. The trust was a member of the national Acute Frailty Network, which was looking at how the pathway for frail older patients could be improved. The service was in its infancy, so its effectiveness had not been fully measured. However, one of the team's consultants told us that currently 73% of emergency department patients over 80 years of age arriving by ambulance were admitted to hospital. This 'conversion rate' had improved since the establishment of the current integrated discharge team and older people's assessment and liaison teams, but there was potential to improve this further.

- The older people's assessment and liaison service was described by the emergency care intensive support team as "an example of very good practice", although its limitations in terms of staffing and resources were noted. The emergency care intensive support team recommended that the older people's assessment and liaison service should have access to a short term assessment unit or clinical decision unit, ideally based at the 'front door'. It also suggested closer working with the ambulatory emergency care unit. There were plans to pilot an older person's assessment and short stay unit, starting in the spring of 2015.
- The trust was piloting a primary care service based in the emergency department. The trial was a joint initiative with the local ambulance service and employed a GP in the department most weekdays. Patients who presented in the emergency department with minor illnesses were directed there. We saw this working very effectively during our evening visit. A significant number of self-presenting patients were seen by the GP, having been directed by receptionists. The triage nurse told us the GP had also worked proactively and cooperatively to "pull" patients who were awaiting triage, thus reducing the time people waited to be assessed. One patient was inappropriately referred to the GP but they were promptly transferred to majors by the GP for urgent medical attention.
- An ambulatory emergency care unit was open between 10am and 6.30pm, Monday to Friday. Patients could be referred by the emergency department or by their GPs or the ambulance service via the single point of clinical access helpline. It was reported to the December 2014 board meeting that activity was increasing steadily, and the service exceeded the anticipated attendance rate during December 2014 and January 2015.
- When we visited the ambulatory emergency care unit, we learned that the department had recently been relocated because of the need for more inpatient bed space in Gloucestershire Royal Hospital. The new temporary 'home' was not fit for purpose, and this, combined with nurse staffing shortages, meant that progress had slowed down. Only three patients were seen on the unit on the day of our visit. A staff member told us that, staff levels allowing, they generally aimed to see 10 patients per day, although in the right environment and with the correct levels of staffing they would aim to see 15 patients a day. They told us that in the current accommodation, they would struggle to accommodate more than eight patients at a time.
- The trust aimed to increase the number of short stay discharges to improve patient flow. A short stay ward opened in Gloucestershire Royal Hospital in November 2014 (Ward 9A).

Learning from complaints and concerns

- Between June and August 2014, 27 complaints were received in unscheduled care (which includes the emergency department, ambulatory emergency care unit and acute assessment unit). This represented 11% of the trust's complaints. The most common cause for complaint was waiting times to be seen in the emergency department.
- The service responded to 98% of complaints within 35 days from June to August 2014. The trust's internal standard was 95%.

Urgent and emergency services

- Staff were familiar with the complaints procedure and felt confident to deal with complaints. They told us that waiting times were the most common cause for complaint, followed by lack of communication and staff attitude.
- The unscheduled care service produced a monthly analysis of compliments, concerns and complaints. This analysis also reported on the response time to complaints and highlighted any significant complaints or themes and actions taken. In February 2015 it was noted that changes were being made to a GP referral pathway for patients with Giant Cell Arteritis, following a complaint of delayed diagnosis. There were also plans to present the learning from this case.

Are urgent and emergency services well-led?

Good

The service had a clear vision to provide a comprehensive and integrated unscheduled care service where people received appropriate, seamless and timely care and treatment. The vision, however, was not well understood by the majority of staff, who were more concerned with the "here and now".

The workforce were passionate about patient care and committed to the delivery of safe and high quality care and treatment. They enjoyed working for the service and felt valued and supported by the management team. The local management triumvirate (comprising medical, nursing and general managers) was a strong and cohesive team, and they were highly respected. Commitment from the executive management team to improve the urgent care pathway was highly evident; the emergency care board had developed a clear trust-wide strategy to deliver improvements and was monitoring progress against this strategy. However, there was less focus on clinical performance and improving patient outcomes. We saw little evidence that clinical audit resulted in improved performance and outcomes for people. There were excellent working relationships with external partners who were working jointly to improve the resilience of the emergency and urgent care pathway. However, internally there was some lack of ownership of the emergency department's four-hour target.

Vision and strategy for this service

- There was a clear vision and a credible strategy to deliver safe, high quality unscheduled care. The vision for the service was for the provision of all strands of unscheduled care to be provided under one roof, 24 hours a day, seven days a week. This included the expansion of primary care services, mental health liaison and support, and ambulatory emergency care, further development of the frail elderly care pathway (including short stay beds), and the provision of larger and updated premises to accommodate these services. It was anticipated that it might take several years for this to be fully realised.
- A series of external reviews had taken place of systems and to examine the issues affecting operational effectiveness and patient flow. These included the clinical commissioning group and the emergency care intensive support team (ECIST). ECIST last visited in September 2014. Its recommendations focused on the management and prompt discharge of inpatients, increasing the number of short stay beds, further developing older people's assessment and liaison and ambulatory emergency care, and better aligning emergency department staffing to demand. Recommendations had been incorporated into the trust's Emergency Care Board (ECB) plan, and progress against milestones was closely monitored both by the ECB and the trust's board.

Governance, risk management and quality measurement

- Robust governance arrangements were in place. The service regularly examined data that provided a holistic understanding of patient safety and patient experience.
- An emergency care board (ECB) met weekly and was attended by senior clinicians and managers hospital-wide. Each month, the ECB reported to the trust's board performance against key performance indicators, identified risks and the ECB milestone plan.
- The corporate risk register and divisional risk register detailed the risks associated with poor patient flow, increased activity and emergency department delays. Three main areas of concern were identified: demand, staffing (medical and nursing) and beds and capacity. These risks mirrored what staff and managers told us were on their 'worry list'. An emergency care plan was in

place to manage and mitigate these risks, overseen by the emergency care board, which reported monthly to the board. Poor performance in national clinical audits was not identified as a risk.

- Relationships were excellent with external healthcare partners including the clinical commissioning group (CCG), the local community trust and the ambulance service.
- A manager from the ambulance service told us they had never worked with a trust that was so engaged with the problem associated with delayed ambulance handovers, and that the trust had worked relentlessly to find a solution.

Leadership of service

- There was a service-wide management triumvirate comprising senior medical, nursing and general managers. They were a well-informed, cohesive team who were highly respected by staff. They demonstrated passion and drive to meet the significant challenges in unscheduled care and to develop and improve their service.
- Staff told us the local management team was visible and approachable. The Matron, Associate Director of Nursing and the General Manager frequently attended the department to provide assistance when there were capacity issues. Most staff told us that more senior managers and executives were less visible. Few staff had met the Chief Executive, Chair or Medical Director but the Director of Nursing and Midwifery was a regular visitor to the department and was better known to staff. We were told that there were regular executive visits to the department but the staff we spoke with were unaware of these visits. It was recorded at a recent staff meeting that meetings had been arranged with the Director of Nursing and Midwifery and staff were encouraged to attend to discuss issues of concern.
- Staff told us they felt valued and supported by their immediate managers, although some felt less valued by the trust. Several staff told us they would not want to work anywhere else.

Culture within the service

- Staff in the emergency department told us they felt respected, supported and valued by their immediate managers. During our evening visit we joined a debrief session at the end of the late shift. The shift coordinator (a senior nurse) gathered nursing staff together for five minutes to discuss how the shift had gone and any issues or concerns that had arisen. It had been a busy shift and staff had been under significant pressure because of a number of gaps in the rota. Their efforts, hard work and team ethic were praised by the coordinator. Staff commented on the way in which doctors and nurses had worked cooperatively during the shift, with doctors taking blood when nurses were too busy. Staff told us this opportunity to sit down together at the end of the shift made them feel valued.
- Staff in ambulatory emergency care, whilst enthusiastic and passionate about their service and its potential to make a difference, had been demoralised by uncertainty regarding the service's future and its location. This was not a reflection of the local managers, who were seen as supportive, but this uncertainty had impacted on staffing as it was difficult to recruit and retain staff. During the week of our visit, recurring funding had been agreed to allow the service to move forward, but there remained some way to go before a permanent home for the service was established.

Public and staff engagement

- The emergency department used the Friends and Family Test to capture patients' feedback. Tokens were given to patients who were discharged from the emergency department. Patients could use these tokens to indicate their level of satisfaction with the service. This system was similar to those used in some supermarkets. Posters were displayed throughout the department encouraging patients to use this system to provide feedback. Response rates had been low (between 5% and 13% from November 2014 to January 2015). During the morning of the first day of our visit we questioned four people leaving the emergency department, and none of them had been offered or given a token. It was, however, recorded at a staff meeting in March 2015 that the response rate had improved and now stood at 19%.
- The service had developed close links with Healthwatch Gloucestershire, and members of this group had visited the department. Healthwatch is a national consumer champion for health and social care which aims to ensure that the voice of the consumer is heard by those who commission and provide services.

- Departmental meetings were held for nursing staff. These were supposed to occur fortnightly, although staff told us that sometimes they took place every three to four weeks. Two nurses told us they had never attended a meeting. Minutes of meetings were held in a communications folder at the nurses' station. Nurses also told us that they received numerous email communications, but some said they didn't have time to look at them.
- Nursing staff had not been actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. None of the emergency department staff we spoke with could articulate the department's vision or strategy.
- Staff told us that they were encouraged to raise concerns and they felt they were listened to.

Innovation, improvement and sustainability

- All emergency department consultants had a designated lead role so that they could champion service improvement. A consultant was designated as research lead. Although research in the department was described as being in its infancy, there were a number of research projects ongoing on the service. Funding had been secured for nurse involvement, and a similar arrangement for the involvement of allied health professionals was under negotiation.
- A lead consultant was identified to work with radiology. The improvement plan for missed radiological pathology (described earlier in this report under 'Safe') was an example of how the service was striving for improvement by ensuring that medical staff were better trained and equipped to recognise abnormal results.

Medical care (including older people's care)

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

Gloucestershire Hospitals NHS Foundation Trust provides inpatient medical services at Gloucestershire Royal Hospital. There are 11 medical wards, two flexible capacity wards, one acute care unit and one medical day unit. There are approximately 300 medical beds.

We visited the medical day care unit and endoscopy, both of which offer a day case service for patients. We visited the following inpatient wards: 9b, general and old age medicine; cardiology; acute care unit; 8a, general medicine; 6b, stoke unit; 7a, gastroenterology; 7b, renal; 8b, thoracic/ respiratory; 4b, general and old age medicine; and the discharge lounge. We also visited gallery wards 1 and 2, which consisted of beds opened in response to the shortage of inpatient beds on the medical wards and Acute Care Unit A (ACUA). We spoke with over 80 members of staff including nurses, doctors, therapists, administrators, housekeepers and porters. We spoke with 38 patients and nine relatives. We reviewed 27 care records, observed interactions between staff and patients, and considered the environment. Before and during our inspection we reviewed the trust's performance information.

Medical services provided by Gloucestershire Hospitals NHS Foundation Trust are located on two hospital sites, the other being Cheltenham General Hospital. Services at Cheltenham General Hospital are reported in a separate report. However, services on both hospital sites are run by one management team (the medical division) and, as such, are largely regarded within the trust as one service, with some staff rotating between the two sites. For this reason, some duplication in the two reports is inevitable.

Summary of findings

We have judged medical care services as requiring improvement overall. This was in relation to the hospital's safety, effectiveness, responsiveness and leadership. Caring was judged as good.

Although the majority of staff we observed were following the trust's infection control procedures, we found some ward staff were not consistently following infection control policies. The hospital was not visibly clean in all areas. There had been a marked decrease in cases of hospital-acquired Clostridium difficile, although cases had recently begun to increase in number.

There was no evidence to show how patient mortality and morbidity was reviewed and actions taken to address any practice that could be improved.

Medicines were safely stored in the majority of areas, although the resuscitation trolleys were not secured in such as a way to show they had not been tampered with. Mandatory training was meeting trust targets. Nursing staffing levels were mostly safe, but there were times when not all shifts were able to be fully staffed.

Staff were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable people from abuse.

The service responded to incidents reported and demonstrated change where it was needed. Data was collected to analyse and address patient harm. Patient

Medical care (including older people's care)

risks were assessed and care plans developed to keep patients safe. These included assessments for mobility, falls, pressure ulcers, nutrition and hydration. Patient records were completed well, although there were some that were not supervised or locked away at all times.

The trust's overall score for the Sentinel Stroke National Audit Programme (SSNAP) had steadily declined; data for April to June 2014 showed a score of E on a scale of A to E, with A being the best. Gloucestershire Royal Hospital performed worse in the heart failure audit 2012/13 compared with other trusts. The endoscopy service required further improvements to attain JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation. Access to seven-day services was variable throughout Gloucestershire Royal Hospital. Most services were working towards providing a seven-day service, and this had been identified on the medical division's risk register. Staff reported a lack of staffing resources to achieve this.

The trust consistently had a high bed occupancy rate, and we were told that flexible capacity wards were not always open in a planned way.

The directors of the medical division were passionate about providing a high quality service. The service was clinically led; however they felt they lacked sufficient autonomy to enable them to drive improvements and instigate change.

Patients were positive about the care and treatment they received at Gloucestershire Royal Hospital. We observed that patients were treated with compassion and kindness by dedicated, professional staff.

Are medical care services safe?

Requires improvement

Safety in medical care services was judged overall as requiring improvement.

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Incidents

- There had been no Never Events (serious, largely preventable patient safety incidents that should not occur if the available preventative measures are implemented) in the medical service.
- Between January and December 2014, 19 serious incidents which required further investigation had been reported trust wide. Of these incidents, 12 were pressure ulcers of grade 3 or above.

Medical care (including older people's care)

- Safety incidents were reported using an electronic system. Staff throughout Gloucestershire Royal Hospital understood their responsibilities to raise concerns and to record safety incidents and near misses. Most ward staff confirmed they had feedback from incident reports they had raised. Incidents that affected the whole staff team were discussed at staff meetings on all of the medical wards. This was to ensure that lessons were learned from the incident investigation.
- We saw that learning from incidents had occurred. For example, root cause analysis investigation reports had been completed for pressure ulcers of grade 3 or above. The trust had implemented further training and information for staff as a response to the incident reports around pressure ulcers.
- Only permanent members of staff had access to the computer-based incident reporting system. Other staff without access to the computer system could use the telephone incident helpline.
- The trust had a system in place to ensure that patients were informed when something went wrong, given an apology and informed of any actions taken as a result. This is known as the Duty of Candour. Medical staff of various grades were not familiar with the term Duty of Candour but from their responses demonstrated their awareness of the need to be open when incidents occurred.
- Some junior doctors told us the medical specialties did not regularly hold mortality and morbidity meetings. The director of safety told us told regular morbidity and mortality meetings were organised at specialty level and the meetings were monitored as part of the quality framework. We viewed the specialty minutes for each specialty, most of which were for a three-month period. We saw that mortality and morbidity was an agenda heading for most specialties. However, there was no minuted discussion about this topic in the minutes we viewed. Each division had to confirm in its divisional quality report that meetings had taken place. We saw in the quality board minutes that the medical specialties had notified the quality board that a meeting had taken place. This was recorded in the form of a green coloured square, which meant meetings had been held on a quarterly basis. The trust told us this was a "self-assessment of process not content". We were unable to view the minutes of the mortality and morbidity meetings and were told, "In general the note-keeping in some of the divisions is not ideal," by the director of safety at the trust. We could not be assured that meetings had taken place to enable any trends to be identified or learning to take place.
- We saw evidence in the minutes of the stroke and transient ischemic attack business meeting held in January 2015 that attendees at the meeting felt that regular monthly multidisciplinary team meetings to discuss mortality and difficult cases would be "useful".

Safety thermometer

- As required, the hospital reported data on patient harm to the NHS Health and Social Care Information Centre each month. This was nationally collected data providing a snapshot of patient harms on one specific day each month. This included hospital-acquired (new) pressure ulcers (including only the two more serious categories of harm) and patient falls with harm. Ward staff in all areas told us they regularly undertook monthly safety thermometer audits, which were sent to the clinical audit department. We saw that safety thermometer audits were kept in files in the manager's office in most ward areas. We observed the safety thermometer results were not displayed as is now considered good practice by many trusts.
- Ward areas undertook a nursing metrics audit which monitored areas of harm-free care, for example hospital-acquired infections and pressure ulcers. These audits were sent to the clinical audit department and were integrated into the trust system for monitoring quality. Ward staff told us that if any concerns arose from the audits, they would be contacted by the relevant department. For example, if the ward had an incidence of hospital-acquired infection they would be visited by the infection control team. The results of all the audits undertaken were discussed in monthly team meetings.

Cleanliness, infection control and hygiene

- There had been a marked decrease in cases of hospital-acquired Clostridium difficile, although cases had recently begun to increase in number. The rate had fallen over the period of April 2013 to November 2014, and particularly since June 2014. However, at the time of the inspection the overall trend across the trust had increased. As a result, the trust reported rates higher

than the NHS England average for the months December 2014 to March 2015. These were not solely attributable, however, to the medical division. In the period January to December 2014 there were three cases reported on the medical wards which was below both the NHS England average and the target set for the hospital trust.

- Senior staff on Ward 6b (stroke ward) told us that between December 2014 and January 2015, 12 patients were found to have acquired methicillin-resistant Staphylococcus aureus (MRSA) on their skin. They told us these cases had been detected early, fully investigated and appeared to have been transmitted by direct contact from ward staff. As a result of this, the ward had taken further precautions to ensure patients were protected from the risk of a hospital-acquired infection. For example, further training and education had been implemented on the ward, hand washing was closely monitored, and cleaning hours increased.
- We saw staff adhering to the trust's infection control policy. Information was clearly displayed above sinks in ward areas to remind staff about correct hand-washing procedures. We observed that staff were 'bare below the elbows' and were seen washing their hands and using hand gel appropriately. We saw an audit of hand-washing compliance conducted across the medical division. The trust's target was 95%. We saw staff regularly exceeded this target, with the exception of October 2014 when 94% of staff adhered to correct hand-washing techniques.
- The majority of nursing staff had completed their updated training in infection prevention and control. The trust target of 90% had been met and exceeded with 95% of the nursing staff having undertaken their training.
- The medical staff were not meeting the trust target for infection prevention and control updated training, with 77% of these staff from a target of 90% having undertaken the refresher course.
- The trust monitored clean, safe care through the Saving Lives audit tool. This tool measured the incidence of infections relating to invasive equipment such as cannulas and urinary catheters. The audit showed the majority of patients received safe care, but 20% of patients fell below the target of delivery of 100% of harm-free care.
- Personal protective equipment was available, and staff were seen changing gloves and aprons in between patients to prevent the risk of cross-infection on the majority of the wards we visited. However, on Ward 9b, we observed a nurse entering two side rooms to dispense medication without wearing protective equipment. On further investigation we ascertained that both patients had Clostridium difficile (a bacterial infection that can affect the digestive system). The nurse should have worn personal protective equipment to prevent the transmission of bacteria to them patients and to other patients. We addressed our concerns to the nurse in charge.
- We spoke with a patient who was cared for in a side room on Ward 4b. Staff and relatives entered the room without wearing personal protective equipment. The patient was showing some symptoms of Clostridium difficile; however, results had not yet been returned by the laboratory. During our visit, the patient was told they had Clostridium difficile. The patient had been placed in the side room as a precautionary measure; however, staff were not consistently adhering to the infection control policy. This put patients at risk of contracting a hospital-acquired infection.
- One patient told us there had been faecal matter on the floor of their side room in Ward 4b. The patient told us this had happened overnight and a nurse had stood in it and spread the matter over the floor. The patient told us the floor had been wiped that morning. However, we observed a partial footprint on the floor, of what we believed to be faecal matter. We raised this concern with the director of nursing, who ensured the room was effectively cleaned.
- The medical day unit was cramped and difficult to clean; we saw some evidence of dust and some sticky residue on the toilet floor. We raised this issue with the nurse in charge.
- We noticed evidence of dead flies and visible dust balls and dirt in the drawers of the clinic room in Ward 9b; we brought this to the attention of the senior nurse in charge.

Medical care (including older people's care)

Environment and equipment

- Staff told us and we observed equipment storage was a problem. Some patients had mobility aids, such as walking frames, by their beds. However, corridor areas were cluttered with wheelchairs and other mobility aids. On Ward 6b we saw trolleys used for sterile dressing procedures stored in the bathroom. We discussed this with a senior member of staff who told us they had nowhere else to store them. Most of the wards we visited had hoisting equipment stored in bathrooms and commodes stored in sluice areas.
- All the areas we visited had portable resuscitation trolleys for use in an emergency. We inspected eight of these in the medical wards. For safety reasons they were all centrally located within the wards. The defibrillators on the top of the trolleys had been serviced and tested each day and this was documented. The trolleys contained such medication and equipment to be used in the event of a cardiac or respiratory arrest. The medication within the trolleys was stored in tamper-evident containers. However, none of the drawers within the trolleys were themselves tamper-evident so medicines could be removed between checks without this being apparent.
- The medical day unit was not fit for purpose. Staff told us they had to reduce the size of the facility five to six weeks ago because of the expansion of the gallery wing ward. On the day we visited, nine patients were in the unit, which consisted of one four-bed bay. There were two reclining chairs plus an assortment of padded chairs. Plastic chairs were also stacked in the room. The environment was cramped, and equipment, for example drip stands and medication pumps, was stored in the middle of the bay. There was no facility for single-sex accommodation, and there was one portable screen which could be used to section off a chair area if required.
- We found expired blood sample bottles on Ward 9b. There were 19 expired blue-top bottles, 32 expired pink-top bottles and five expired black-top bottles. Blood samples could have been inaccurate if expired bottles had been used. We alerted the nurse in charge to this, who was going to arrange disposal of the bottles.

Medicines

- We saw that controlled medication was securely stored in locked cupboards. In most areas, this medication was checked daily to ensure the amount of medication stored was correct. We saw on Ward 7a that the controlled medication had not been checked daily. Senior staff told us this was not always possible because of time constraints.
- Refrigerator temperatures were recorded twice daily, in the morning and afternoon, to ensure medication was stored at the correct temperature. Records showed that the temperature was at the recommended level.
- On the whole, medication trolleys were securely attached to the ward when not in use. We noticed on Ward 6b that one medication trolley was not attached to the wall to prevent the trolley from unauthorised access. We brought this to the attention of the nurse in charge.
- Pharmacy staff, including pharmacy assistants, medicines management technicians and pharmacists, visited the wards on a planned basis, Monday to Friday. We saw the necessary medicines reconciliation checks to ensure that patients were taking the correct medication.

Records

- We reviewed 27 care records. All records showed that risks to patients had been identified and a care plan put in place. For example, we saw that a patient who was at risk of falls had an assessment in place for the use of bed rails.
- Records were not consistently stored securely on the wards. We saw on Gallery Ward 1 that notes were kept in a lockable room behind the nurses' station, and on Ward 7b notes were stored in non-patient areas. However, on Ward 4b notes were stored in open trolleys beside the nurses' station. During our visit to Ward 4b, a doctors' round was in progress; the notes trolley was left unattended in the main corridor. On Gallery Ward 2, the notes trolley was behind the nurses' station; however, it was unlocked and could be accessed by unauthorised personnel.

Safeguarding

- All staff we spoke with were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults from abuse. From training records sent to us by

the trust for January 2015, we saw the trust ran two safeguarding courses and the target for attendance was 90%. For the medical division trust wide, we saw that 93% of all staff had attended the safeguarding adults' awareness course. Eighty-eight per cent of staff had attended the safeguarding awareness level 2 course.

Mandatory training

- Staff told us they were able to attend regular mandatory training in subjects such as manual handling, fire and infection control. The trust's target for attendance at study days was 90% of all staff. We saw that between August and November 2014, between 91% and 93% of staff had attended training. This meant staff ensured they remained up to date with their skills and knowledge to enable them to care for patients appropriately.

Assessing and responding to patient risk

- All ward areas used an early warning score to determine whether patients were at risk of deteriorating. We saw in the patients' records reviewed that the early warning scoring system had been used appropriately and advice from doctors sought if the patient required a medical review.
- Risk assessments were in place, relevant to patients' needs. These included assessments for mobility, falls, pressure ulcers and nutrition.
- The trust's target for completion of venous thromboembolism (VTE) risk assessments was 95% of all patients. From information sent to us by the trust we saw that for the period August to December 2014, between 90.8% and 91.9% of patients had received an assessment, which was below the trust's target. During our inspection we saw that the majority of patients had received an assessment and prophylactic medication prescribed if required.

Nursing staffing

- Monthly nursing metrics audits were conducted. This was an assessment tool used by the trust to monitor the safety and quality of care delivered. This included areas such as staff vacancies, completion of early warning scores and monitoring of hospital-acquired infections. The results of the audit were analysed by the clinical audit department and any areas for concern were fed back to senior ward staff and discussed in the divisional quality report. Action plans were produced to address any concerns. Most ward staff were not routinely aware of how their ward performed on the nursing metrics assessments, because the results of the audits were not displayed. Ward staff told us they relied on their managers to pass on relevant information.
- Staff from all ward areas told us they felt there were not enough staff to enable them to care for patients appropriately. Patients told us they felt that ward staff were very busy and at times they took a long time to answer patients' buzzers. During our inspection we noted that most ward staff were able to answer patients' requests for assistance promptly. Most wards were staffed as planned, and any gaps in staffing had been filled by bank or agency staff to ensure that enough staff were available to care for patients.
- During our unannounced inspection, which took place out of hours, we saw that wards were fully staffed.
- We visited Gallery Ward 1, a flexible capacity ward. Staff told us the planned trained nurse requirement was four registered nurses. They had two registered nurses plus one registered nurse who was unable to perform some nursing tasks, for example administer medication. The trained nurses told us the medication round was late and they felt the ward area was unsafe because they were unable to meet the care needs of patients. They told us they had escalated their concerns to senior management and had been allocated another healthcare assistant; however, the acuity of the patients meant the ward required further trained staff. There was also no ward clerk cover and we observed the phone ringing for long periods on four occasions. We met with senior nursing staff who had arrived to assess the situation on the ward and discussed our concerns with them. We returned to the ward later to find another trained agency nurse had been allocated to the ward.
- We saw nursing handover sheets which contained information about care needs, past medical history and plans for discharge. We observed that ward nurses used the sheets throughout the bedside handover. Information was discussed about care needs, and patients were included in these discussions to ensure information was correct.

Medical care (including older people's care)

- From data sent to us prior to the inspection, a 3.67% nursing vacancy rate across the medical division was recorded.
- Use of agency and bank nurses was high in some areas at Gloucestershire Royal Hospital. For example, Gallery Ward 1 (flexible capacity ward) from September to November 2014 had between 53.3% and 56.2% agency staff. Ward 4b from September to November had between 11.8% to 14.7% agency staff. Ward staff told us they tried to ensure the same agency and bank staff were employed on the ward to ensure continuity of care for patients. The trust had identified that recruitment of nurses was an issue and had recently visited other countries to recruit nurses.
- Because of the high usage of agency and bank staff and lack of permanent ward staff on the flexible capacity wards, senior nurses had recently been allocated to these areas to coordinate care. Senior staff on Gallery Ward 2 told us they currently had no ward clerk, which meant ward staff had to spend time answering the phone, which took them away from patient care.

Medical staffing

- Junior and middle grade doctors consistently told us throughout our inspection that they felt there were not enough doctors to provide care for patients, and they often felt "unsafe". During our inspection, we found one junior doctor on Ward 6b with no consultant support. The doctor told us there was usually a consultant available every weekday. The junior doctor was supported by two medical students. The doctor had highlighted their concerns to senior medical staff.
- We viewed the medical division staffing rotas, and sufficient medical staff were on duty.
- Junior doctors consistently raised concerns about the handover process for patients between doctors in Acute Care Unit A (ACUA). Medical staff told us the handover was ineffectual, did not address the recent admissions into the unit, and focused on patients that had been on the ward for a while. Junior doctors felt this did not give them enough time to raise questions and discuss recent admissions with the medical staff who had finished their shift and were about to leave the ward. Some consultants told us they were conducting a project to look at the handover of care on the ACUA and address concerns raised by junior doctors.
- Junior doctors consistently raised concerns about the handover from patients from ACUA to the wards. Doctors told us that often patients arrived on the ward with no medical or nursing handover. Some nursing staff on the wards told us there had been times when patients arrived on the ward without a sufficient handover from ACUC; however, this was not a regular occurrence.
- We saw in the minutes of the county cardiology meeting held in December 2014 that discussions had been held as a result of negative feedback from trainees with regards to staffing concerns in cardiology. We read that a business case was in progress to ensure more staff were appointed.
- From information sent to us before the inspection, we saw that between September and November 2014 agency locum rates were between 2% and 3.5% for the medical division.

Major incident awareness and training

- The trust had a major incident and business continuity plan. The major incident plan identified staff responses to different types of incidents. Ward staff we spoke with were not consistently aware of their role in the event of a major incident.

Are medical care services effective?

Requires improvement

The trust performed worse in the Sentinel Stroke National Audit Programme (SSNAP) and the heart failure audit compared with other trusts. The SSNAP audit showed for October to December 2013 that the trust's stroke services attained an overall score of D on a scale of A to E, with A being the best. Since then the trust's overall score has steadily declined; data for April to June 2014 showed a score of E.

The Myocardial Ischaemia National Audit Project (MINAP) showed that 85% of patients were seen by a cardiologist or member of the team compared with the England average of 94%; however, 68% were admitted to a cardiac unit or ward compared with the England average of 53%, and 82.7% were referred or received an angiography compared with the England average of 73%.

Medical care (including older people's care)

There was evidence-based care and treatment within the trust, for example the use of the nursing metrics audit to ensure care was delivered safely and to national guidelines. However, we found care and treatment delivered that was not evidence based; for example, there was no seven-day transient ischaemic attack service. This had been identified and was part of the five-year strategic plan for the medical division.

The endoscopy service required further improvements to attain Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation. Areas for improvement had been identified and a plan put in place to reapply for accreditation in 2015.

Access to seven-day services was variable throughout Gloucestershire Royal Hospital. Most services were working towards providing a seven-day service, and this had been identified on the medical division's risk register.

Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.

Patients told us that pain-relief medication was delivered when necessary.

Evidence-based care and treatment

- The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) had found that the service at Gloucestershire Royal Hospital did not meet the accreditation standards framework. The last visit from the advisory group in May 2014 had highlighted further areas for improvement, for example compliance with single-sex accommodation and environmental adjustments to address the health and safety risk of trailing wires in the scoping room. We saw in the minutes of the endoscopy users group meeting held in January 2015 that there was a plan to apply for JAG accreditation in 2015.
- The National Institute for Health and Care Excellence (NICE) quality standards/clinical reference group met monthly to establish a system of quality assurance for NICE clinical quality standards. NICE standards were discussed and guidance sent to the appropriate specialties. We saw evidence that NICE guidance was discussed at specialty meetings.
- There was no transient ischaemic attack seven-day service. This was not in line with NICE stroke guidance (2008). A plan to develop this service had been described in the trust's strategic plan for 2014/19.
- Patients with heart failure did not always receive treatment in line with NICE guideline CG187, which states, "Ensure that all people being admitted to hospital with suspected acute heart failure have early and continuing input from a dedicated specialist heart failure team."

Pain relief

- Patients told us that pain-relief medication was delivered when necessary.
- The Abbey Pain Scale tool was used to assess whether patients were experiencing pain when they had difficulty communicating.

Nutrition and hydration

- There were protected meal times on all the wards we visited.
- Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.
- Patients were mainly positive about the food provided at Gloucestershire Royal Hospital. They told us there was a choice of food and they were usually able to have their first choice. One patient told us the food "could be better". Sandwiches were available if patients did not want anything from the menu.
- Red trays and jug lids were used to alert staff to patients who required support to eat and drink. We observed a lunch service on Ward 6b and saw that staff selected appropriate adapted cutlery to enable patients to eat their lunch. Staff sensitively supported patients who required help to eat and drink.
- We audited 20 patients on several wards to ascertain whether they had a drink within their reach. All the patients had access to a drink, and all of their fluid balance charts had been completed to enable staff to monitor their fluid intake.

Patient outcomes

- In the Sentinel Stroke National Audit Programme (SSNAP) for October to December 2013, the trust's stroke services attained an overall score of D on a scale of A to E, with A being the best and E being the worst. Since then, the trust's overall score has steadily declined; data for April to June 2014 showed a score of E. This meant that the highest standards of care were not being met

for most patients with improvement being needed in some aspects. The main areas for improvement were the timely use of physiotherapists, occupational therapists and speech and language therapists. Senior managers told us the therapists were managed by another division and a business case had been produced to manage the therapists within the medical division. We were told this would enable the division to allocate therapists to support medical patients more effectively.

- Gloucestershire Royal Hospital performed worse in the heart failure audit 2012/13 compared with other trusts. For example, 41% of patients had input from a specialist doctor compared with the England average of 78%, and 55% of patients received an echocardiogram compared with the England average of 91%.
- The Myocardial Ischaemia National Audit Project (MINAP) showed that 85% of patients were seen by a cardiologist or member of the team compared with the England average of 94%; however, 68% were admitted to a cardiac unit or ward compared with the England average of 53%, and 82.7% were referred or received an angiography compared with the England average of 73%.
- The standardised relative risk of readmission for clinical haematology, gastroenterology and respiratory medicine was lower than the England average.
- The older people's assessment and liaison team benchmarked results with other trusts and was part of the Acute Frailty Network to ensure outcomes for patients were met.

Competent staff

- All the staff we spoke with told us they had recently received an appraisal.
- The medical division had set a target for 90% of staff to receive an appraisal. In the data sent to us by the trust it was recorded that 80% of medical staff and 87% of nursing staff had received an appraisal from July to November 2014. This meant that some staff had not been given an opportunity to discuss areas for improvement or further development in their role.
- Nursing staff told us they were encouraged to attend further training to develop their skills and knowledge and were able to access study leave. Nurses on the stoke wards told us they were able to attend specialist stroke training to enable them to more effectively support the patients on their wards. However, non-clinical staff told us that access to further study and development was limited.

Multidisciplinary working

- We observed a multidisciplinary team meeting which included nurses, doctors, physiotherapists and occupational therapists. We observed all areas of care were discussed, action plans finalised and discharge arrangements made.
- Staff told us patients were able to access mental health support if required. We heard discussions during our attendance at the multidisciplinary team meeting about access to psychological support for a patient in preparation for their discharge home.
- Staff on Gallery Ward 1 told us the flexible capacity wards did not have an allocated physiotherapist. Physiotherapists were usually called from their permanent wards to visit patients. However, during our visit a physiotherapist had been allocated to Gallery Ward 1.

Seven-day services

- Junior doctors told us they regularly covered five wards at night and felt they were 'fire-fighting'. During our out-of-hours unannounced inspection, junior doctors told us there were sufficient medical staff on duty to meet the needs of patients in Gloucestershire Royal Hospital.
- Access to seven-day services was variable throughout the hospital. Most services were working towards providing a seven-day service, and this had been identified on the medical division's risk register. Staff reported a lack of staffing resources to achieve this.
- There was a 24-hours-a-day, seven-day-a-week rota for medical staff to provide cover for any patients who had gastrointestinal bleeds that might require further investigation.
- Ward 9b (general and old age medicine) had a medical ward round on Saturday and Sunday for new and ill patients and to check patient discharges.

Medical care (including older people's care)

- There was no consultant-led weekend ward round on the stroke, gastroenterology, or diabetes and endocrinology wards.
- A consultant was on call from 9am to 12 noon at weekends on the renal ward.
- The cardiology ward had a consultant-led ward round on both days at the weekend; however, cardiology staff told us they felt the ward was unsafe at weekends because there were insufficient senior medical staff on duty. We discussed this with the cardiology consultants, who agreed and stated there was a conflict between ward rounds and emergencies elsewhere in the hospital.
- The consultant for diabetes told us their specialty was small and there were not sufficient staff to manage seven-day working. They told us there was an informal arrangement that the consultant was called at home if further guidance was required for a patient who had diabetes.
- Physiotherapists and ward staff told us there was only one on-call physiotherapist at the weekends for Gloucestershire Royal Hospital.
- Ward staff told us there was no access to speech and language therapists at the weekend. Trained nurses had undergone further training to assess patients swallowing reflexes if there was no speech and language therapist available out of hours.
- There was a dispensary open for medications during the day at weekends. Pharmacist presence on the ward at weekends was limited to new medical admissions to the ward.
- The medical day unit was open seven days a week.
- There was a 24-hour chemotherapy helpline. Patients were able to call the helpline and obtain advice and support from trained nurses and a medical registrar.
- There was an assisted discharge scheme for respiratory patients, which operated seven days a week.
- To meet national guidelines, the trust had commenced a seven-day working project to plan for developing services across the trust to meet this requirement.
- Weekend discharges were problematic. A review of weekend and the time of day of discharges showed that few patients were discharged at the weekends. Recommendations were made in the review that the seven-day-working project should include a focus on delivering discharges seven days a week.

Access to information

- Staff told us there was sufficient information in patients' care records to enable them to care for patients appropriately.
- Information was displayed on computerised screens by the nurses' station. Staff could access test results, care records and other relevant information about patients on the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act 2005. They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.
- We heard discussions about patients' capacity and how to support patients to make decisions about their care during our visit.
- We did not see any patients subject to Deprivation of Liberty Safeguards during our inspection.

Are medical care services caring?

Good

Patients were treated with compassion and respect. All patients told us they felt safe and were happy with the care provided by the staff. However, some patients told us they thought the nurses were very busy and at times they had to wait long periods for their call bells to be answered.

Staff explained treatment plans to patients and we witnessed positive interactions between staff and patients.

Most of the patients we spoke with told us they had enough information about their medical condition.

Compassionate care

- Patients were treated with compassion and respect.

Medical care (including older people's care)

- All the patients we spoke with were positive about the care they received at Gloucestershire Royal Hospital. One patient told us, "I feel very safe because of the quality of the nurses who know precisely what they are doing," and another patient told us "Staff are 100% good."
- Privacy and dignity was maintained on the wards. We observed curtains were closed around patients' beds if personal care was required. One patient told us "All the nurses make sure the curtains are drawn round and they very politely ask before doing anything."
- Staff on the medical day unit told us they did not have access to curtains; however, they had a small portable screen which could be placed around patients if required.
- The medical division used the Friends and Family Test to capture feedback about patients' experiences at Gloucestershire Royal Hospital. Between April 2013 and July 2014, the average trust-wide response rate was 18.8% compared with the England average of 30.1%. The response rate for Gloucestershire Royal Hospital was 18.2%. Between April and July 2014, monthly results of the Friends and Family Tests showed that over 70% of patients receiving medical care would be either likely or extremely likely to recommend the service.
- We audited whether patients were able to reach their call bells across a variety of medical wards. Out of 20 patients audited, 18 patients had their call bell within reach. This meant the majority of patients were able to alert staff using the call bell if they required assistance. We alerted staff to the two patients who were unable to reach their call bell.
- Patient-led Assessments of the Care Environment (PLACE) 2014 scored the trust as 88 for privacy, dignity and wellbeing compared with the England average of 87.

Understanding and involvement of patients and those close to them.

- During our inspection, we heard information being given to patients about their care. Information was provided sensitively and patients were given time to ask questions and contribute to future plans. We observed that information and explanation was given to a patient to explain why treatment had been delayed. The patient was supported by staff and given time to ask questions in order to resolve any concerns.
- There was evidence of when patients' families had been involved in their relative's care and discharge plans. For example, discussions with family members were documented in patients' notes within the stroke services. These discussions detailed information about the care and support patients would require when discharged from hospital.
- The Cancer Patient Experience Survey 2013/14 showed that the trust was in the middle 60% of trusts for 'patients definitely involved in decisions about care and treatment' and in the bottom 20% of trusts for 'patient's family definitely having an opportunity to talk to a doctor'. The trust was in the top 20% of trusts for 'hospital staff did everything to control pain all of the time'.

Emotional support

- The Cancer Patient Experience Survey 2013/14 showed that the trust was in the middle 60% of trusts for 'patient being able to discuss worries or fears with staff during their visit'.
- Patients had access to further support from clinical nurse specialists; for example, a liver nurse specialist was available to support patients with liver disease on the wards and when they visited the medical day unit.
- Respiratory nurse specialists provided telephone support to patients in the community. A nurse told us, "Sometimes patients get worried at home and they can call us for support if required."
- All the patients we spoke with told us they would feel comfortable approaching a member of ward staff for support if required.
- Patients had access to mental health professionals if required.

Medical care (including older people's care)

Are medical care services responsive?

Requires improvement

The trust regularly had a bed occupancy rate of above 91%. It has been identified that bed occupancy rates above 85% could start to affect the general running of Gloucestershire Royal Hospital and the quality of care given to patients. The average length of stay for elective (planned) admissions at Gloucestershire Royal Hospital was 8.1 bed days compared with the England average of 3.9. This meant some patients were staying in hospital for longer periods of time compared with other trusts. Staff told us this was because there was difficulty in accessing community placements.

The flexible capacity beds on Gallery Wards 1 and 2 were not always opened in a planned way. Staff were often moved from other wards to cover the gallery wing wards, and a high proportion of agency and bank staff were used. Ward staff voiced concerns that this impacted on the continuity of care for patients and at times left the other wards short-staffed.

Staff in Acute Care Unit A (ACUA) told us a significant number of patients were moved to the wards from their department at night, because of "lack of forward thinking" of senior staff. The staff felt this was inappropriate for some patients, and they had, at times, refused to discharge patients to the ward at night. This was because they felt there were not enough staff available at night to accept patients and to complete the admission processes.

In some wards across Gloucestershire Royal Hospital, a 'you said, we did' board was displayed. The aim of this board was to show the response of the ward to any complaints or concerns raised by patients and relatives who had visited the ward. We noted that the comments and complaints were the same for every board across the trust and did not reflect any particular information pertinent to individual wards.

The medical day unit enabled patients to receive regular intravenous medication without the requirement for a hospital admission. Patients told us they were able to arrange their appointments to fit in with their work schedules.

There was a dementia focus group on Ward 9b. This was a weekly activity group where patients were able to play bingo, watch films, take part in reminiscence, paint, sing and eat lunch together. Activities were tailored to individual preferences, and relatives were encouraged to be involved.

Service planning and delivery to meet the needs of local people

- The medical day unit was open seven days a week. Patients who required regular intravenous medication or diagnostic tests were able to attend the unit as day patients. Patients we spoke with told us they were able to choose the times of their appointments to fit in with their working lives. One patient told us, "I would have been admitted to hospital so many times if it wasn't for this unit."
- The respiratory service ran an assisted discharge scheme. Patients who were identified as suitable for care at home were supported in their home by a nurse and physiotherapist. The assisted discharge scheme enabled some respiratory patients' discharge to be facilitated sooner.
- We observed a trust bed management meeting. These were held on a twice-daily basis; however, during our inspection, extra meetings were held because of the limited availability of beds for patients. Immediate decisions were made to manage the bed situation across the trust. We saw a list of medical outliers, and discussions were held to ensure patients were in the optimal place for their care. The trust took part in a twice-daily teleconference between commissioners, the local authority and the trust. The aim was to discuss the availability of beds and the flow of patients and instigate any changes that might facilitate a more timely patient discharge.

Access and flow

- The trust regularly had a bed occupancy rate of above 91%. It has been identified that bed occupancy rates above 85% could start to affect the general running of Gloucestershire Royal Hospital and the quality of care given to patients.
- The trust operated a single-point-of access system, which meant all admissions to Gloucestershire Royal Hospital went through the emergency department. On the whole, most patients went from the emergency

department to Acute Care Unit A (ACUA), where they were assessed by medical staff. Some patients were cared for on the ACUA and then discharged home. Patients requiring specialist ward input were transferred to the appropriate ward if a bed was available. We saw that the average daily admission rate to ACUA between April and July 2014 was between 40 and 45 patients daily. Staff in ACUA told us they often had to keep patients longer than planned if no bed was available on the ward.

- Staff stated that patients could experience up to four bed moves during their stay in hospital. Patients typically attended the emergency department, were transferred to ACUA and then transferred to the ward. If patients were awaiting discharge, they could be transferred to a step-down ward whilst discharge arrangements were finalised.
- Senior staff in ACUA told us that decisions were often made too late in the day and there was a lack of forward thinking from senior staff. Patients were often moved late at night because discharge to wards had not been planned for earlier in the day. A medical review held in September 2014 showed that between May and August a significant number of patients had been moved between 10pm and 6am. For example, we saw in the review that over 60 patients were moved at 10pm and over 40 patients at 3am. Particularly for patients who had cognitive impairment and other patients who were acutely unwell, an out-of-hours bed move was not ideal. Senior staff in ACUA confirmed there was often tremendous pressure to move patients out of ACUA, and because of this they had ensured that senior nurses worked on every shift to facilitate discussions with bed managers and prevent inappropriate discharge of patients out of hours.
- Staff told us that the flexible capacity beds on Gallery Wing Wards 1 and 2 were not always opened in a planned way. Staff were often moved from other wards to cover the gallery wing wards, and a high proportion of agency and bank staff were used.
- Discharge planning was started on the day of admission. During our visits we saw that planned discharge days for each patient were displayed on the computerised board on each ward. We noted that some patients had not been discharged on the planned day. Staff told us there were often delays for more complex patients because of a lack of community placements and funding difficulties. We saw this had been documented in some of the patients' notes we reviewed.
- In March 2015, the trust had conducted a review into weekend and the time of day of discharges to improve the patient flow throughout the trust. The review concluded that obstacles to effective discharges were the lack of weekend discharges because of limited staff availability, a historic culture that discharges don't happen on a weekend, combined with difficulty in organising community placements or support for patients over a weekend. The report made recommendations, some of which were to improve the discharge of patients before 12 noon and the role of the ward coordinator to facilitate effective discharge.
- There was a discharge lounge furnished with chairs. No beds were available. Staff felt that for some patients a wait for up to four hours without a bed to rest in was unacceptable. The discharge lounge was open from 9am to 7pm. Waiting times for transport sometimes delayed a patient's discharge or resulted in patients being unable to go home. Staff told us that a one-man crew had arrived to transfer a patient who could not mobilise and required a stretcher. The patient had to be returned to the ward and wait until another ambulance was organised to enable them to be discharged home.
- There was an integrated discharge team within the trust to help facilitate patient discharges. The team consisted of nurses, physiotherapists, occupational therapists and social workers. Members of the team attended daily ward board rounds to ascertain which patients were ready for discharge. The team supported patients to ensure they were able to be discharged home in a timely manner. For example, if a patient required mobility assessments prior to discharge, a physiotherapist ensured they were completed.
- Ward and medical staff told us medical outliers (patients admitted to a ward that was different from their required specialty; for example, a patient with a respiratory illness admitted to a surgical ward) were identified electronically. A daily list was produced which all medical specialties had access to and which identified the medical outliers.

Medical care (including older people's care)

- Staff in the day surgery unit told us that medical patients had recently been admitted to the unit because of the shortage of beds across the trust. They told us it was often difficult to access a medical review of the patients. They had discussed their concerns with a medical consultant, who was investigating ways to improve medical support to the day surgery unit when they cared for medical inpatients.
- Senior cardiology staff told us they had concerns that access to invasive cardiology was limited. They told us that the equipment required to care for patients was located at Cheltenham General Hospital. If patients were admitted to Gloucestershire Royal Hospital and required further treatment, they were transferred by patient transport to Cheltenham. Senior staff told us this delayed patient care.
- Since February 2014, the referral-to treatment-time performance had fallen, but it had been better than the England average since August 2014.
- The average length of stay for non-elective admissions to Gloucestershire Royal Hospital was 6.3 bed days, which was a lower length of stay than the England average for non-elective admissions of 6.8.
- The average length of stay for elective admissions at Gloucestershire Royal Hospital was 8.1 bed days compared with the England average of 3.9. The trust was developing systems to ensure that patients were discharged in a timely manner from hospital, for example working with hospital staff and community care providers to facilitate discharges at weekends.
- The cancer waiting time target for people waiting less than 31 days from diagnosis to first definitive treatment for all cancers was 93%.The trust was consistently above this target each quarter between April 2013 and December 2014.
- The cancer waiting time target for people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was 85%. Between April 2013 and December 2014 the trust had met the target in two quarters (quarter 1 2014/15 and quarter 2 2014/15). Figures for the latest quarter (October 14 to December 14) showed that the trust did not meet the target (only 78.6% waited less than 62 days).

Meeting people's individual needs

- We saw communication books being used for patients on a variety of wards. The books were used for patients who struggled to communicate verbally. The books were also used for patients who did not speak English.
- Each ward had posters and leaflets displayed informing patients about a variety of medical conditions. All the information was in English. Staff told us they did not have access to written information in other languages.
- Most of the ward staff informed us that interpretation services were difficult to organise. Staff said they often used a website to translate simple words. Some staff told us they asked patients' relatives to translate when necessary. Staff were not consistently aware that this practice might breach patient confidentiality if the patient did not want relatives to know details of their medical condition.
- The trust used a purple butterfly to help identify patients with cognitive impairment. Purple butterflies were in place on the main ward computer board to alert staff that patients might require extra support with some areas of their care. Most patients also had purple butterflies behind their beds to act as a reminder for staff. However, patients did not always have further documentation to support their care. For example 'this is me' documentation was not always completed in a timely manner. (The 'this is me' document details information about each patient's likes and dislikes, previous life history, hobbies and so on. The document is used to enable staff to care for people who might have communication difficulties.)
- All wards had dementia champions, who attended further training to enable them to support patients more effectively and cascade information when required.
- Staff told us about the dementia focus group on Ward 9b. This was a weekly activity group where patients were able to play bingo, watch films, take part in reminiscence, paint, sing and eat lunch together. Activities were tailored to individual preferences and relatives were encouraged to be involved.

Learning from complaints and concerns

- None of the patients we spoke with had any complaints about the care and support they received.
- Staff told us they tried to resolve any complaints and concerns as they arose.

Medical care (including older people's care)

- In some wards across Gloucestershire Royal Hospital, a 'you said, we did' board was displayed. The aim of this board was to show the response of the ward to any complaints or concerns raised by patients and relatives who had visited the ward. We noted that the comments and complaints were the same on every board across the trust and did not reflect any particular information pertinent to individual wards.
- We read in minutes from the divisional quality board that complaints were discussed at a divisional level.

Are medical care services well-led?

Requires improvement

There was poor monitoring of the mortality and morbidity meetings. Specialties were required to notify senior management that the meetings had taken place; however, we were not able to view any minutes of these meetings for the medical division. Therefore we could not be assured that meetings had taken place to enable any trends to be identified or learning to take place.

The directors of the medical division were passionate about providing a high quality service. The service was clinically led; however, they felt they lacked sufficient autonomy to enable them to drive improvements and instigate change. Issues identified were not yet being managed effectively.

Nursing staff felt there was an open culture and felt they were listened to by their managers; however, junior doctors consistently told us they were not listened to when they raised any concerns.

Vision and strategy for this service

- The trust had a clear five-year strategic plan for development of the service. For example, options were being discussed to provide cardiology services on one site and develop a seven-day service for all medical specialties. The seven-day service was currently being piloted on the respiratory ward.
- The directors of the medical division were clearly passionate about delivering a high quality and safe service to patients.
- Senior ward staff were able to tell us about the trust's values, which were listening, helping, excelling, improving and uniting. However, ward staff were not consistently clear about the values and what they meant in their day-to-day work.

Governance, risk management and quality measurement

- Monthly quality board meetings were held. We saw from the minutes there were discussions and actions planned around incidents, patient complaints, risks to patient safety and health and safety concerns.
- There was no robust process for monitoring the occurrence of mortality and morbidity meetings. The director of safety told us regular morbidity and mortality meetings were organised at specialty level and the meetings were monitored as part of the quality framework. Each division had to confirm in its divisional quality report that meetings had taken place. We saw in the quality board minutes that the medical specialties had notified the quality board that a meeting had taken place. We were unable to view the minutes of the mortality and morbidity meetings and were told, "In general the note keeping in some of the divisions is not ideal," by the director of safety at the trust. We could not be assured that meetings had taken place to enable any trends to be identified or learning to take place.
- Adherence to infection control procedures was variable throughout the medical division. This put patients at risk of a hospital-acquired infection, because trust policies and procedures were not uniformly followed.
- The medical division had its own risk register which detailed appropriate risks recognised across the division. Senior staff were aware of the risk register and how to raise a risk to be included on the register.
- Each specialty had a risk register that documented risks in its areas. For example, the stroke division had highlighted risks related to the lack of occupational therapists and the impact of this on the care delivered to patients

Leadership of service

- Senior staff told us the division was clinically led, which meant the needs of patients were paramount in their day-to-day work and in the service's plans for the future. However, we were told that senior teams would like

more autonomy in their decision-making processes and did not have the freedom to make decisions on a day-to-day basis. For example, we were told senior management were not able to arrange locum doctors if medical cover was required. We were told they had "the responsibility but not the power". Issues identified were not yet being managed effectively.

- All the managers we spoke with told us that their teams worked hard within a busy environment.
- All staff were aware of their immediate managers and felt supported by them.
- We were told matrons were visible and easy to approach.

Culture within the service

- Staff were positive about working for the trust, although at times they told us they felt under extreme pressure because of the volume of patients in Gloucestershire Royal Hospital.
- Nursing staff told us there was an open culture and they felt confident about raising concerns.
- Junior doctors consistently told us they often did not feel listened to when they raised concerns.

Public and staff engagement

- Most staff felt informed about and involved with the day-to-day running of the service.
- Patients and visitors were asked to feed back their experiences of care. We saw 'you said, we did' information displayed in wards; however, the comments were the same on every board we saw. These were, "I could not find anyone to talk about my worries and fears," and "I missed my meal because I was asleep." The trust had investigated these two complaints and responses were displayed next to the concerns. We could not see information pertinent to feedback from patients and relatives on individual wards.

Innovation, improvement and sustainability

- A mobile chemotherapy unit provided care closer to people's homes to prevent frequent travel to the hospital.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Good

Information about the service

Surgical services provided at Gloucestershire Royal Hospital are for both elective and emergency surgery. The surgical specialties include general surgery, trauma and orthopaedics, breast, ear, nose and throat (ENT), and oral and maxillofacial surgery.

The operating department at Gloucestershire Royal Hospital has 14 theatres. A 19-bed recovery room is located in the main theatres. There are separate facilities for children and a three-bed recovery room located in the Orchard day surgery unit. Gloucestershire Royal Hospital has five surgical wards, two day surgery units and a surgical admissions unit.

We visited wards 2b, 3b, 5a and 5b, the surgical admissions unit, the preadmission clinic, the day surgery unit, the Orchard day surgery unit and the central sterile stores department (CSSD). We spoke with 25 staff, including theatre managers, the head of nursing, matrons, ward sisters, consultants, doctors, junior doctors and nurses. We also talked with housekeepers, healthcare assistants, pharmacy staff and physiotherapists. We spoke with 12 patients. We observed care and looked at 10 sets of patients' records. We reviewed data provided in advance of the inspection.

The trust had 49,560 admissions in 2013/14; of these, 49.6% were surgical. Of surgical admissions, 58% were day cases, 21% were elective surgery and 21% were emergency surgery.

Surgical services provided by Gloucestershire Hospitals NHS Foundation Trust are located on two hospital sites, the other being Cheltenham General Hospital. Services at Cheltenham General Hospital are reported on in a separate report. However, services on both hospital sites are run by one management team (the surgery division) and, as such, are largely regarded within the trust as one service. For this reason it is inevitable that there is some duplication in the two reports.

Surgery

Summary of findings

We have judged surgery services in Gloucester Royal Hospital as good in relation to safety, effectiveness, caring and leadership. Improvements are required to make surgery services responsive to patient needs.

Staff were encouraged to report any incidents on the trust's computer system. Learning from incidents that had been investigated at ward level was shared at meetings and included in the minutes so staff could refer to it at a later date.

The trust was working on its compliance with the World Health Organization (WHO) surgical safety checklist following the results of its audits. Use of the checklist was also being monitored for compliance to improve patient safety. A safety briefing and recording document had been introduced in theatres.

Due to the increased demands on its services and beds, the day surgery unit was open out of hours and at weekends. The unit was staffed by bank and agency staff at these times, which meant continuity of care might have been affected and patients' needs might not always have been met. Patients from other specialties were placed on this unit, and staff felt they didn't always have the skills and knowledge to meet the unit's needs.

Storage on some wards and units for patients' notes was not secure, which meant visitors to the hospital could have had access to these confidential records.

The trust participated in national and local audits. These included the national bowel cancer audit, in which the trust was above, better than, the England average.

There was good multidisciplinary working within the units and wards to make sure there was coordination of patient care. Patients we spoke with felt the care they received was very good and that staff respected their privacy and dignity. Information was provided for patients about their operations, and patients were able to ask questions and were kept up to date on their progress. Relatives were able to be part of this process with the consent of the patient, and other arrangements were in place for patients who were not able to consent although documentary evidence to support this was not consistent.

The trust had not met it target for the year for the number of patients cancelled on the day of their operation for non-medical reasons and had only met the national targets for rebooking patients within the 28-day timescale in one month.

The 18-week referral to treatment targets were being met in almost all surgical specialities. Urology and ophthalmology were just behind the 90% target at 85% and 87% respectively. The trust was below (that is worse than) the NHS England average 62-day cancer waiting time target. The trust was treating 74.7% of cancer patients within the 62-day target against the NHS England average of 81.2%.

Staff told us they were aware of the trust's visions and values. Staff on the wards and units told us they felt supported and listened to by their management team, divisional management and executive board.

Surgery

Are surgery services safe?

Good

Staff were encouraged to report any incidents on the trust's computer system. Learning from incidents that had been investigated at ward level was shared at ward meetings and included in the minutes so staff could refer to it at a later date. Learning following Never Events was seen with the introduction of the surgical safety checklist for interventional radiology.

The trust was working on its compliance with the World Health Organization (WHO) surgical safety checklist following the results of its audits. Use of the checklist was also being monitored for compliance to improve patient safety. A safety briefing and recording document had been introduced in theatres.

Due to the increased demands on their services and beds, the day surgery unit was at times open out of hours and at weekends. This was staffed by bank and agency at these times, which meant continuity of care might have been affected and patients' needs might not always have been met. Patients from other specialties were placed on the day surgery unit, and staff felt they didn't always have the skills and knowledge to meet their needs.

The trust had devised its own method of recording patients' controlled medication. Not all packs of medicines for patients to take home complied with the labelling requirements for a medicine supplied against a prescription, or the trust's own documentation.

Storage of patients' notes was not consistently secure and meant visitors to the hospital could have had access to these confidential records.

Incidents

- Staff told us they were encouraged to report incidents on the computer system. However, not all staff said they received feedback after reporting any incidents. The divisional surgical management team told us it was working on how to improve the feedback to staff following any incident reporting, as the system had no automatic feedback to the member of staff reporting the incident. All staff who worked for the trust had access to the reporting of incidents on their computer system. To assist staff, a helpline was also in place. The divisional surgical management team felt that not all incidents were reported, because of the changeover from paper reporting to the computer system and the disengagement of staff because of concerns with feedback. The divisional surgical management team had identified an area where reporting of incidents had reduced. The team told us the management for this area was working with staff to improve this.
- All ward or unit managers, lead nurses and the director of nursing for the surgical division reviewed all reported incidents. Ward managers told us they investigated some of the incidents, for example falls with harm to patients. They then fed back any learning to the ward or unit staff at their meetings. Incidents were also discussed at the monthly clinical governance meetings for each division. Any incident that was rated as 'orange' was also examined by the risk manager for the trust.
- The divisional surgical management team told us about the learning that had been shared with all staff at both locations following a serious incident. The incident had highlighted some areas of concern, which were shared with both hospitals. One of these was about nurses not feeling able to contact consultants if they were concerned about a patient. This had been discussed with consultants at a recent meeting and with student nurses on induction. We spoke to ward sisters and staff nurses, who all told us they would contact a consultant directly if they were concerned about the condition of a patient.
- The manager for the Central Sterile Services Division (CSSD) told us if there was an incident with equipment they provided to theatres, it would be documented on the computer incident recording system and they would be notified of it.
- On one ward, safety notices were displayed for all staff to see; for example, there was a safety bulletin about the use of methotrexate.
- Staff were able to tell us about the principles of the Duty of Candour regulations. They told us the regulations were about being open and transparent with patients following incidents and apologising to them.
- Within the surgical division, 13 incidents were reported to the Strategic Executive Information System (STEIS) for the year from January 2014 to December 2014. These

incidents included pressure ulcers, slips, trips, falls and delayed diagnoses. These were discussed in the division's governance meetings, and learning was shared with staff in ward or unit meetings.

- We saw records of the morbidity and mortality meetings. These were held for each of the surgical specialties, for example upper gastrointestinal surgery, general surgery and breast surgery. We saw presentations where each specialty discussed individual cases and the learning required.

Safety thermometer

- NHS Safety Thermometer information was routinely displayed in the ward areas. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. This tool enabled wards and units to measure harm and the proportion of patients that were harm-free from pressure ulcers, falls with harm, urinary tract infection with catheters, and venous thromboembolism (VTE, or blood clots) during their working shifts.
- On the wards we visited we saw their nursing metrics were displayed. This included early warning scores and the actions taken by staff, number of falls, and staffing levels, including the number of trained and untrained staff. Some of the information was inconsistent. For example, the safety thermometer showed no falls, but the nursing metrics stated there had been falls. It was difficult to see the explanation for this, as the font was very small, but the safety thermometer was taken on one day each month whereas the nursing metrics covered the whole month.

Cleanliness, infection control and hygiene

- Cleanliness and control of infection were managed effectively.
- Each ward had a hand hygiene and cleanliness score on display. For example, on Ward 3b for January 2015 hand hygiene was rated as 100%, and the cleanliness score for the ward was 95%.
- Hand hygiene scores for the surgical division had an average of 100%, with the trust average being 97%.
- Ward 5b had a cleaning score of 93% for January 2015. Staff told us there had been some changes to the way domestic staff were organised. They said domestic staff were no longer dedicated to the same ward, which ward staff felt made it harder to manage the cleaning on their ward.
- Staff in theatres told us they had night domestics and felt the standard of cleanliness was good. A total disinfection/deep cleaning treatment for each theatre was carried out routinely. The domestic supervisors monitored the standards of cleanliness.
- The surgical division dashboard for November 2014 said there was 10 cases of Clostridium difficile between December 2013 and November 2014. The overall trust's target maximum for the year was 55 cases.
- Although the trust did not have a trust-wide audit for MRSA screening to make sure patients were being screened prior to elective and emergency surgery, it did have systems in place to monitor this. For example, at patients' first outpatient appointments, where they were reviewed by a consultant or registrar and the decision made to have surgery, an MRSA screening was taken. This was followed up at either the preadmission assessment or on admission. The admission records for patients asked for details about the MRSA screening process. The trust's audit plan from April 2015 will include an MRSA audit to assess compliance with policy, as its policy was updated in 2014.
- The surgical division infection control report for January 2015 (which had data from November 2014) said the division had had three patients identified post 48 hours with MRSA.
- All staff were 'bare below the elbows' in wards and theatre areas, in line with hygiene recommendations.
- The surgical site infection rate for Gloucestershire Royal Hospital from October 2014 to December 2014 for total knee replacement surgery was 0.1% lower than the five year England national average of 2.2%. The rate for hip replacements was 0.9% higher than the five year England national average of 1.3%. For the trust overall for total knee replacements was lower at 0.7% and for hip replacements they were lower at 0.2%.

Environment and equipment

- Resuscitation equipment on each ward and in theatres was checked daily, with records in place showing completion. However, we found some gaps in the recording of this on Ward 3b.
- Medication within the resuscitation trolleys was stored in tamper-evident containers. However, none of the drawers within the trolleys were themselves tamper-evident so medicines could be removed between checks without this being apparent.
- Staff told us surgical equipment was tracked and traced, and we saw records of this in patients' notes. This was important in case any issues with patients or the equipment after surgery were identified and needed to be followed up.
- Equipment provided by CSSD was also traceable. We saw the tracking stickers from this equipment in patients' notes.
- Representatives from the CSSD met with theatre staff each day during the week to discuss equipment requirements and any issues with this.
- The manager for CSSD told us the majority of endoscopes used in Gloucestershire Royal Hospital were cleaned in the endoscopy department because it had all the specialist cleaning equipment to undertake this task.
- The theatre manager told us the theatre had issues with operations being cancelled because of a lack of equipment/prostheses, and at times had used loan equipment. The department now had a sole provider of all hip and knee prostheses to reduce the complexity of ordering and tracking this equipment.
- In theatre, a stock control manager arranged orders, loan kits, trays and specialist orders. The theatre manager told us this was an invaluable appointment as the stock control manager made sure all the equipment required for operations was available to prevent operations being cancelled.
- Specialist equipment, including specialist anaesthetic equipment, was available to support bariatric patients.
- The equipment maintenance policy was under review at the time of our inspection.

Medicines

- We were shown the pathway the trust had in place for patients who were taking Warfarin in the pre assessment clinic. This contained four protocols for staff to follow depending on the patient's condition and international normalised ratio results. The staff told us the anaesthetist decided which protocol to follow for the patient.
- We spoke with a pharmacist who covered Ward 3b. They told us their role was to review all medicine charts and provide advice and support to medical staff, nursing staff and patients. They visited the wards from Monday to Friday. There was a limited service at weekends. One of the roles of the pharmacy department was to maintain stocks of medication the wards.
- The antibiotic compliance audit showed that all surgical wards were above the 95% target which was outstanding practice.

Records

- Nursing records were held at the end of patients' beds and at the nursing station. Medical records accompanied patients to and from theatre.
- Records were comprehensive and included details of the patient's admission, risk assessments and treatment plans, and records of therapies provided. We saw preoperative records, including completed preoperative assessment forms.
- On Ward 2b we found that patients' notes were not stored in a secure trolley and were positioned in the main corridor area, where they were easily accessible to visitors. We also found on the surgical day unit that patients' notes were out on top of a trolley in the reception area. On Ward 3b, patients' notes were stored insecurely by the nursing station.

Surgical safety

- We observed the use of the World Health Organization (WHO) surgical safety checklist in all theatres. The National Patient Safety Agency recommended that this process be used for every patient undergoing any surgical procedure. It involved a number of safety checks designed to ensure that staff avoided errors.

- The divisional management team told us it was revisiting the use of the WHO checklist. It was re-engaging staff in its use to make sure the checklist was not being used as a tick-box exercise.
- We saw the results of the WHO audit undertaken by the Matron for the theatres in December 2014. This had some areas rated as green and met the target; some areas were rated as amber or red. For example, clear announcement of safety checks was rated as amber. This related to silence during the checks. This meant not all staff were following the safety procedures correctly. The trust told us this audit covered both the completion of the form and the clinicians input which was good practice.
- Staff in theatres told us that each morning they had a surgical safety operating list briefing. A form was completed that included, for example, the order of the list, and whether all staff were aware of the planned surgery for all patients on this list. The forms were audited for compliance with this process. The manager told us they followed up on any non-compliance.
- Following a Never Event in gynaecology, changes had been made in theatre to the swab boards (this was where details about swabs used in each operation were recorded). Each theatre had the same board to make sure there was consistent practice across the trust.

Safeguarding

- Staff told us they knew how to make a safeguarding referral and were aware of who were the safeguarding leads for the trust for adults and children.
- Information about safeguarding was displayed on a noticeboard on Ward 3b.
- Figures up to 31 January 2015 stated that in the surgical division, 95% of staff had completed training in safeguarding adults' awareness. Ninety per cent had completed training in safeguarding adults' level 2.
- Ninety-five per cent of staff in the surgical division had completed child awareness training, and 93% had completed safeguarding children level 2.
- Seven staff from the surgical division had completed safeguarding training for adults at level 3.

Mandatory training

- Staff on the surgical admissions unit told us they were up to date with their mandatory training, and the unit's sister said it was their role to monitor this.
- Staff in theatres and on the wards told us they were mostly up to date with their mandatory training.
- We saw the training figures for nursing staff for mandatory and statutory training for the surgical division. This included fire, infection control, moving and handling, and the code of confidentiality. All these were over the trust's 90% target. Basic adult resuscitation training was just under the 90% target, at 89%.

Assessing and responding to patient risk

- Some patients for elective surgery attended a preoperative assessment clinic where all the required tests were undertaken, for example blood tests and an electrocardiogram (ECG). MRSA screening was undertaken in the outpatient clinic prior to the patient's pre-assessment visit. A consultant anaesthetist was present to review patients the nursing staff had assessed as requiring further input because of their medical condition. The nursing staff checked on any test results, including MRSA. They also started the care pathway for the type of surgery the patient was receiving. Some patients who were assessed as being fit and well were contacted by telephone for their preoperative assessment.
- On admission, patients had an assessment for the risk of venous thromboembolism (VTE). Evidence of the actions taken where risks were identified was recorded. For example, we saw that patients had been prescribed anticoagulants or were wearing anti-embolism stockings. On checking this information in several patients' notes we found it had been completed on admission but not reviewed within the timescale as directed on their form. The divisional management team told us it had identified issues with VTE, as this trust used to be rated as one of the top trusts but was now in the bottom 20%.
- We saw audit results for the surgical division for VTE assessments. These were done weekly and included day cases and inpatients. We saw for some weeks all wards and units had nearly met the 100% target, where on other weeks the scores varied.

Surgery

- We observed patients being seen by the anaesthetist and surgeon/registrar before their surgery to assess their risk score for anaesthesia and to confirm the planned surgery.
- The trust used the National Early Warning Score (NEWS). This tool is used to aid recognition of deteriorating patients, based on scored observations including temperature, pulse, blood pressure and respiratory rate. A high total score activated an escalation pathway outlining actions required for timely review, to ensure appropriate interventions for patients; these were clearly documented on the form. Staff explained how they used this tool and when they would contact doctors for additional support.
- Staff on the surgical day unit told us they had problems with doctors attending to see and review their patients, especially medical patients. Staff told us that, in the last three months, three patients had been transferred to the surgical day unit on a detox programme, and they felt they did not have the skills or knowledge to care for these patients.

Nursing staffing

- On the day of our inspection, Ward 3b was running under its allocated number of staff. The ward was one trained nurse and two healthcare assistants short. The ward manager, who was supervisory, was helping out on the ward. The ward was also waiting for agency staff to cover a vacancy on one of its other shifts. One patient had a one-to-one member of staff because of their medical condition. Six members of staff had recently left this ward.
- The surgical admissions unit had a handover each morning to discuss the day ahead and the planned admissions. It had the required staffing levels in place.
- The day unit staff told us the day unit had the correct number of staff as per its allocation. Bank and agency staff were being used to cover the unit at night and weekends, as it was open because of pressure on beds. This meant that patients might not have had continuity of care and their needs might not have been met.
- The Orchard day surgery unit had two qualified nurses on duty and one healthcare assistant. These were their allocated numbers. It used regular bank staff and its own staff to cover any vacancies.
- The nursing staff on Ward 5b were working at their allocated numbers. They said they would soon have their full complement of staff once some had returned from maternity leave.
- The staffing levels for theatres, to include anaesthetics and recovery, were meeting the Association of Perioperative Practice (AFPP) guidelines. Staff had been recruited from overseas to fill vacancies.
- The surgical division had a 4% nursing vacancy rate.

Surgical staffing

- This trust had slightly more consultants, at 42%, compared with the England average of 40%. It had 15% middle grade doctors compared with the England average of 11%. For the registrar group, it was slightly lower, at 33% compared with the England average of 37%, and the same for junior doctors at 9% compared with the England average of 13%.
- Staff on the day surgical unit told us they did not routinely see surgical doctors at the weekend and they had to contact them if they required medical support. They felt this delayed discharges.
- The on-call anaesthetist provided cover for the acute pain team at weekends and out of hours. They received a handover prior to the weekend so they were aware of patients who might require their support.
- There was a daily safety and staffing briefing in theatres.
- The divisional management team told us they used locums to cover any vacancies for consultants and middle grade doctors.
- We were sent copies of the duty rotas for out-of-hours cover. This showed that junior doctors, middle grade doctors and consultants were on call to review and assess any patients admitted out of hours to their specialty.
- The staff on Ward 2b told us there was an ear, nose and throat (ENT) consultant and registrar on call out of hours and at weekends. For maxillofacial surgery, there was also a consultant, registrar and junior doctor on call out of hours and at weekends. ENT and orthopaedics shared junior doctor cover out of hours and at weekends.

Surgery

- The National 2014 General Medical Council (GMC) training survey highlighted four patient safety concerns over the medical staffing levels during the surgical 'take' (times when the team accepted patients as surgical emergencies) , especially out of hours. The trust told us it was redesigning the on-call rota and was bidding for advanced nurse practitioners to support trainees.

Major incident awareness and training

- Action cards that described the roles of each member of staff were in place for major incidents. We saw these were displayed in theatres. Staff told us which areas were used for triage of patients. An outside company visited the trust regularly for training exercises.
- The trust had declared a major incident in January 2015 because of extreme demands on its services, and this had resulted in elective operations and some trauma operations being cancelled.

Are surgery services effective?

Good

Staff had access to policies and procedures that were based on national recognised guidance, for example National Institute for Health and Care Excellence (NICE) guidance. The trust had identified where it was not meeting NICE guidance.

The trust participated in national and local audits, for example the national bowel cancer audit, and it was above the England average for a number of the national audits. This meant patients had good outcomes. The average length of stay for elective surgery in some specialties was lower that the England average.

There was good multidisciplinary working within the units and wards to make sure patient care was coordinated and the staff in charge of patients' care were aware of their progress. We saw physiotherapists and occupational therapists assessing and working with patients on the wards then liaising with and updating the nursing and medical staff.

There was inconsistent documentation of patient's mental capacity to consent to care or treatment.

Evidence-based care and treatment

- Medical and nursing staff had access to policies and procedures based on National Institute for Health and Care Excellence (NICE) guidelines.
- The trust had documented on its risk register where it was failing to meet service-specific NICE guidance, for example in intestinal failure in adults and clinical guidance for lower limb peripheral arterial disease.
- The surgical division took part in local audits, for example surgical site infection rates and venous thromboembolism (VTE).

Pain relief

- A dedicated pain team consisted of a consultant lead and three senior nurses.
- The pain team told us it was aware of patients who would require epidurals and patient-controlled analgesia prior to their surgery, as this was identified on the theatre lists.
- The team provided support and advice to ward staff and patients regarding pain control and for patients with epidurals and patient-controlled analgesia.
- A pain assessment tool was used, and we saw that ongoing pain management to assess whether the level of pain relief was appropriate in meeting each patient's pain.
- The vast majority of patients we spoke with about their pain told us it was well controlled and they would ask the nurses if they needed more pain relief. One patient did say they were concerned about their pain control as they had had a drain fitted during surgery which they were not expecting.

Nutrition and hydration

- Patients were assessed on admission using the Malnutrition Universal Scoring Tool (MUST) Patients who were for day surgery were not assessed, as they were felt not to be at risk. The patients' records we reviewed showed that none of the patients were at risk of malnutrition. Staff told us that if they had any concerns about nutrition for patients, they could make a referral to a dietician.

- Fluid charts were used to record input and output, and the amounts were added up at the end of the shift. This was so staff could assess the balance of fluid going into and out of the patient. None of the patients we saw were on food charts.
- Staff at the preadmission clinic told us there was guidance for patients about when they should be 'nil by mouth' from, depending on their operation time. It also mentioned patients should not have sweets or chewing gum. Patients were able to have water up to two hours prior to surgery. Information about fasting was also included on the trust's website.
- Some patients told us the food was good, whereas others felt it was not. All said they had a choice for their meals. They told us they chose their meals the day before, from a menu.
- Patients told us they had access to water, and hot drinks were brought round at frequent intervals throughout the day. We observed on one ward where a member of staff had left the patient's bedside trolley out of the patient's reach after attending to them. This patient was not able to reach their drink. This was reported to the staff and addressed.
- The staff on the day unit said they were concerned about there not being a process in place for patients to receive regular hydration through drinks rounds, as on the wards as they didn't have a dedicated domestic to help give drinks out.
- We spoke with a dietician, who told us they saw patients who were referred to them for review of their dietary needs. They were able to prescribe supplements for patients as required. They also reviewed the care of patients undergoing **total parenteral nutrition feeding.**
- **A new nutrition team had started in the week of our inspection, and this included dieticians, pharmacy input and a senior nurse.**

Patient outcomes

- The trust performed above the England average in most of the national audits in which it took part.
- The trust's performance in the national bowel cancer audit was above the England average for all areas except one. The number of cases discussed at multidisciplinary team meetings was 98.4%, compared with the England average of 99.1%.
- In the lung cancer audit, the trust performed worse than the England average for cases discussed at multidisciplinary team meetings, at 93.6% compared with the England average of 95.6% The number of patients receiving a computerised tomography (CT) scan before bronchoscopy was 82.2% compared with the England average of 91.2%.
- The trust had been identified as having a mortality outlier in relation to head of femur replacement. The trust had reviewed all deaths between July 2014 and October 2014 to find out why there was an increase in mortality between these dates and to indicate which hospital patients were admitted to. The divisional management team told us it had commissioned an independent review by the Royal College of Surgeons as their own investigations had not been able to identify the increase. This review was due to take place in April 2015.
- The trust performed better than England average for varicose vein patient-recorded outcomes.
- The length of stay at trust level for elective surgery was 3.2 days compared with the England average of 3.3 days; for non-elective surgery it was 5.3 days compared with the England average of 5.2 days. This was for trauma and orthopaedic surgery, colorectal surgery and urology.
- At Gloucestershire Royal Hospital, the average length of stay for elective surgery was 2.9 days compared with the England average of 3.3 days. This was for trauma and orthopaedics, colorectal surgery and upper gastrointestinal surgery.
- For non-elective surgery for trauma and orthopaedics, general surgery and ear, nose and throat (ENT) surgery, the average length of stay was 5.1 days compared with the England average of 5.2 days.
- The standardised relative risk of readmission for the trust for elective surgery in trauma and orthopaedics, urology and upper gastrointestinal surgery was lower than England average at 86 compared with the England

average of 100. (A value below 100 means fewer observed readmissions than expected.) For non-elective surgery, the trust was lower in general surgery, urology and trauma and orthopaedics, at 93 compared with the England average of 100.

- At Gloucestershire Royal Hospital, the standardised relative risk of readmission for elective trauma and orthopaedics, ENT and upper gastrointestinal surgery was 91, lower than England average at 100. The non-elective standardised relative risk of readmission was 98, lower than England average at 100 for the same specialties. However, ENT was above the standardised relative risk of readmission compared with the England average.
- We received some feedback prior to the inspection from a patient who told us they had received foot surgery and said everything was "excellent".

Competent staff

- Staff working in CSSD had a local induction tailored to the department and a trust induction programme. Staff also had a number of competencies that had to be completed for each area within the CSSD. We were shown records of these. There was also online NHS e-learning in relation to decontamination that all staff needed to complete. The manager told us that all new staff had mentors to guide and support them.
- Staff on the surgical admissions unit told us they all had to complete a skills and knowledge framework. We were shown several of these. Healthcare assistants undertook competency training which needed to be completed within three months of starting on the unit. They were also trained to take on extra roles, for example venepuncture and electrocardiogram ECG monitoring. The unit sister told us they completed all the appraisals on staff and were up to date on these.
- The ward and unit staff told us they had link nurses for specific areas, for example pressure ulcers.
- A member of staff told us about the apprentice course they were on. They had a competencies book to complete and felt well supported by the other staff.
- For the surgical division between January 2012 and December 2014, 1,336 staff had completed training in dementia awareness level 1 out of 4,517 staff trust wide; 635 staff had completed training in dementia awareness level 2 out of 1,848 trust-wide staff.
- Of staff in the surgical division, 412 had also completed the e-learning training for patients with a learning disability, out of 1,630 trust-wide staff, between January 2012 and December 2014.
- The surgical division was not meeting the trust's target of 90% for appraisals, with nursing appraisals at 87% and medical/dental at 79%.

Multidisciplinary working

- We spoke with physiotherapy staff, who told us they liaised with nursing staff and doctors about the patients who were referred to them to make sure patients' care was coordinated and meeting their needs.
- Some wards had a multidisciplinary meeting several times a week to update all professionals involved in the care of patients. This included representatives from the nursing staff, occupational therapists, social workers and physiotherapists.
- For patients who had complex needs and required detailed planning prior to their discharge, a discharge liaison team was available to provide assistance for the ward staff. For example, they would liaise with external professionals, including care homes. The staff on Ward 2b told us they visited their ward each morning and they were assisting with a complex discharge at the time of our inspection.
- Staff from the dedicated pain team told us they liaised with staff from the wards, including nurses and doctors, on the advice and recommendations they had made in relation to a patient's pain relief.
- A dietician told us they attended some of the consultant-led surgical wards rounds, especially the colorectal rounds as they often required more input from them. They said their role was to provide advice and support regarding nutrition.

Seven-day services

- Not all services provided by Gloucestershire Royal Hospital were available seven days per week.

- Some surgical patients were reviewed daily by a consultant and at weekends. The CSSD provided seven-day-a-week cover. There was also an out-of-hours on-call system that covered both hospital locations. At Gloucestershire Royal Hospital, it had staff who worked night shifts.
- There was no out-of-hours cover for occupational therapy.
- For physiotherapists, criteria were in place for weekend visits. This included for elective orthopaedic ward patients, new patients and patients needing to be discharged. A physiotherapist was also on call at nights.
- The dedicated pain team did not work weekends. Any support required was provided by the on-call anaesthetist.
- The dieticians told us they did not provide an out-of-hours, on-call or weekend service.
- Theatres, including anaesthetics and recovery, had staff on duty out of hours and at weekends to cover any emergencies. They also had staff on call to cover a second theatre if required.
- Staff told us they had access to an out-of-hours pharmacy and imaging. The pharmacy was open at weekends.
- We saw the out-of-hours rota for surgery for each specialty. It included junior doctors, registrars and consultants. A consultant was on call at all times for each of the specialties, alongside a registrar and junior doctor.

Access to information

- When patients were transferred between wards, all their nursing and medical records were transferred with them. Staff told us they always provided a verbal handover as well as the written records.
- We observed a handover between theatres and the ward staff. Staff in theatres told us they needed to make sure they handed over all relevant information, for example details of the last time the patient had pain relief, how the operation had gone and whether the recovery time had been satisfactory.
- We saw that one patient who had been transferred from the critical care unit (CCU) had comprehensive notes which detailed all the interventions they had received during their time there. Staff told us they also had a verbal handover of the patient's needs from the staff on the CCU.
- Staff told us that when a patient was discharged to other services, they completed a letter that included details of the patient's needs and what support and treatment was needed from the new service. We saw one letter to a practice nurse asking them to remove sutures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital used four different types of consent form, including one for children and one for patients who lacked capacity to consent to their procedure/ operation. The consent forms we saw that were completed in full and had been signed by the doctor and patient were for patients who were able to consent. These included details about the procedure/operation and any possible risks or side effects.
- We saw in one patient's notes that their family had requested to speak with the doctor without the patient present. The patient had capacity, and we saw that doctors had informed the patient of this request and documented that the patient had stated they would feed back to their family.
- On the Orchard day unit, two patients were being admitted for day surgery who had been assessed prior to this admission as not having capacity to consent to surgery. We saw in both records that best interest decisions had been undertaken. Relatives had been involved in the decisions, and one record had been signed by a doctor from outside the trust who was involved in the care of this patient. Consent form number 4 (for patients who are not able to consent) was in place, and staff told us this would be completed by the surgeon prior to surgery.
- On Ward 3b, staff were able to describe the processes they would follow if a patient lacked capacity. We examined the records of one patient who had been in hospital since December 2014. It was documented in the patient's notes they had early signs of dementia and confusion. It was also mentioned that they had tried to leave the hospital, and the ward had increased staffing levels because of this. We were not able to find an

assessment recorded of the patient's capacity to make certain decisions in their notes. The ward sister told us this would have been completed. We asked whether an application had been made to deprive the person of their liberty (Deprivation of Liberty Safeguards) and were told it had not. A confusion proforma had been completed on 20 December 2014, and the score was 6, which meant no further assessment was required. There was no documentation to confirm if this had been reviewed since, despite a change in the patient's condition. A care plan for wandering and confusion was in place with ongoing evaluations. Consent form number 4 had been used for their operations; this was used for patients who were not able to consent to procedures/operations. The staff on the ward said they were trying to act in the patient's best interests; however, there were no records in place to support this. We asked the ward sister to review this patient and obtain advice if they were unsure.

- Training figures up to 31 January 2015 for the surgical division showed that 93% of staff had completed Mental Capacity Act awareness training and 94% had completed Deprivation of Liberty Safeguards awareness training. The trust's target for these was 90%.

Are surgery services caring?

Good

Patients and their relatives told us they received a good standard of care and they felt well looked after by nursing, medical and allied professional staff. Privacy and dignity were respected by the staff and maintained by the use of curtains or by closing the door in side rooms or bathrooms.

Medical and nursing staff kept patients up to date with their condition and how they were progressing. Information about their surgery was shared with patients, and patients were able to ask questions. Relatives were able to be involved in these discussions.

Access to support from specialist nurses and teams, for example stoma nurses and a pain team, was available.

Compassionate care

- Each ward had details about its Friends and Family Test results. For example, Ward 3b for January 2015 had a response rate of 23%, and from these responses the ward had a positive score of 81.2% and 0.4% negative score. Ward 2b had a response of 22%, and of these responses 94.4% were positive.
- On the surgical admissions unit, the staff told us they had concerns about the privacy discussions taking place in the cubicles. Whilst they had male and female areas, the cubicles did not provide any privacy when the patient and doctor were having a discussion, and other patients were able to hear what was being said. Also, if the department was busy, it could be difficult for patients to hear. The unit did have one room where patients could go with a doctor if they needed to have more privacy.
- We observed that staff maintained patients' privacy and dignity – for example, using the curtain around their bed, and knocking on doors before entering. Patients told us they had no concerns about how staff maintained their privacy and dignity.
- Patients on the day surgical unit told us the staff were "great" and "very kind".
- We spoke to patients on all the wards we visited and they all had positive comments to make about the staff. For example, "Staff are wonderful, can't fault them," and "They really care." Some patients told us they felt the staff were very busy and there were not enough of them at times.
- We received some feedback from a patient prior to this inspection, and they told us they had spent the night in recovery department following their surgery as they had been unwell. They said, "This turned out to be a truly amazing experience, as the nursing care was absolutely second to none. I could not fault it in any way whatsoever, and although I did try to convey my gratitude I would like it to be known that the staff are fantastic and deserve huge praise."

Understanding and involvement of patients and those close to them

- Patients were involved with their care and with any decisions taken. They were able to ask staff any questions about their condition and surgery. One patient said, "They keep changing what is happening to me, but they keep me updated and I am able to ask questions."

Surgery

- We spoke with patients who had undergone surgery. They told us they had been given details about the operation, any risks involved and what to expect post operation. Relatives were able to be involved in these discussions if the patient had given them permission. We saw documented in the notes of one patient detailed discussion with their family and details of the treatment and surgery they had had. This patient had been assessed as not having capacity and had an advance directive in place allowing these details to be shared with their family.

Emotional support

- Staff in the preadmission clinic told us that patients who were undergoing bowel surgery and would require a stoma would see the stoma nurse at this clinic. They would also see the same stoma nurse in hospital and in the community to maintain continuity of care.
- Spiritual support was available from within Gloucestershire Royal Hospital, as the chaplaincy and a team of spiritual advisors were on call at all times. Patients were able to have support through their own local connections and networks.
- Patients had support from nurses with additional knowledge; for example, there were nurses with link roles in matters relating to mental health, learning disabilities and dementia. Nursing staff said carers, families and care workers were encouraged to come into the unit to provide emotional support and were helped to overcome any of their own anxieties so they could provide comfort to confused, scared or disorientated patients.

Are surgery services responsive?

Requires improvement

Before and during our inspection, the trust was experiencing a high number of admissions and increased pressure on its services. In December 2014 and January 2015, the trust declared an internal major incident because of this. The increased demands on the trust's services and beds resulted in a high number of elective operations being cancelled. The trust had not met it target for the year for the number of patients cancelled on the day of their operation for non-medical reasons and had only met the national targets for rebooking patients within the 28-day timescale in one month.

The 18-week referral to treatment targets were being met in almost all surgical specialities. Urology and ophthalmology were just behind the 90% target at 85% and 87% respectively. The trust was below (that is worse than) the NHS England average 62-day cancer waiting time target. The trust was treating 74.7% of cancer patients within the 62-day target against the NHS England average of 81.2%.

The trust had lower lengths of stay for elective and non-elective surgery compared with the England average.

Patients told us they had no concerns or complaints about their care. We saw posters on display informing patients and visitors about how to report a complaint or concern.

Service planning and delivery to meet the needs of local people

- The trust told us it was planning to reconfigure some more of its services. (This is where the trust moves a specific service to one location rather than being at both hospitals.) It said that prior to any decisions being made, it would consult with staff and the public. This had taken place in the past, as ear, nose and throat (ENT) is located at Gloucestershire Royal Hospital and ophthalmology is at Cheltenham General Hospital. Cheltenham General Hospital has a specialist eye department which includes a ward for day surgery and outpatient clinics. By having the facilities on one site, the trust was able to have enough consultants, doctors and nursing to meet the needs of these patients.

Access and flow

- Some elective patients used the surgical admissions unit. This was where patients for surgery came to be prepared for theatre and were then taken to a ward post operation. The staff told us this was to help improve the flow of patients through the hospital. This unit was open from Monday to Friday, from 7am to 5pm; however, staff told us this unit had been opened once overnight in January 2015 because of high demand on hospital beds.

Surgery

- The trust had declared an internal major incident in December 2014 and January 2015 because of increased demand on its services. The day surgery unit had been opened at night and at weekends prior to the major incident in order to meet the rise in demand for beds.
- Ten operations were cancelled for the day surgery unit on the first day of our inspection, and there was a possibility of one patient being cancelled the next day. Staff told us patients were contacted the day before their surgery if it was going to be cancelled. However, staff said they had incidents where patients had turned up for operations that had been cancelled but they had not received the message.
- The trust sent us information on how many elective patients had their operations cancelled more than once for non-medical reasons. Between December 2014 and February 2015, 501 patients were cancelled more than once.
- The bed occupancy levels for this trust had been running at over 91%. The England average is 88%.
- From 4 January 2015 to 14 January 2015, the trust cancelled 436 operations, and of these 43 were cancelled on the day because of intense pressure on its services. For Gloucestershire Royal Hospital in this period, 219 operations were cancelled out of 1,279.
- The information on the NHS England website for quarter 2 in 2014/15 stated the trust cancelled 245 operations. Of these, 11 were not rebooked within the 28-day timescale. For quarter 3 in 2014/15, 327 operations were cancelled, and of these 19 were not rebooked within the 28-day timescale. Performance had not improved in February 2015 with number of patients cancelled for non-medical reasons and the number not rebooked within 28 days still not meeting the targets.
- An emergency coordinator had been appointed in the main theatre suite. Part of their role was to make sure lists were running to time.
- The trust was meeting the referral-to-treatment time for general surgery, trauma and orthopaedics, ENT, oral surgery and thoracic medicine. It was not meeting the referral-to-treatment time for urology and ophthalmology. This information was from March 2013 to November 2014. It was also not meeting the maximum wait of 62 days from urgent GP referral to first treatment (excluding rare cancers) which it had met for three months out of the 11 from April 2014 to Feb 2015 inclusive but had not met for the last seven i.e. from August 2014 to Feb 2015.
- The average length of stay at Gloucestershire Royal Hospital for elective surgery in trauma and orthopaedics, colorectal and upper gastrointestinal surgery was 2.9 days compared with the England average of 3.3 days.
- For non-elective surgery, the average length of stay was 5.1days compared with the England average of 5.2 days for trauma and orthopaedics, general surgery and ENT.
- Staff told us about an elderly patient who was 94 years old and had been moved four times before coming to the day surgical unit. The doctor for this patient had not been informed of their move and had no medication for them. These moves had caused the patient to be anxious and concerned about their medication.

Meeting people's individual needs

- Staff had access to translation services, both in person and by the telephone. A member of staff told us about a patient who was booked for surgery the next day, and they had booked an interrupter for them.
- A learning disability liaison team supported staff to care for and support patients with complex needs and their carers. On the day of our inspection, we heard of two areas that this team had visited on that day.
- On the Orchard day surgery unit, staff told us they often had patients with learning disabilities. Some patients brought in their 'passport'. This document informed staff about the patient's needs whilst they were in hospital. Staff said they tried to make such patients' stays as least traumatic as possible by providing private rooms and allowing their carers stay with them. Patients were normally first on list and admitted as late as possible. They tried to discharge them as soon as they were medically fit.
- Staff told us that on the day surgical unit they often had difficulties in accessing other services for patients, for example specialist diabetic nurses. When orthopaedic patients required overnight stays, they did not have the space for mobilising them and they often needed input from physiotherapists.

- Patients on the day surgical unit who were staying for longer than the day did not have a locker for their personal belongings and they had less room between the bed spaces than on a ward.
- Patients who were living with dementia were highlighted on the trust's 'purple butterfly' system. We saw this was on the main board where information about patients was stored; this was to highlight to staff that these patients required more support and care.

Learning from complaints and concerns

- All patients we spoke with were happy with the care they had received and did not feel they needed to make a complaint. Patients told us that if they wanted to make a complaint they would speak with a member of the nursing staff.
- We saw that the trust's complaints and comments procedure was displayed on noticeboards around some of the surgical wards.
- The surgical division had received 21 complaints for February 2015; this was below its target of 22. We saw the monthly report where complaints, concerns and compliments were recorded. It also listed how many complaints had been sent to the Parliamentary and Health Service Ombudsman (PHSO). Each complaint for a ward or department was listed and by it any actions taken, for example an apology to a patient. It also mentioned, for example, whether the complaint and outcome were to be discussed at ward/unit meetings.

Are surgery services well-led?

Good

Staff were aware of the trust's values and visions. A number of staff we spoke with had been working at this trust for over 20 years and said it was a good place to work. Some staff told us that if incidents took place, they wanted to be open and transparent with patients about any failings. The culture of learning from incidents was promoted among staff, and they told us they were encouraged to report incidents.

The divisional management team had plans to develop the surgical division, and this was included in the trust's five-year strategic plan.

Staff on the wards told us they felt supported and listened to by their immediate line manager, divisional level and by the executive board.

Appropriate governance systems were in place. Risks were identified and discussed at divisional level, and these were recorded on each specialty's risk register and included in the surgical division's risk register. Serious risks were shared with the executive team.

Vision and strategy for this service

- **We saw a copy of the surgical division's newsletter for July 2014. It listed the divisional objectives. We were told this was shared with all staff.**
- **The trust had a five-year strategic plan in place for general surgery which covered all specialties. For example, one of its risks was** difficulty in maintaining the acute pathway at all times on two sites because of difficulties in recruiting middle grade doctors. This plan also listed risks to financial sustainability and the trust's plans on how to readdress this.
- Staff told us they were aware of the trust's visions and values and their role in achieving them. They also said their main priority was patient care and safety, and they wanted to be transparent with patients about any failings.

Governance, risk management and quality measurement

- The central sterile services division (CSSD) had internal governance arrangements and it was also audited by an external governing body. This was to make sure it was compliant with a number of areas including its policies and procedures, maintenance of equipment and decontamination systems. This enabled the CSSD to provide its services to other healthcare institutions, for example community hospitals and GP surgeries.
- The divisional management team told us about the top risks. We examined the risk register and found that all of these were included on it, for example inability to provide a formal out-of-hours interventional radiology rota for vascular surgery and urology, and failure to meet certain National Institute for Health and Care Excellence (NICE) guidance. A member of staff responsible for the monitoring these risks was included on the risk register. Dates of review were also included.

- Each specialty had its own risk register, for example trauma and orthopaedics. These fed into the surgical division's risk register. We saw that some of these risks were also on the corporate risk register, for example inappropriate use of day surgery/recovery for patients requiring to stay after operations.
- Appropriate governance systems were in place. For example, each specialty had governance meetings and these reported into the divisional governance meetings. Any issues from these were reported into the trust's quality governance meetings. These meetings included a number of topics, for example review of all serious incidents, complaints received and the patient experience.

Leadership of service

- There were trust-wide management arrangements for the surgical division. The division was led by a chief of surgery and then two divisional directors, a director for nursing and a director of operations. Each specialty, for example orthopaedics, was led by a clinician and under them general managers and modern matrons. The management arrangements after this were based in the individual hospital.
- Staff told us they felt supported and listened to by their immediate line managers, divisional management and the executive board.
- All staff knew who the chief executive and nursing director were. Nursing staff said they felt well supported by the nursing director, and all said they could approach the nursing director with any concerns.
- Some senior nursing staff told us they felt they were being listened to by the executive team and things were getting done, especially in relation to patient safety.
- Some staff also told us about the executive walk-arounds and how they had taken part in these and fed back any issues.
- All staff spoke highly of their immediate line managers and felt well supported by them.

Culture within the service

- The management teams we spoke with said they encouraged staff to provide the best and safest care possible to patients. They were aware that their staff were under great pressure, especially because of the increased high demands on their services. They all liked to be visible to staff, and they also work on the wards. Staff said they felt supported by their line managers.
- A number of staff we spoke with said they had worked for this trust for over 20 years, and all said it was a good place to work**.**
- Staff told us they would report any concerns they had, and most were aware of the 'say and see' telephone line. Others said they would use their internal intranet site to find out details on how to report concerns. Staff were also aware of the trust's whistle-blowing policy and raising concerns policy and where to find them.
- Staff told us there was an open culture that was not about blame. They were encouraged to report incidents, as incidents were seen as by the trust as important learning opportunities.

Public and staff engagement

- Patients were able to feed back their views on the ward via the Friends and Family Test. They were asked whether they would recommend the ward to their friends and family. We saw results of these on display in the wards.
- One member of staff told us they were the representative for their department at the staff engagement meetings where all disciplines of staff met the executive team. They told us they fed issues from their team into this meeting and reported back again. They felt these meetings were worthwhile and enjoyed taking part, and they had also been invited to attend board meetings.
- Some staff told us they had been involved in the executive management team walk-arounds of wards and departments. They all said they felt able to express any concerns they had with the member of the executive team.

Innovation, improvement and sustainability

- Ward 3b had a large display of information, guidance and pictures about pressure ulcers. This also included the pressure ulcer pathway used by the trust. The ward sister told us the ward had won a prize for this from the executive board.

Surgery

- The surgical division had undergone a period of reconfiguration to look at ways of sustaining its surgical services and providing a more effective and efficient service to patients. A number of surgical specialties had been transferred to one of the other hospitals. For example, urology and vascular surgery was now located only at Cheltenham General Hospital, and ear, nose and throat (ENT) and maxillofacial surgery was based at Gloucestershire Royal Hospital.
- The manager for the central sterile services division (CSSD) at both locations said they had plans in place to refurbish both units and to look at how they can reprocess/clean some of the latest new equipment being used, for example a robotic **surgical system used for urology surgery. At the moment, this is being cleaned off site by another provider.**

Critical care

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

Information about the service

The department of critical care at Gloucestershire Royal Hospital supports patients who need intensive care (described as level 3 care) or high dependency care (described as level 2 care). The department has 19 bed spaces, of which a maximum of 17 are funded to accommodate patients at any time. There are 13 beds in the combined general intensive care unit (ICU) and high dependency unit (HDU), with a further six bed spaces in the newly opened (January 2015) surgical HDU. This new unit is in a separate area but adjacent to the general ICU/HDU and within the physical footprint of the department of critical care. The number of patients accommodated in the general ICU/HDU depends upon what level of care is required. The unit cannot exceed a maximum of 10 patients who require level 3 intensive care, but can accommodate up to 13 patients if there is a mix with level 2 high dependency patients. At the time of this inspection, the new surgical HDU was funded to accommodate up to four patients.

The general ICU/HDU has nine bed spaces and four side rooms, two of which provide specialist isolation facilities. There are two central nurses' stations facing the patient areas in the general ICU/HDU, and a further station in the surgical HDU. Each bed area is screenable by curtains. Both units have windows and natural light.

The number of patients admitted to the unit was increasing with the opening of the new surgical HDU, but in 2014 the general ICU/HDU cared for around 700 patients aged 16 years and above. A small number of children under 16 years were admitted either prior to retrieval to a paediatric intensive care unit, or for emergency specialist care.

On this inspection, we visited the department of critical care on Wednesday 11 and Friday 13 March 2015, and made an unannounced visit in the evening of Friday 20 March. We spoke with a full range of staff, including consultants, doctors, trainee doctors, and nurses from different grades. We met the general manager, the matron and lead consultant for critical care, who are responsible for the services of critical care in both Gloucestershire Royal Hospital and Cheltenham General Hospital, which are both managed by Gloucestershire Hospitals NHS Foundation Trust. We spoke with physiotherapists, nurses from the outreach team, one of the cleaning team, the lead pharmacist, a dietician and the ward clerk. We met with patients who were able to talk with us, and their relatives and friends. We observed care and looked at records and data.

Critical care services provided by this trust were located on two hospital sites, the other being Cheltenham General Hospital. Services at Cheltenham General Hospital are reported on in a separate report. However, services on both hospital sites are run by one critical care management team and, as such, are regarded within and reported upon by the trust as one service, with many of the nursing and senior staff working at both sites. For this reason it is inevitable there is some duplication in the two reports.

Critical care

Summary of findings

We have judged the overall critical care service at Gloucestershire Royal Hospital as outstanding.

The effectiveness, caring and leadership of the service were outstanding, and safety and responsiveness were good. Treatment, care and rehabilitation by all staff were delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Innovation, high performance, and the highest quality care was encouraged and acknowledged. All staff were engaged in monitoring and improving outcomes for patients. They achieved consistently good results for patients who were critically ill and with complex problems and multiple needs.

Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Staff went above and beyond their usual duties to ensure that patients experienced compassionate care and that care promoted dignity. People's cultural, religious, social and personal needs were respected. Innovative caring for patients, such as the development of patient diaries, was encouraged and valued.

The leadership, governance and culture of the services were used to drive and improve the delivery of high quality person-centred care. All the senior staff were committed to their patients, their staff and their unit, with an inspiring shared purpose. There was strong evidence and data to base decisions upon and drive the service forwards from a clear, approved and accountable programme of audits. There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and consistently high levels of constructive engagement. Innovation and improvement were celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

There was a good track-record on safety, with lessons learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and by a desire to get things right. Staff responded appropriately to changes in risks to patients. There was high-quality equipment and a safe environment. The unit was clean and well organised. Staff adhered to infection prevention and control policies and protocols. There were good levels of nursing and medical staff meeting Core Standards for Intensive Care Units to keep patients safe. There was a daily presence of experienced consultant intensivists and doctors, and rarely any agency nursing staff or locum cover used. Patients' records were excellent, clear, legible and contemporaneous, although their security needed to be improved.

Some improvement was needed to ensure stocks of medicines and other consumables were stored safely, in date, and recorded accurately. The patient harm data showed good results, but the internal and external recording and display of some information could be improved.

The critical care service responded well to patients' needs. There were bed pressures in the rest of the hospital that sometimes meant patients were delayed on discharge from the unit, but incidences were only just above the NHS national average for similar units. Some patients were discharged onto wards at night, which was recognised as less than optimal for patient wellbeing, but the rate was the same as the NHS national average rate. There was a very low rate of elective surgical operations being cancelled because of unavailability of a critical care bed.

The facilities in critical care were excellent for patients, visitors and staff, and met all of the modern critical care building standards. The trust had responded to the need to improve patient flow by opening a new surgical high dependency unit with four new beds (and expansion capability to six beds) in January 2015.

Patients were treated as individuals and there were strong link-nurse roles for all aspects of patient need, including learning disabilities, dementia and mental health. There were no barriers to people who wanted to complain. There were, however, few complaints made

Critical care

to the department. Those that had been made were fully investigated and responded to with compassion and in a timely way. Improvements and learning were evident from any complaints or incidents.

Are critical care services safe?

Good

We judged the safety of the critical care unit as good. There was a good track record on safety, and lessons were learned and improvements made when things went wrong. This was supported by staff working in an open and honest culture and by a desire to get things right. There were reliable systems and experienced staff to keep people safe from abuse that reflected national guidance and legislation. Incidents would be reported, but staff accepted they did not necessarily recognise all events as reportable incidents, and this needed reflection.

Patients were methodically and thoroughly assessed and monitored. Staff responded appropriately to changes in risks to patients. There was high quality equipment and a safe environment. The environment met all the requirements for modern critical care units, including for isolation facilities. Plans were in place to deal with changes to demand and respond to national emergencies.

The unit was clean and well organised. Staff adhered to infection prevention and control policies and protocols. There were good levels of nursing and medical staff meeting Core Standards for Intensive Care Units to keep patients safe. There was a daily presence of experienced consultant intensivists and doctors, and rarely any agency nursing staff or locum cover used. There was cover by experienced and skilled physiotherapists, although not enough of them to meet the recommendations of the core standards. A high number of staff were compliant with their mandatory training. Patients' records were excellent, clear, legible and contemporaneous, although their security needed to be improved.

Of the large quantity of well-rotated stock, there were a small number of consumable and disposable items of medical stock that were past their use-by date. Some of the medicines in the resuscitation kit were variants on those described and signed for, although safe for what they were intended for. There was good storage for medicines, but the liquids were not as secure as they should be. There was also a lack of clear recording for one of the controlled

drugs, although that for the others was accurate. The patient harm data showed good results, but the internal and external recording and display of some information could be improved.

Incidents

- Staff were open, transparent and honest about incidents. All staff we spoke with, including the domestic staff and ward clerk, said there were no barriers to reporting incidents and that they were encouraged to do so. A number of the nursing staff said they recognised clear incidents and reported these through the trust reporting system and internally within the department. However, they accepted there might be times, albeit infrequently, when they might not remember or think to report an incident onto the incident reporting system. In talking with some of the nursing staff, we heard and saw evidence of occasional events and/or near misses not always being recognised as reportable incidents, and thus not being reported. The trust was below the NHS England average for reporting incidents, which could be an indicator of staff not reporting incidents as frequently as they should.
- All staff we asked said they felt they were not blamed for errors or omissions. They were listened to, able to be fully honest and open, and treated fairly. Staff said this meant they were not afraid to speak up when something went wrong or could have been done better.
- Incidents were reviewed and investigated. The environment, circumstances, systems and processes were examined to see why something had occurred, and how, if possible, to avoid any repeat. Staff competence was considered if there was evidence of it needing improvement. The clinical nurse educator was engaged in this process to ensure update training or teaching was delivered where necessary. There was a formal process for serious incidents requiring investigation. We reviewed three from 2014 involving category 3 pressure ulcers acquired by patients. The investigations undertaken were extensively reported upon and presented through the trust's safety experience review group for shared learning.
- Learning from incidents was shared between clinical staff at divisional level and across sites. Incident reports were a standing agenda item for the Gloucestershire critical care business meeting. The moderate- through to major-graded incidents were discussed. Learning points and requests to check for recurring themes with emerging trends were discussed and minuted.
- Incident reports were produced to identify any trends and learning required. From a review of the incidents, we saw themes being highlighted and, where patterns were identified, evidence of learning being disseminated to staff; for example, staff hand-outs were produced about the documentation of pressure ulcers and the checking of intravenous fluid bags to avoid medication errors. The reporting and learning was shared between the sites, as they were managed by the same leadership team and nursing staff worked flexibly at both sites.
- Staff in the critical care division were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong. From November 2014, NHS providers are required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. Although this was a relatively new requirement, senior staff in critical care were aware of their duty to inform all relevant parties of notifiable patient safety incidents. Staff were aware of the requirement to be open, transparent and candid and to issue a meaningful apology to the relevant person or people. We saw in serious incident report templates requirements to inform and apologise to the family.
- Patient mortality and morbidity was reviewed and discussed each quarter. This was undertaken at critical care division level as part of the service's multidisciplinary team meetings. Minutes of the meetings showed that the cases reviewed were well considered. Any actions arising were attributable to a member of the team, and there was evidence to show any lessons from the reviews were learned and changes made if required.
- There were also paediatric mortality and morbidity meetings each quarter. If a paediatric patient who had been cared for on the unit was presented at a mortality and morbidity meeting, relevant staff would attend. As a result of one discussion, a new care plan was introduced

following a review of child intubation. We saw that this was included within the paediatric intubation trolley in the general intensive care unit (ICU)/high dependency unit (HDU).

- There was clear oversight of incidents. All incidents were discussed at the appropriate divisional committee. This started with the specialty clinical governance group, moved through to the divisional health and safety committee, then the divisional quality assurance group, before being presented to the divisional board.

Safety thermometer

- For all patients, assessments were in place for risks from falls, pressure ulcers, venous thromboembolism (VTE) and urinary tract infections. Care plans were in place, and there were daily patient safety checks for these areas of risk. Care plans were being reviewed and followed.
- Data regarding patient harm was captured and reviewed. In the six months from September 2014 to February 2015, there had been no incidents of venous thromboembolism (VTE) or urinary tract infection (UTI). There had been three falls, but with no harm to the patient. They had all been thoroughly investigated. No category 3 or 4 pressure ulcers (the more serious categories) had been acquired on the unit in this period. There were six pressure ulcers of category 1 or 2, and all had been investigated and appropriate actions taken. The safety thermometer data for VTE, UTI, falls and pressure ulcers was not, however, captured in the otherwise extensive audit of 'harm free care'. It was reviewed along with an audit of incidents and was discussed at staff meetings, but not expressed as clearly as it could be. There was also no public display on the unit in relation to safety thermometer data.

Cleanliness, infection control and hygiene

- Rates of unit-acquired infections were low. Data reported by the hospital to the Intensive Care National Audit and Research Centre (ICNARC) (an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally) supported this evidence. All rates of infection had, over time, mostly been below (better than) the national average, as at the time of this inspection. There were no unit-acquired methicillin-resistant Staphylococcus aureus (MRSA) infections in the 12 months to September 2014 (the most recent data available). There was one event of unit-acquired Clostridium difficile in the same period, which was the same as the national average. There had been two unit-acquired bacteraemia infections (not MRSA) in the year to September 2014, and no MRSA infections in blood for the past five years.
- At the time of our inspection, the unit and equipment were visibly clean, well-organised and tidy. Bed spaces were visibly clean in both the easy- and hard-to-reach areas. Bed linen was in good condition, visibly clean and free from stains or damage. The cleaning of the unit was audited and checked each week. The unit had scored above the 95% target on all but six of the weeks for the 12 months of 2014. The majority of results were around 98%.
- Used and new equipment was stored and sealed to prevent cross-contamination. All disposable equipment was in sealed bags in drawers or cupboards where possible, to prevent damage to packaging.
- Used disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. None of the waste bins or containers we saw were unacceptably full, and nursing staff said they were emptied regularly.
- We observed doctors and nursing staff following policy in washing their hands between patient interactions, using antibacterial gel and wearing disposable gloves and aprons at the bedside. All staff were 'bare below the elbows' (had short sleeves or their sleeves rolled up above their elbow) when they were within the unit. Results for hand hygiene, compliance with uniform policy, and the use of personal protective equipment were good. The department scored 100% in almost all hand-hygiene and personal protective equipment audit observations from April 2014 to January 2015.
- Visitors were required to follow infection control protocols. They were asked to use alcohol gel when arriving on the unit, and this was freely available and clearly visible. Visitors were asked to consider their own health when visiting and to not come to the unit if they were unwell or becoming unwell. There was a policy of limiting the amount of property left with the patient in

the hospital, for reasons of infection control. Staff explained this upon admission to the unit, and it was also described in the leaflet produced by the department for patients and visitors.

- There was induction for all clinical staff when newly working on the unit. The service had produced an extensive guide detailing the clinical procedures that can increase the risk of infection if not performed correctly.
- There were guidelines for both doctors and nurses in relation to their responsibilities around protection from cross-infection for certain procedures. The document explained whether these procedures were treated as surgical (therefore masks and hats to be worn along with other standard personal protective equipment) or used a non-touch aseptic technique. Care provided was audited against best practice on a monthly basis. For example, with urinary catheter audits, the need for a catheter and whether it was removed at the earliest opportunity were questioned. For peripheral venous cannula insertion, the audit included whether the site was reviewed at least every day, and whether the dressing was dry and intact. Most results were good, and the majority at 100% for completed documentation. Where this was not the case, action plans were produced and staff were accountable for improvements in results.
- Monthly infection control reports were produced for the divisional board meeting, based on surveillance data. There were reports for the division (critical care was part of the surgery, anaesthetics, pain and critical care division), and there were reports for the various services within the division.

Environment and equipment

- The unit had been built to modern critical care building standards. Each bed space was at least 25m^2 to allow for safe access to patients and equipment and allow two visitors to sit comfortably in each bed space. Each space could accommodate five staff to work with a patient if required.
- The bed spaces in critical care – both the general unit and the surgical high dependency unit (HDU) – had appropriate safe levels of equipment. The units met all the Department of Health requirements for safe equipment in a critical care unit. At patient bed spaces there were, for example, flat-screen monitors, multi-parameter patient monitoring equipment, a minimum of three infusion pumps, and a minimum of four syringe pumps. There was other relevant equipment including a portable x-ray machine, an ultrasound machine, haemodynamic monitors and a defibrillator.
- The beds, mattresses and chairs for patients met the requirements of the Core Standards for Intensive Care Units. Each bed was capable of attaining different positions for patient comfort and to assist staff. All beds had air mattresses to relieve pressure to the body when a person was lying in the same position for long periods. There were a variety of chairs for patients to use when they were well enough to sit up out of bed.
- The unit had appropriate equipment for use in an emergency. There was a difficult airway intubation trolley divided into different trays according to the intubation strategy and equipment to be used with the patient. The trolley was to be checked each day, but on three days between 1 and 11 March 2015 records showed that the trolley had not been recorded as checked.
- There was a standard resuscitation trolley. The trolley had been checked each day, and the check recorded. The trolley had a list of equipment to be carried. Almost all the kit listed was as required, with the exception of some drugs which were not as per the checklist. In the case of one drug, the amount to be carried was not stated, and with another the dosage carried was not the same as stated in the checklist. The matron and the lead pharmacist took action, and by the time of our unannounced inspection this had been rectified.
- Staff were trained and competent to use equipment. The nursing staff maintained good training records for equipment and competencies. There was extensive training for trainee doctors on the equipment used in the department. The competencies were reviewed and signed off by the consultants.
- A few items of consumables were out of date in the store in the general unit. The stock in the equipment cupboard was said by the matron to be routinely checked for being near or past the expiry date. These items were removed and disposed of and a more thorough check instigated.

- There was good storage space for equipment, to enable the environment to be free from clutter and from equipment that was used infrequently. Most was stored in cupboards and storage spaces. One area of storage for equipment, consumables and fluids was in an area away from patients' beds, behind the nurses' station, but was accessible to anyone coming onto the unit. There was no door to this area, and the consumables – specifically liquids – were not secure from tamper.
- The units (both the general unit and surgical HDU) were secure on entry from the main corridor. There were close-proximity cards (which offer better infection control than swipe cards or keypads) for staff to use to gain access to the clinical areas. However, once visitors had entered the reception and waiting area, there was no barrier to entry to the general intensive care unit (ICU)/HDU. This door was not locked or secured with card access. This had been raised by staff with the hospital trust. The surgical HDU was otherwise locked to unauthorised access.

Medicines

- Medicines, including those requiring cool storage, were stored appropriately, although some liquids were not locked away. There was, therefore, a risk from tamper. Records showed that medicines were kept at the correct temperature and so would be fit for use. Refrigeration temperatures were checked each day, as required, and recorded. Medicines were stored in locked cupboards in a clinical area, and their location was marked on the doors. Controlled drugs were kept in a suitable standard metal cabinet.
- A senior pharmacist visited the unit every weekday. They attended daily ward rounds to provide support with prescribing and use of medicines. There were appropriate stocks of medicines to make sure patients had access to them when they needed them. The visit of the pharmacist helped to ensure medicines were used safely. There was a pharmacy top-up service for the unit's stock, and other medicines were ordered on an individual basis. The pharmacy team provided an on-call system to make sure advice was provided at all times.
- Patients' medicine records were well managed using standard drug charts. There was a mix of standard pre-printed charts for intravenous medicines which were often administered following standard protocols. The main drug charts were written up by the medical staff. All of those we reviewed were complete, relatively legible and clear.
- The senior pharmacist for critical care followed antibiotic protocols, and compliance was audited. Audits were carried out of drug charts and patients' notes against various indicators. This included, for example, whether any allergies to antibiotics were clearly documented, whether the date for stopping or review was documented, and whether antibiotics were being given in the most appropriate way (such as orally or intravenously). The compliance results for April 2014 to January 2015 were almost all 100% (98% in September 2014 and August 2014).
- Controlled drugs were recorded clearly, and stocks were accurate in all those records we checked, with the exception of one error. There was some confusion about a controlled drug as to whether it was administered or not when the expiry date had been found to have passed. We investigated this with the patient's records, the lead pharmacist and the Matron. We found the out-of-date drug had been destroyed by the pharmacist, and the patient had been given the drug as prescribed from the stock held in the recovery room located next door. However, the recording of this transaction was unclear. The Matron could see how the record should have been made, and took this up with the staff concerned.

Records

- There were clear, legible and ordered patient notes. We reviewed six random sets of notes and checked current and historic information. Documents were clearly written in chronological order, and were dated, timed and signed. Contributors printed their name and added contact details. All results were documented, and abnormalities were identified with a clear written plan of action. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided. A rolling audit carried out over the three years prior to our inspection showed the 'daily goals' sheet was being used throughout.
- Records demonstrated communications with the patients' relatives. A relatives' communication sheet

recorded all the details of the family that could be ascertained. Communication was recorded on this sheet by any member of the team who had spoken with or attempted to contact a relative.

- The patient's treatment plan was clear and could be followed through the records. This included the prescription of medicines, which were then tracked to the drug chart. Any requested reviews from the physiotherapist were recorded, and we noted these reviews had been carried out. Nursing care plans were up to date and all interactions had been documented.
- The standard daily observation chart was designed by staff in the department. One of the nursing team was responsible for the large observation chart used for each patient in critical care. This was reviewed with a departmental consultation every six months to enable new assessments or changes to existing procedures to be added. This made the chart as relevant and current as practically possible.
- Patients' paper notes were not stored, to ensure confidentiality and security. In the high dependency unit (HDU) part of the general unit, paper notes were in an open trolley but within the nurses' station area. In the intensive care unit (ICU) part they were to the side of the nurses' station in an open trolley. They were supervised at times by staff, but when we first entered the unit staff were caring for patients and both sets of notes were therefore not fully secure. At no time did we see patients' confidential information left visible and unaccompanied on any screens or boards. Shortly after our announced visit to the unit, the Matron informed us new trolleys had been ordered for the unit with closable and lockable tops to secure patients' records.

Safeguarding

- Staff were trained to recognise and respond in order to safeguard a vulnerable patient. This included any children admitted to the unit or associated with a patient or visitor. Mandatory training was delivered, and almost all nursing staff were up to date with their knowledge. Compliance at the end of January 2015 ranged from 94% to 98% for the eligible staff. The data for consultants and doctors working in critical care was included in that for the anaesthetics team at the hospital. We were not able to separate their training data from the whole cohort, but the compliance rate for anaesthetists was overall between 94% and 97% at the end of January 2015. The nurses and doctors we spoke with in the general ICU/HDU knew who to contact within the hospital who had responsibilities for both adult and child safeguarding. Staff were clear about their responsibilities to report abuse, as well as how to do so.
- There were policies, systems and processes for reporting and recording abuse. The policies included how and when to involve the police in safeguarding concerns, the protocols around taking photographs, and policies in the event of the death of a patient subject to safeguarding. There were clear checklists for reporting concerns for both adults and children, which, as required, were subject to different procedures. The checklists included the requirement to raise an incident report alongside any safeguarding referrals.

Mandatory training

- The majority of nursing staff were up to date with the mandatory training subjects. Training requirements for staff in mandatory subjects were approved and revised as necessary through a board-approved training needs analysis. Training was also relevant to the job role for each member of staff. Each member of staff was responsible for their own training being completed within the year. This was discussed at their annual appraisal, and staff would not have their performance review signed off unless all training had been completed. The trust's compliance rate for nursing staff at 31 January 2015 with mandatory subjects was 95%. The unit was able to produce a report at any time showing which staff had not completed their training and which specific courses were outstanding. Most staff on the list had between one and three courses to complete of the suite of up to 13 topics.
- Mandatory training was in subjects appropriate to the needs of critical care units. A fairly new member of staff told us they had completed their training on their induction. They said the courses were mostly computer based and were clear and relevant. Other members of the nursing team told us the courses made sure staff were updated with changes in practice and kept their knowledge current.

Assessing and responding to patient risk

- The nursing team and medical staff assessed and responded to risk well. Ward rounds took place at

regular intervals. There were two ward rounds led by the consultants on duty each day, morning and evening, including at weekends. There was input to the ward rounds from unit-based staff, including trainee doctors, nurses and the pharmacist. Other allied healthcare professionals were asked to attend when required. On a ward round, we observed that a full range of clinical indicators were available within patients' records for all patients, including blood results, radiology results, observations and physiological data. Routine patient care was discussed in a structured manner for the patients we observed during the ward round. This included the management of invasive lines, sedation, analgesia and venous thromboembolism, and pressure ulcer prophylaxis.

- There was methodical and thorough review of patient risks. This extended to all patients, even those who had been on the unit for a long time, where progress might be slow or minimal. Trainee doctors were completely involved with patient reviews, able to participate, and given support, feedback and close supervision from consultants.
- Detailed handover sessions were held each morning. The sessions were carried out with a recognised routine to minimise the risk of any changes or developments in patients being missed. All the relevant staff were involved with handover sessions.
- This hospital had a policy in place for monitoring acutely ill patients on the wards. It had implemented and was using the National Early Warning Score (NEWS). This collated patient observations to determine the level and frequency of observations and action to take in the event of the deterioration of the patient.
- There was a good system for responding to deteriorating patients. In many NHS trusts, the outreach team is generally a service managed by critical care. However, in this trust, it was part of the acute care response team (ACRT). It did, however, have close links with critical care at all times. The ACRT outreach team was sufficiently staffed to provide almost full cover, and an increase in staffing had been agreed in order to cover 24 hours a day, every day. The specialist nurses were a major part of the response team for acutely unwell patients elsewhere in the hospital. The ACRT outreach team provided teaching and education services in responding to risks to the rest of the hospital as part of its role. Staff told us they were concerned that the teaching and education role would not be as good as it should be when the response role extended to a full 24-hour service.
- Delays in managing deteriorating patients elsewhere in the hospital and throughout the trust were minimised. The communication between both Gloucestershire Royal and Cheltenham General Hospitals was excellent. Trust referrals were made promptly via any of the possible routes; these included the ACRT, trainee doctors, nursing staff, the emergency department and other senior medical staff. Feedback on appropriate and inappropriate referrals was professionally managed, further exhibiting the no-blame culture we observed.
- Patients were monitored for different risk indicators. For example, each ventilated patient was monitored using capnography, which is the monitoring of the concentration or partial pressure of carbon dioxide in respiratory gases. Such monitoring was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions. Continuous end-tidal carbon dioxide monitoring was employed in all patients with an artificial airway receiving ventilatory support (as recommended by the 2011 Royal College of Anaesthetists' fourth National Audit Project report).
- Patients were handed over when discharged from critical care (usually to a medical or surgical ward), with their risks clearly recorded. This included their risk of dehydration, whether they required an air mattress for risks of developing pressure ulcers, and their vital signs including their NEWS and oxygen levels.

Nursing staffing

- There was a safe level of nursing staff. The nursing staff levels were based upon the dependency (acuity) levels of patients. This followed the Faculty of Intensive Care Medicine Core Standards recommendations for safe nurse-staffing levels. Therefore, when a patient needed intensive care, there was one nurse for each patient. When a patient needed high dependency care, one nurse looked after two patients. There were a maximum of 11 nurses per shift, with one supernumerary as the unit's nursing lead. However, each shift was planned against patient acuity and expectations, and staffing

levels were adjusted in real time to meet the acuity levels. We reviewed staffing rotas for two months and how they were planned for the coming weeks, and found this to be the case. Senior nurses reviewed the actual staffing levels each month and produced reports on any shortages of staff. Staffing levels had generally not met the plan because of the acuity of patients being less than anticipated or elective surgery having been cancelled. On our visits, including the unannounced visit, there was a safe level of nursing staff.

- The nursing staff had a flexible working system in order to raise and lower staffing levels to meet patients' needs. This gave staff the opportunity to not work a shift, or part-shift, when the acuity level did not demand it, but to come into work to cover increases in acuity levels or unplanned staff absence. A policy for this, which supported both safe staffing and a work–life balance, had been agreed with the nursing staff. All the nurses we met said this was an effective system which meant the critical care department rarely needed to use agency staff. There was a stable bank staff cohort of around seven nurses, which meant that when bank shifts were necessary, these were fulfilled by regular, experienced staff.
- Patient care was not compromised by high levels of bank of agency staff. The Core Standards for Intensive Care Units recommended there was never more than 20% of any shift staffed by agency or bank staff workers. The use of agency or bank staff rarely exceeded 2%, and between June 2013 and November 2014 had been 1% on average.
- Senior nursing staff were not counted in the staffing numbers (they were supernumerary) in order for them to manage the nursing teams. The Core Standards for Intensive Care Units recommend that a supernumerary clinical coordinator is on duty at all times for a unit of this size. The staff rotas demonstrated there was at least one band 7 supernumerary nurse on duty at all times.

Medical staffing

- The experienced consultant presence on the unit followed the recommendations of the Core Standards for Intensive Care Units. There were eight consultant intensivists (consultants trained in advanced critical care medicine) working in rotation in critical care and on call. There was a good consultant-to-patient ratio. A consultant was on duty or on call across the general ICU/HDU unit for a maximum of 13 beds, although the average number of beds was closer to 10. This was better than the core standards' recommended ratio of one consultant to a maximum of 15 beds. The cover extended to the nurse-led surgical HDU, and the department ensured that the consultant/doctor cover was risk-based to ensure a safe level of care. To this end, the consultants were accompanied by two trainee or staff grade doctors during the day shifts.
- There was a good commitment of consultant time on the unit. The eight consultant intensivists worked 45% of their time in critical care and 55% as anaesthetists. The core standards require consultants to have a minimum of 15 programmed activities of consultant time committed to critical care each week, and this was met or exceeded. There had been no requirement to use a locum doctor in the unit for at least 10 years.
- There was full coverage from consultants. They were on duty from 8am to 6pm or later to complete the evening ward round, then on call at home in the evening. Consultants regularly attended the units out of hours (around two or three times a week was usual) and frequently took calls from staff. This arrangement was in place seven days a week, with no difference in the level of cover at weekends. When consultants were on duty or on call, this was only for critical care and not extended elsewhere in the hospital. A doctor was on duty in critical care overnight – usually an anaesthetist trainee or experienced staff grade doctor. The minimum amount of experience required for the trainee was six months on the anaesthetic rota before working in critical care. In practice, the doctor on duty had a much higher degree of experience. Also, the medical rotas were organised in advance to ensure there was always a registrar or airway supervisor on duty with any less experienced staff. On our visits, including the unannounced visit, there was a safe level of medical staff.

Allied healthcare professional staffing

- There was dedicated pharmacy support which, depending upon the acuity of patients, met the recommendations of the Core Standards for Intensive Care Units.

- There was dedicated physiotherapy support, but this did not meet the recommendations of the Intensive Care Core Standards. Departments were recommended to have one physiotherapist for every four beds. If the surgical high dependency unit (HDU) had four patients (that is, it was full) and the general unit had eight or more patients, the department would need at least three physiotherapists; in practice, there were only two on duty. Most of the clinical staff we spoke with said the crucial work of the physiotherapists was stretched by their availability. This had been raised at the clinical governance meeting in October 2014 and remained an open item.
- Other allied health professional staff visited when needed. An occupational therapist and speech and language therapist were available for advice and support upon request, and the speech and language therapist visited regularly.

Major incident awareness and training

- The trust had a major incident response plan which staff were aware of. The latest version had been released in June 2014 and reviewed in January 2015. The plan referred to action cards for each department which were available in the major incident file and written for individual members of the leadership team. The plan was available to all staff on the trust's intranet. A simulation exercise in disaster medicine was planned for late April 2015 with Public Health England. This would involve the department, including two doctors and four nurses, and its role in a simulated major public incident.
- Contingency plans were developed by critical care staff at local level. There was a plan, for example, for how to respond in the department to a full power failure, loss of refrigeration for medicines, loss of vacuum suction, loss of medical gases and loss of the water supply. These plans told staff what to do in the event of these situations and who to contact for urgent support.

Are critical care services effective?

Outstanding ☆

We judged the effectiveness of the critical care service as outstanding. Treatment by all staff, including therapists, doctors and nurses, was delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Innovation, high performance and the highest quality care were encouraged and acknowledged. All staff were engaged in monitoring and improving outcomes for patients. They achieved consistently good results with patients who were critically ill and with complex problems and multiple needs.

Staff skills were continually examined, and competence and knowledge recognised as being integral to ensuring high quality care. Staff were proactively supported to obtain new skills and share best practice. Trainee doctors were exceptionally well supported, and a number had changed their career path in order to take up a career in intensive care medicine and anaesthetics. The nursing staff were supported by strong and professional teaching and training. All nursing staff were trained or being trained in post-registration qualifications in critical care nursing. The whole service had a collaborative approach with a multidisciplinary attitude to patient care. All staff were treated with respect and their views and opinions heard and valued.

Consent practices were embedded in the care and treatment provided to patients. Staff spoke of always acting in the best interests of patients while protecting and supporting their rights. There was individualised care and support provided to both patients and those close to them. Patients and families understood what was happening and were fully involved in decisions and plans of care.

Evidence-based care and treatment

- The relevant guidance from professional bodies was incorporated into policies and followed in practice. For example, the policy for how to respond to a deteriorating patient was based on the guidance of the Royal College of Physicians (July 2012), National Institute for Health and Care Excellence (NICE) guidance 50: Acutely ill patients in hospital, and guidance from the NHS Litigation Authority.
- Gloucestershire Royal Hospital had a policy for responding to acutely ill patients in ward environments. The policy was based upon national guidelines and developed as recommended by the Royal College of

Physicians to standardise the assessment of the severity of acute illness in the NHS. The basis of the policy was completion of the patient National Early Warning Score (NEWS) by ward/unit staff. Outreach nurses said the policy was followed in practice by ward staff, and critical care was informed of patients who triggered a risk. Nursing staff said the NEWS result would be overridden if there was clear evidence the patient was very unwell, but the NEWS result did not necessarily trigger action.

- The consultant team members were trained in advanced investigative practices. Patients in critical care were enabled to be moved to the imaging department to have magnetic resonance imaging (MRI) scans within the hospital, with all appropriate portable supportive equipment taken with them. There were also four consultants trained in echocardiography scans, enabling both thorax and heart scans to be undertaken at the patient's bedside. The scans could be videoed and reviewed also by the consultants with echocardiography technicians.
- The physiotherapy team followed a programme of evidence-based treatment. Patients were assessed in terms of their physical and non-physical presentations. They were scored against assessment criteria which, depending upon the score determined, led to a treatment pathway being commenced. Patients were given physiotherapy 'rehabilitation prescriptions' which would leave critical care with the patient when they were discharged. They were designed to ensure that physiotherapy continued if the patient went onto the ward, to community settings or home.
- The unit followed NHS guidance when monitoring sedated patients. Each patient who was sedated was subject to a 'sedation hold' each day using the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the doctor or nurse discontinuing the sedation infusion and monitoring the patient's response. Sedation was then continued or adjusted depending on how the patient reacted to the change. The results were recorded in the patients' notes and on the daily care record used for each patient.
- The average length of stay on the unit was lower (better) than the national average. It is recognised as suboptimal in social and psychological terms for patients to remain in critical care for longer than necessary. Length of stay was measured by the Intensive Care National Audit and Research Centre (ICNARC) (an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally). The average length of stay was lower for all types of admission (that is, ventilated patients, patients admitted with severe sepsis, emergency surgical admission patients, and patients admitted with trauma, perforation or rupture), with the exception of elective surgical patients, where the length of stay was just above the national average. The mean length of stay for all admissions was 3.7 days, compared with the national mean of just over four days.
- Patients admitted to the unit were formally assessed for delirium. The Faculty of Intensive Care Medicine Core Standards recommended that all patients were screened for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM – ICU). Clinical staff recognised the need for delirium screening, as the condition was often one of the first indicators of a patient's health deteriorating.
- The nursing staff followed national guidance for oral care. The unit used the Adapted Halstead Oral Assessment Tool for the 'awake' patient to determine how oral care should be provided. There was also a protocol to follow based upon the use of chlorhexidine gel (a chemical antiseptic) and how, when and when not to use it.
- The unit participated in and led on organ-donation work for the trust. The trust had a clinical lead for organ donation and was supported by a specialist nurse for organ donation. The trust was part of the UK national organ donation programme and followed NICE guideline CG135: Organ donation for transplantation. We were given up-to-date data for the period from 1 April 2014 to 18 March 2015, which showed rates of donation were small but were increasing. There had been 23 patients in critical care eligible for organ donation during this period. Of these, 14 families were approached to discuss donation. Eleven of these families (79%) were approached with the involvement of the specialist nurse, against a national average of 78%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved in discussions with the family. Six patients went on to be organ donors, and 13 organs were retrieved for donation

and transplanted to 13 people. These patients included one heart donor. The specialist nurse for organ donation commented upon the strong support for organ donation from the department and the trust.

Pain relief

- Pain relief was well managed. Patients we were able to speak with said they had been asked regularly by staff whether they were in any pain. Nursing staff said, and we observed, that patients who were awake were regularly checked for pain. Observations were recorded each hour and formal assessments at least every four hours.
- Pain was managed with different protocols depending upon the patient's treatment. For example, patients who were postoperative might have epidural pain management, which was managed by a tailored assessment. Patients might also have a 'pain buster', which was local anaesthetic continuous wound infiltration managed via a catheter. All of these procedures were known and understood by the medical and nursing teams, who showed a clear knowledge of how they managed them.
- There was a hospital-wide acute pain service. The pain team worked with patients throughout their hospital treatment. Patients were identified by the pain team in the post-anaesthetic recovery unit, and followed through into critical care and when they were discharged to the ward. Staff in critical care said they had an excellent relationship with and support from the pain team, who were available during normal working hours for advice and guidance. Out of hours, the anaesthetists would provide specialist pain advice and treatment.
- Pain was checked and recorded with appropriate frequency. We checked a number of patients' charts to find them fully complete. There were individual charted assessments of pain for certain situations. This included epidural management, patient-controlled analgesia and different infusions in use. There was a pain management chart for the 'awake' patient who was able to articulate their pain as opposed to the unconscious patient. The Abbey Pain Scale was used for patients with cognitive impairment. This enabled the nursing team to assess pain for people with dementia who were not able to verbalise, and score it by observations of the patient and their different behaviours.
- Pain assessment charts, along with other important metrics, were sent with the patients' records when they were discharged to a ward. Along with this were transcriptions of the patient's vital signs (based on the NEWS results) from the intensive care observation charts, so ward staff had all the appropriate information.

Equipment

- Advanced scanning was available to enable patients to be examined without transfer to another site. The hospital had recently installed a new magnetic resonance imaging (MRI) scanner capable of imaging intensive care patients with all their support equipment. This service had been effectively planned for by the department, ensuring it had obtained a ventilator suitable for use with an MRI scanner. The ability to scan locally enabled advanced examination to be carried out whereas, in the past, there would need to be a careful risk assessment weighing up the risks and benefits of moving a patient to another hospital for imaging tests. Four members of the department were now trained to perform the scans and monitor the patient during the procedure, and others were scheduled to be trained soon by one of the experienced consultants.

Nutrition and hydration

- Patient nutrition and hydration needs were assessed, and the provision was effective. The patients' records we reviewed in the general intensive care unit (ICU)/high dependency unit HDU were well completed, and safe protocols were followed. Fluid intake and output were measured, recorded and analysed for the appropriate balance, and any adjustments necessary were recorded and delivered. The method of nutritional intake was recorded and evaluated each day. A rolling audit over the last three years showed that appropriate enteral feeding was undertaken. The malnutrition universal screening tool (MUST) was used for all patients. Nutrition and hydration regimes were designed to meet patients' needs and reflect individualised care. Checks were carried out for nutrition and hydration as part of the critical care unit's daily record.

Critical care

- The units had support for specialist feeding plans. A dedicated dietician attended the units on weekdays to support patients with nasogastric tubes, total parenteral nutrition feeding (nutrients supplied intravenously through a central line), and percutaneous endoscopic gastronomy feeds. There were dietician-designed and approved protocols for nursing staff to commence enteral feeding at weekends. Nutrition care plans were drawn up for all patients to identify patients who needed supplements. Energy drinks and food supplements were prescribed and used for patients who needed them.
- For patients able to take their own fluids, particularly in the HDU, drinks were available on bedside tables and within reach of patients. Unconscious patients had their circulatory fluid volumes continuously monitored by nursing staff through central venous pressure lines.

Patient outcomes

- The unit produced data to determine patient outcomes against recognised national indicators. It demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards. This participation provided the unit with data benchmarked against other units in the programme (95% of NHS hospitals) and units similar in size and case mix. The data returned was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to be identified from the results.
- Very few transfers were made to other critical care units for non-clinical reasons, such as a bed not being available at the right time. There had been none from March until November 2014.
- Mortality levels on the unit were better than the national average. For the general ICU/HDU (the surgical HDU was not opened when the latest data was produced), expected death-rate ratios fluctuated, but over time were at anticipated levels. The latest ICNARC Case Mix Programme data for the ICU covered 1 July to 30 September 2014 and was for 198 patients. Unit mortality ratios in the most recent reporting period were below (better than) expected levels. Post-unit hospital deaths were at much the same levels as in similar units, at around 5%. These were patients who died before ultimate discharge from hospital, excluding those discharged for palliative care.
- Patients were not discharged prematurely. There was a low ratio of patients needing readmission to the unit. The early readmissions to the unit (those readmitted within 48 hours of discharge) for the latest ICNARC period were around 1% (two patients) against a national average of around 2%. Late readmissions (those readmitted later than 48 hours following discharge, but within the same hospital stay) were around 5% (seven patients), which was just above the national average of 4%. However, those patients readmitted were readmitted for a new condition.
- Patients being admitted or discharged from critical care were carefully managed. There was a policy for patients being discharged onto wards with tracheostomies to ensure that they were only placed on wards where staff had the skills to deal with these patients. This policy had been adopted following a serious incident on a ward and learning from an investigation into what improvements could be made. There was seven-day input from the mental health team for safe discharges of patients where risks of possible self-harm had been identified. Any patients admitted to the hospital from a local specialist neurological rehabilitation hospital who had a tracheostomy were admitted only to critical care. Their physician or surgeon was aware of this and would support them on the unit. Admissions to the unit could only be approved by a consultant under clear criteria and either from a direct or telephone consultation.
- Local audit work to reflect national guidance was regularly undertaken. A calendar of audits were planned for 2014/15, which were assigned to a clinical lead. Audits were used to judge quality and effectiveness of care and treatment or demonstrate continuous improvement. The majority of audits were done monthly and included recognised outcomes. These included the incidence of ventilator-associated pneumonia, incidence of central venous catheter infection, incidence of Clostridium difficile infections and MRSA, and percutaneous tracheostomy audits. Any shortcomings were then followed up by being raised at monthly clinical meetings, and actions agreed.

Re-audits were undertaken to improve patient outcomes and the unit's performance. Results were all at the high end of the scale – showing a high compliance with good outcomes.

- Patients' needs and treatments were assessed and monitored for good outcomes. Patients' records documented all results and highlighted any abnormalities or anomalies. Where any existed, there was a clear written plan of action with an alternative if the patient did not respond as expected.
- The unit had a physiotherapy-led ventilator weaning programme in place. This was a multidisciplinary approach where evidence from national guidance meant care delivered was more effective and could reduce the length of stay for ventilated patients. Intensive Care National Audit and Research Centre (ICNARC) data showed the length of stay for ventilated admissions was mostly below the NHS national average over the last five years.
- The department contributed to national programmes and reviews, such as the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), On the Right Trach: A review of the care received by patients who underwent a tracheostomy (2014). The unit had carried out a self-assessment from the national recommendations of the audit. The critical care department had complied almost fully with all recommendations. There was partial compliance with the involvement of speech and language therapists to assist with high quality communication strategies. This had led to a multidisciplinary team meeting and work ongoing to complete a 'swallow assessment tool' for all critical care patients.
- The unit had been part of the National Cardiac Arrest Audit. We reviewed the reports for the period 1 April 2013 to 31 March 2014 and 1 April to 31 December 2014. In both reports, the ratio of observed to predicted survival was above 1. This meant more patients survived a cardiac arrest than predicted.

Competent staff

- There was a strong commitment to training and education within critical care. The service had a clinical nurse educator with extensive experience in critical care. There was a programme of training and education and comprehensive workbooks and portfolios for nursing staff to complete. The induction for newly qualified nurses or nurses joining to train in critical care was for one year. The clinical nurse educator worked alongside trainee doctors and new nurses or those requiring identified or requested education or development. Training programmes included opportunities for band 5 nurses to train for the clinical coordinator's role. There was an extensive workbook for all staff to complete in relation to clinical and equipment competencies. These were checked and countersigned by the supervisor or mentor when staff had achieved competence.
- There was an experienced nursing team, in line with the Core Standards for Intensive Care Units. More than 50% of nurses had a post-registration qualification in critical care nursing. Funds received from organ donation work were used within the department to train band 5 nurses to achieve band 6 status.
- New starters had a full induction to critical care. Study days were organised each week and run by the clinical nurse educator with input from other experienced staff. Subjects covered all those areas relevant to critical care, such as assessment of critically ill patients, airway management, tracheostomy management, invasive and non-invasive ventilation, and patient diaries. There was a mannequin in the department, used for staff training. Study days included testing different patient scenarios, and examinations of competence. New staff, even if experienced, were supernumerary for two weeks, or longer if this was deemed necessary.
- Medical staff were evaluated for their competence. The consultants we met said the revalidation programme was well underway. This was a recent initiative of the General Medical Council, where all UK licenced doctors are required to demonstrate they are up to date and fit to practise. Doctors participate in a robust annual appraisal leading to revalidation by the GMC every five years. Appraisals of medical staff were carried out each year, and evidence demonstrated they were up to date.
- Appraisals for non-medical staff (medical staff were part of the revalidation programme) were meeting the trust's targets. Records for nursing staff across both hospitals for January 2015 showed 88% of the staff had been appraised. There were 13 of the 136 staff due for an appraisal, although almost all of these had fallen due in December 2014 and January 2015. This had dropped back from 94% in the previous two months. All staff

knew who was responsible for their appraisal, and this was recorded in the electronic staff system. Reports could be produced at any time, and these included a list of all staff who were falling due for appraisal in the next two months. All the staff we talked with said they had been appraised in the last year, and the process was respected and taken seriously.

- There was excellent support for trainee doctors. There was an extensive guide written by one of the intensivists on all aspects of working in critical care. Each trainee was evaluated for their competence and not signed off until this was demonstrated. There were two trainee doctors on rotation in the department, working on day shifts. We observed good training and education at the ward round. The trainee staff we observed came across as confident and were encouraged to ask questions and look for guidance. The trainees we spoke with said the department had a high reputation for excellence in teaching and practice. In accordance with the Core Standards for Intensive Care Units no foundation year one (FY1) doctor was left in charge of the department. In this department, no foundation-year doctor worked out of hours. The local training panel of the Postgraduate Medical Education School of Acute Care (part of Health Education South West) had rated the training in the trust's critical care departments (including that at Cheltenham General Hospital) as A – excellent. This was based on comments from trainee doctors, such as, "busy job but well supported", "excellent post, good rotas", and "excellent training opportunities".

Multidisciplinary working

- There was strong and cohesive collaborative working by all staff contributing to the units. We observed a common sense of purpose among staff from all disciplines. Staff genuinely and proactively supported one another, with a focus on improving patient care. We observed no obstructive hierarchical structure, and all staff were valued for their input and roles. Staff who were visiting the unit to review patients who, for example, were postoperative, or who came to perform tests or take patients for tests, knew who to speak with or ask for. Visiting consultants were proactive when calling into the unit for advice about a patient or to review a patient they had discharged into the care of the unit. The consultants spoke specifically about excellent support from surgeons, consultant neurologists and cardiologists visiting patients on the surgical high dependency unit (HDU).
- There was active input from the rehabilitation team. Each patient coming onto the unit was assessed with a short assessment scoring tool used to address immediate needs. There was a daily round for each patient, which included reviews of ventilation, mobility, nutrition and communication. The physiotherapist-led rehabilitation ward round had multidisciplinary team input. This took place each week, and all staff involved were aware of the need to attend. This included the senior nurse, senior physiotherapist and a consultant or nominated doctor. We saw comprehensive notes from these rounds, which included a focus on moving the patient forward and goal setting.
- There was appropriate support from the microbiologists (healthcare scientists concerned with infection prevention and management). They visited the unit three times a week and undertook a round with the consultant intensivist and other staff as required.
- There was a close working relationship with the hospital paediatric team. The critical care team met every three months with paediatric consultants to review any cases where children had been admitted to critical care for emergency care or prior to retrieval to a paediatric intensive care unit. The meetings were attended also by a paediatrician from the admitting paediatric intensive care unit. The meetings could be held more frequently should the number of new paediatric patients increase. Any nurses involved with the case, or any with a special interest, were able to join this meeting. Any doctor or nurse treating a child admitted to critical care would be able to contact and obtain specialist advice from a local paediatric intensive care unit.

Seven-day services

- There was good cover from the consultant intensivist team out of hours. Consultants all lived within a 30-minute journey of the unit when they were at home but on call.
- There was good cover from the allied health professionals across the whole week. Physiotherapists

were on call when not present on the unit. Pharmacists provided a full service during the week and on Saturday and Sunday mornings. They were also on call at other times for any urgent prescriptions or discussions.

- Examination services were available during the week. This included x-rays, computerised tomography (CT) or computerised axial tomography (CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, and echocardiograms (ultrasound heart scans).

Access to information

- Patients' records were usually available in good time. Staff said records were provided relatively quickly for emergency admissions (all patients' records were on paper). We requested the patient records for a patient discharged during the previous week and another discharged around four months previously. All these records were found quickly and efficiently.
- Test results were provided in good time. Staff said the service was usually excellent. During our observation of a ward round, results for the patients were all available and discussed appropriately.
- There was good handover information when patients were discharged from critical care. There was a comprehensive proforma handover document with appropriate information, risks and care planning to be documented. Those we saw completed in patients' notes were done well. We saw from an investigation report that where handover information provided to the critical care department from one of the wards had been inadequate, this has been raised and addressed with the ward concerned.

Consent and Mental Capacity Act

- Patients gave their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness or when the emergency situation had been controlled. We saw good recording of consent, where patients were able to provide it, in patients' records.
- Patients were assessed in line with the Mental Capacity Act 2005. Care and treatment for patients who could not give valid informed consent was given in their best interests and protecting their rights. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration, and performing tests, were made in patients' best interests by the medical and nursing teams. If decisions on more fundamental issues were needed, staff would hold best interest discussions in line with the provisions of the Mental Capacity Act 2005. These involved those people who could speak for the patient to hear and discuss all the views and opinions on the treatment options. Staff said they had access to independent mental capacity advocates should there be no one to speak independently of the department on behalf of the patient. Such discussions were documented in the patients' notes reviewed.
- Staff used the guidance of the Mental Capacity Act 2005 when assessing whether a patient was being or could be deprived of their liberty. There was a flowchart for deciding whether a deprivation of liberty might be taking place. This followed the provisions of the Mental Capacity Act 2005 as it related to decision making and capacity to consent. The Deprivation of Liberty Safeguards were, like with many other critical care departments in the NHS, under review at the time of our visit, and new guidance was awaited from the Faculty of Intensive Care Medicine.
- Decisions about giving resuscitation to a patient who was assessed as at risk from cardiac or respiratory arrest were well documented. We saw an example of the record of a decision to not commence resuscitation, and this had been discussed with and communicated to the patient's relatives, and the conversation documented. The reasons for the realistic success of resuscitation were clearly recorded. Doctors we spoke with knew how the discussions should be held and how they should be recorded, and ensured that all relevant staff were aware when a decision had been taken.
- The unit had aids to protect patients if restraint was needed. There were mittens for use as a last resort when a patient was known to be or assessed as at risk of pulling out their medical devices such as tubes and lines. Any use of mittens was discussed with the patient's relatives where possible and only done in the best interests of the patient. There was a multidisciplinary clinical discussion taken and use of the

mittens recorded in the patients' notes. A risk assessment was undertaken for the patient following any use of restraint of any type. This risk assessment accompanied the patient throughout their stay in the hospital (if they were discharged to another ward) to enable all staff to know about risks already identified.

Are critical care services caring?

Outstanding ☆

We judged the caring given to patients by the critical care team as outstanding. Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Staff went above and beyond their usual duties to ensure that patients experienced compassionate care and that care promoted dignity. Staff got to know patients and built relationships with those who stayed for short or long periods and with the families and those close to them.

People's cultural and religious, social and personal needs were respected. Staff described how they would think before they performed any action about whether this was right for the patient. This was particularly so with patients who were at the end of their life or had passed away. There was a bereavement team and advice and guidance for staff to provide appropriate and sensitive care. Innovative support for patients, such as through the development of patient diaries, was encouraged and valued.

Compassionate care

- Patients and relatives we met spoke highly of the service they received. Because of the nature of critical care units, we often cannot talk to as many patients as we might in other settings. However, the three patients we were able to speak with said staff were kind, thoughtful and caring. One patient, who had been on the unit for a relatively long stay, said they "cannot speak highly enough of them". Consultants, doctors and nurses were said to be respectful and compassionate. Cards and comments displayed on the unit and in the visitors' book, without exception, expressed thanks to staff for the care and kindness to the patient or their family and friends.
- We observed excellent attention from all staff to patients' privacy and dignity. We saw curtains drawn around patients and doors or blinds closed in private rooms, when necessary, and voices lowered to avoid confidential or private information being overheard. The nature of risk and ensuring patient safety in critical care units meant there was often reduced opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to considering privacy and dignity and also with respect for other cultural or religious needs. If available, one of the side rooms in the general intensive care unit (ICU)/high dependency unit (HDU) would be used for a child or if a patient was at the end of their life and safe to be moved to a side room.
- The unit was sensitive to patients' needs. A long-stay patient said staff knew they liked having their hair washed, and this was done regularly. They also enjoyed certain programmes on television, and staff made sure they were able to watch them. They patient told us staff always made sure they were comfortable and warm and checked whether they needed anything.
- Visiting times were flexible, but prioritised the needs of the patient while being supportive to relatives. There were no set visiting hours, but visitors were encouraged to visit from mid-afternoon if possible and refrain from visiting between 1pm and 3pm to allow patients to rest. There was limited space in the units, and visitors were asked to restrict numbers where possible, as too many visitors had been recognised as tiring for patients in critical care. However, staff said they would accommodate visitors as much as possible at all times, and those visitors we met agreed that this happened. Visitors said staff had indicated when they needed to support the patient, and visitors had been asked to step outside for a short time. Visitors said the staff explained why this was necessary. We saw a number of different staff asking whether visitors who were in the waiting area were okay and making sure they knew they could make themselves a drink if they wanted to.
- Care from the nursing staff, medical staff and allied health professionals such as physiotherapists and dieticians was delivered with kindness, patience and warmth. Nurses talked quietly with patients and reassured them continually. We saw them holding the hands of patients while they spoke with them. The

atmosphere was calm and professional, without losing warmth and reassurance for everyone concerned. All staff introduced themselves to patients and their visitors. Nurses were observed talking to patients and explaining what care they were delivering, even if the patient was not conscious. Staff said it had been recognised that patients might well be able to hear conversations or pick up words or even atmospheres, even when minimally conscious. Staff kept this in mind, particularly with difficult conversations with relatives and friends, and these took place where possible away from the patient's bedside.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing and encouraged to ask questions and have things explained things in their own words. They were told about any tests or examinations being arranged, how long they were expected to be staying on the unit, and the treatment provided or planned. One of the patients said they knew and fully understood the plans made for them and expectations about their treatment. They said, "I feel safe here." We observed staff giving good explanations to patients of what was happening around both small and bigger things.
- Staff, including the approachable, friendly and helpful ward clerk, made sure visitors were identified, and only gave information to them if they were entitled to have it or the patient was able to give permission.
- Friends and relatives of patients were kept informed and involved with decisions when appropriate. Relatives and friends we met said they were updated about the patient on each visit to the unit, and staff always greeted them and asked how they were. They said they were able to ask questions and could telephone the unit when they were anxious or wanted an update. Staff said they were aware the unit could be overwhelming for visitors, and therefore would give information as sensitively as possible. A doctor and a nurse mentioned how they would look for signs of anxiety or distress when delivering difficult news to relatives and friends and make sure the person was supported.
- Patients and relatives were enabled to communicate. There were communication boards so patients with tracheostomies could write words either in pen or with magnetic letters. One member of the nursing team supported a patient to communicate with us using this method.
- Patients and relatives said staff asked appropriate questions about the patient to get to know them. This included, for example, what the patient wanted to be called, whether they had any specific interests, and what foods and drinks they preferred. We saw this reflected in patients' notes. This involvement extended to the patients who had no other visitors apart from their neighbours. Staff showed gratitude to the neighbours for visiting, and asked them for any information they felt might help the staff provide support to the patients. Staff had taken time to explain to the visitors what was happening with the patients, reassure them, and ask their advice in any appropriate matters.
- Relatives were approached with compassion when a patient was a possible eligible organ donor. We met the specialist nurse for organ donation and were impressed with their knowledge, experience and genuinely warm character.

Emotional support

- Psychological support was available from within the hospital. Staff from that service would visit patients if requested by the clinical staff, the patient or a relative. There was also support from the chaplaincy and a team of spiritual advisors who were on call at all times. The matron said the unit would bring in support from anywhere if they thought it would benefit the patient or their relatives. This included spiritual or other support from the patient's own local connections and networks.
- There were formal assessments for patient depression and delirium screening. Research has shown that patients might get depressed or anxious or have other mental health issues for which they might need additional support following long stays in intensive care units (ICUs).
- Patients had support from nurses with additional knowledge. There were nurses with link roles in matters relating to mental health, learning disabilities and dementia. The staff told us they all understood how

being admitted to a critical care unit could often provoke anxiety in patients without any mental impairment, so it was likely to be even more difficult for patients with mental health needs. Nursing staff said carers, families and care workers were encouraged to come to the unit to provide emotional support, and were helped to overcome any of their own anxieties so they could provide comfort to confused, scared or disorientated patients.

- The department was using some of the latest innovative ideas for patient support. Patient diaries were in use and had been developed through a multidisciplinary review led by one of the consultants in intensive care. A report from the review by the critical care team around the use of the diaries highlighted how research has shown that patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Patient diaries were introduced to provide comfort to patients and their relatives both during the stay and post discharge. Diaries were said to not only "fill the memory gap, but also provide a caring intervention, which can promote holistic nursing". There was criteria for the use of patient diaries, advice for staff on the format to use, and encouragement to friends and relatives to make entries. Photographs were also known to help patients, and these could be used with appropriate consent. If the diaries were not passed to the patient or relatives (for any of a number of reasons), they would be kept secure for six months so either the patients or relatives could see them if they wished.
- The department had a strong focus upon bereavement and care in the last days of life. There was a link nurse for bereavement and a bereavement team within the department. The trust had produced a care plan to be used in the specific circumstances of a patient approaching death. The bereavement team had specific responsibilities and would speak as often as possible to the relatives and friends of a patient who had died. Relatives were given a card when they left the department saying someone from the team would call them in six to eight weeks to provide support for any questions that had not been asked or comments that were unsaid. A remembrance card was also sent to the family a year after the death of a patient within critical care. We saw two patients' records where all the communications with the families about bereavement were recorded and follow-up information was recorded.

Are critical care services responsive?

Good

The critical care service responded well to patients' needs. There were bed pressures in the rest of the hospital that sometimes meant patients were delayed in their discharge from the unit, but incidences were only just above the NHS national average for similar units. Some patients were discharged onto wards at night, when this was recognised as less than optimal for patient wellbeing, but the rate was the same as the NHS national average rate. There was a very low rate of elective surgical operations being cancelled because a critical care bed was not available.

The facilities in critical care were excellent for patients, visitors and staff, and met all of the modern critical care building standards. The trust had responded to the need to improve patient flow by opening a new surgical high dependency unit with four new beds (and expansion capability to six beds) in January 2015.

There was a good response from consultants and nurses when new patients were admitted. All patients were seen by a consultant within 12 hours of admission. Patients were treated as individuals, and there were strong link nurse roles for all aspects of patient need, including learning disabilities, dementia and mental health.

There were no barriers to people who wanted to complain. There were, however, few complaints made to the department. Those that had been made were fully investigated and responded to with compassion and in a timely way. Improvements and learning were evident from any complaints or incidents.

Service planning and delivery to meet the needs of local people

- As with all critical care units, the occupation of the beds fluctuated over time. However, there had been an increase to the higher levels of bed occupancy in recent years. The trust had responded to this identified growing need for bed capacity by opening the new

surgical high dependency unit (HDU). This unit was designed for a short stay for postoperative patients who needed HDU care and observations. Patients would benefit from dedicated targeted care, in terms of recovery and reduced length of stay.

- There was a good response from consultants when new patients were admitted. The shift patterns were established so all patients were seen by a consultant intensivist within 12 hours of admission.
- The environments in the general and surgical HDU were designed to meet patients' and visitors' needs. As recommended by the Department of Health, there were separate entrances for visitors and patients. There was an intercom and CCTV at the main entrance. Staff were able to see patients in the open bed space areas, and patients in the side rooms in the general ICU/HDU were supported by and visible to staff working in the immediate area. Side rooms were, as recommended, square or rectangular, and not L-shaped, where visibility could be reduced. When we visited the unit, the air temperature was comfortable. In the general intensive care unit (ICU)/HDU, the bed spaces and side rooms were of a good size, and each had lockable storage for a patient's medicines and valuables. There were work surfaces and chart stands for staff to use, and each bed space was fully screenable from the next.
- Patients' and relatives' facilities were good. There was a large relatives'/visitors' waiting room with plenty of comfortable chairs, kitchen facilities and information about the unit. There were toilet facilities for visitors close to the waiting area. There was a second small room with chairs and a sofa bed, in which one person could stay overnight, and another bedroom on the floor above for visitors to stay. There were rooms for more private conversations with visitors. All areas were suitable for people using wheelchairs or other aids for disabilities.
- There were good facilities for staff to work and rest. There were staff offices and changing rooms. Senior staff shared offices, but said there was always somewhere available for private conversations.
- The hospital had the ability to temporarily increase its capacity to care for critically ill patients in a major incident, such as a pandemic flu crisis or serious public incident. This would involve using the recovery unit in theatre, where staff were trained in caring for critically ill patients and would be supported by the critical care team.
- There was a range of booklets and information for both patients and families. This included leaflets that could be given to visitors and information on the trust's website. The leaflets were designed by the unit and explained aspects of the environment and specific treatments, such as use of a tracheostomy, intravenous cannulas, and information on preventing blood clots (venous thromboembolism) and pressure ulcers. There was a helpful booklet designed for patients about leaving hospital. It included advice on how to remain hydrated and nourished. Information extended to explaining how sleep patterns might change, and possible mood swings. There was a contact number for the unit, and patients were encouraged to remain in touch. There was also a list of support groups, their contact details and website addresses. There was, however, no reference within the leaflets to how to obtain the information in another language or format.

Meeting people's individual needs

- Patients were treated as individuals. There were telephone translation services for both patients and relatives where English was not spoken or not easily understood. There were communication boards on which patients with tracheostomies could write messages or point at symbols and images. Staff spoke about equality and diversity and had knowledge of different cultural and religious needs. In each conversation with staff they spoke about treating patients as individuals and wanting the best outcomes for patients, including respecting their individuality.
- To meet individual needs, the unit had a wide range of nurses with link roles. At least 15 link roles were identified in the unit. They included nurses leading on such subjects as tissue viability, infection control, nutrition, pain management, and patients with learning disabilities, among others.
- Patients with a learning disability were supported by trained and experienced staff. There was a link nurse with a special interest in people with a learning disability. They were part of the hospital-wide team directed by the lead for supporting patients with a

learning disability. The trust had developed a resource for staff for caring for and supporting patients with a learning disability. This covered areas such as mental capacity, behaviours that challenge, and guidance about behavioural strategies. There was a guide with the 'top 10 tips for consultation for people with a learning disability'. The speech and language team had provided guidance about swallowing and safe nutrition regimes. There was also information on communication and discharge arrangements. Patients who came to the hospital from a community care setting were asked to bring or produce a 'hospital passport'. This is a recognised document used for people who live with a learning disability, so staff are able to know as much about them as possible should they have difficulty with communication.

- People with a dementia were given additional support using national guidance. A specific care plan was designed for the patient experiencing memory loss and disorientation and known to have dementia. The care plan referenced the Department of Health National Dementia Strategy 2009 and Mental Capacity Act 2005. Patients were to be assessed for memory loss, orientation and comprehension. The mental health liaison team was highlighted as a source of additional support for staff. If it had not already been done, carers were asked to complete the 'this is me' document, which would be used to plan patient care against specific needs or characteristics.
- There was natural light from the windows, but not all patients were able to see a clock. It is well recognised in critical care units that patients can become disorientated, particularly around day and night. There were no 24-hour clocks on the unit, and although most patients could see a clock, it had not been checked whether all patients could, and the clocks were obscured for some of the bed spaces.
- Patients' rights were observed. Where possible in the circumstances, there was fast-tracking for patients who were deemed to be at the end of their life and wanted to go home to die.
- At the time of our inspection, there was no critical care follow-up clinic. These sessions were a part of National Institute for Health and Care Excellence (NICE) guidance for rehabilitation after a critical illness, but were recognised as taking time to arrange and hold, and with only limited uptake from patients. As part of its future strategy, the department was looking at holding telephone follow-up consultations with patients around two to three months post discharge.

Access and flow

- The discharge of patients from critical care was mostly achieved at the right time for the patient. Studies have shown discharge at night can increase the risk of mortality, disorientate and cause stress to patients, and be detrimental to the handover of the patient. Intensive Care National Audit and Research Centre (ICNARC) data (1 July to 30 September 2014) for discharges made out of hours (between 10pm and 7am) placed the unit at around the same rate as the national average for night-time discharges for similar units. Approximately 5% (10 patients) of all discharges took place at night.
- Similar to most critical care units in England, for this unit ICNARC reported a high level of delayed discharges from the unit. Over 70% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. That was just above (slightly worse than) the NHS national average. Four hours is the indicator used for comparison with other units and set by ICNARC. It is used to demonstrate the ability or otherwise to move patients out of critical care in a timely way. Although patients remained well cared for in critical care, when they were medically fit to be discharged elsewhere the unit was not the best place for them. This was recognised by staff, who were aware that the unit could also be a difficult place for visitors. The delays were, however, mostly less than 24 hours, and none were more than four days. The rate of delayed discharges had been relatively stable for the last three years.
- Patients who needed a critical care bed were rarely not accommodated. This was demonstrated by the low rate of transfers to other hospital units and low rate of early discharges, although, when unavoidable, some discharges were made at night to be able to accommodate unplanned admissions. Also, because no ward beds were available, discharges were often delayed, but no more so than in other NHS critical care units. Any patients who were waiting for a bed could be cared for in the post-anaesthetic recovery unit, where they would receive care by appropriately trained staff supported by the intensivists. The new surgical high

dependency unit (HDU) was also available to use as a step-down unit for patients no longer needing intensive care. Twice each day, the department completed a potential admissions and discharge document for the bed management team, to highlight the status of the department, although there was no face-to-face meeting with this team.

- Occupancy levels on the unit were increasing. The number of admissions to critical care had increased from around 150 each quarter in 2009, to 2012 to close to 200 in the third quarter of 2014. In the ICNARC data from 1 July to 30 September 2014, there were few patients transferred into the unit from an HDU or intensive care unit (ICU) in another hospital. This rate was below, that is better than, the national average for similar units in the third quarter of 2014. Patients had never been admitted to the unit from other units for non-clinical reasons – that is, admitted to the unit because there was no bed capacity in another hospital unit. The unit was therefore mostly managing its own patients and predictable admissions. Patients were not often transferred to other units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist care. There was one non-clinical transfer for the ICU in the latest ICNARC data period (when a bed was needed in another unit as the unit was full), which was the same as the national average.
- There was a very low rate of urgent operations being cancelled because of lack of an available bed in critical care. A significant number of cancelled operations were reported to and published by NHS England for this trust, but these had not been because of the lack of availability of a critical care bed. The last incidence of this was in August 2014. This was further demonstrated by operations being cancelled when we visited, but this was because of a lack of ward beds, as the surgical HDU had available beds. The rate of cancellations because of the lack of a bed in critical care was also lower than in NHS units of a similar bed capacity.
- There was a low rate of patients being discharged from critical care too early onto wards (that is, when they were not quite well enough) to make way for new admissions. In the ICNARC data from 1 July to 30 September 2014, the rate was just over 2%, which was just above (slightly worse than) the average for similar units and all other NHS units. However, prior to this quarter, the unit had only rarely been above the national average, and was mostly well below.

Learning from complaints and concerns

- There had been very infrequent complaints to the critical care department. Information was available in visiting areas and on the trust's website outlining how to make a complaint and how it would be dealt with. We looked at complaint, concern and compliment statistics for August 2014 to February 2015 (excluding November), and there were no complaints or concerns in this period, but 32 compliments.
- The service managed complaints well and learned from things that went wrong. We reviewed a past complaint relating to poor communication. The relative who contacted the department was given a full explanation in response to their concerns and a fulsome apology. An action plan was attached to the complaint with lessons learned from the complaint and a record of how and when these were communicated to all staff. Another past complaint was around the last offices given to a deceased patient. There had been a misunderstanding and miscommunication with the family. Again, the family had received an explanation that the deceased had been treated correctly, but this had not been properly explained to the family. There was a fulsome apology. An action plan included the revision of the bereavement procedures and updated training for nurses on policy and procedure.

Are critical care services well-led?

Outstanding ☆

We judged the leadership of the critical care service at Gloucestershire Royal Hospital as outstanding. The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with an inspiring shared purpose. There was strong evidence and data to base decisions upon and drive the service forwards from a clear, approved and accountable programme of audits. There was accountability for driving through actions and improvements.

Critical care

The unit participated in the national audit programme through the Intensive Care National Audit and Research Centre (ICNARC). Data returned by ICNARC was adjusted for patient risk factors, and the unit could benchmark itself against other similar units to judge performance.

There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and consistently high levels of constructive engagement. Staff were actively encouraged to raise concerns through an open, transparent and no-blame culture. The leadership drove continuous improvement, and staff were accountable for delivering change. Innovation and improvement were celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

Vision and strategy for this service

- The unit had a set of objectives, each with its own actions and deadline for completion. There were objectives for the team, patients, the business and the service. Patients and relatives were described as "our patients" and "our relatives". The objectives for the future included patient follow-up telephone consultations, the introduction of a neurally adjusted ventilator system with the view to being a satellite unit for the research project, improvements to the bed-booking system, and continuing to enhance professional development. All staff roles were reflected in the vision for the service.
- Through the content of the governance papers and talking with the staff, we saw that the leadership of the department reflected the requirement to deliver a safe, effective, caring and responsive service. All members of the team were encouraged to be leaders themselves and to work towards the strategy and objectives for the service.
- The service was part of the trust's five-year strategy. Plans included working towards the appointment of or training to gain advanced nurse practitioners on the team and address the potential future shortages of trainee doctors that had been recognised. The lead consultants attended the trust-wide 'futures group'. This was to ensure that the impact upon critical care of any changes proposed for the hospital was considered.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance. This demonstrated how the critical care department fed into the hospital trust structure and how assurance was made through the various committees into the divisional board and then trust board.
- Sufficient time and resources were given to governance and safety, quality and performance review. There was a dedicated consultant intensivist governance lead for the unit and a dedicated band 7 nurse for nursing governance and investigation of serious incidents. There were other staff with lead and link roles. This aspect of risk management and quality measurement was strongly promoted, and staff were enabled to suggest any aspect of care in the department for which to take a link or lead role.
- A comprehensive review of the department was held each month within the anaesthetics, critical care and pain team. There was an extensive presentation of audit and governance information. We looked at the presentation from the previous meeting and the one being prepared for the next. Information included actions from the last meeting, identifying those that could be closed or remained open. Patient experience was discussed along with any complaints, comments or concerns. The meeting then covered safety issues, audit performance, the risk register, assessments under National Institute for Health and Care Excellence (NICE) guidance, objectives and how they were progressing, business cases in development, capital requirements, and staff metrics (such as sickness, training and appraisal compliance).
- A wide-ranging set of audits and performance measures of aspects of care and safety within the unit was carried out with a high frequency and in accordance with an approved divisional audit calendar. There was a programme for standardised audits – such as ventilator-associated pneumonia incidence, or central venous catheter line checks – to demonstrate or show the need for continuous improvement. Performance data and quality management information was collated and examined by the unit to look for trends, celebrate good performance or question any poor results.
- The unit understood, recognised and reported its risks. The divisional risk register was being used to raise those identified risks and concerns relating to critical care. Staff were proactive when raising risks, and we saw that

these were monitored and actions taken to reduce them. The risks around delayed discharges had been escalated to the register, as well as the lack of a seven-day outreach service. The business case to increase the outreach team had received board approval, and staffing was being increased to provide full coverage for attending patients. Any risks scored at 15 or above were escalated to the trust's corporate risk register.

- There were extensive investigations into any serious incidents and actions taken to prevent recurrence. We reviewed three root cause analysis reports for two pressure ulcers acquired in 2014 and a serious incident involving a patient transfer. The reports had clear actions and we saw evidence of how the changes to practice that had been identified had been put in place. The reports also extended to include notable good practice found during the investigation. We also saw how a serious incident not directly involving critical care had been shared, and learning from this event had been taken on board by the department.
- The unit participated in a national database for adult critical care as recommended by the Faculty of Intensive Care Medicine Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported that the data supplied was well completed and of good quality. There was evidence from governance reports of the findings from these respected reports being presented to the executive team and divisional board to demonstrate the strong outcomes for patients therein.
- Staff were included in and informed about the running of the unit. A wide range of unit and divisional meetings were held at regular intervals. All meetings were minuted. The meetings had a range of staff input depending upon the nature of the meeting. For example, there were clinical governance meetings for the department of critical care across both hospitals. These were held each quarter. There were monthly clinical governance meetings for the department of anaesthesia, critical care and pain. Other meetings for which we saw and read minutes included: critical care departmental meetings for all nursing staff grades led by one of the sisters, band 7 nurses, band 5 nurses and healthcare assistants, cross-site band 7 nursing meetings (held quarterly), and an infection control meeting. The minutes were carefully recorded for each meeting and covered a range of subjects including clinical matters, budget discussions, staffing levels and skills, the risk register and any serious incidents arising.
- Audit information was made available at clinical governance meetings, including the mortality and morbidity meetings. This included the quality indicators from ICNARC, whether the department had met the Core Standards for Intensive Care Unit for doctor and nurse cover (it consistently had over the three years in the latest report), whether there had been structured handovers (there had), multidisciplinary rounds (there were) and appropriate isolation performed (there had been), and whether the daily goals sheet for patients was in constant use (it was).

Leadership of service

- The leadership of the service by the clinical lead consultant intensivist and the team of experienced staff was strong and committed. There was a commitment to an outstanding service and clinical governance that was delivering a consistently safe, effective, caring and responsive service. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the allied health professionals, and worked as a cohesive and collaborative team.
- The nursing leadership of the service was strong. The matron and senior nursing staff demonstrated a strong commitment to their staff, their patients and one another. They were visible on the unit and available to staff. The Matron, who was relatively new in the post and had been promoted from within the department, was respected by all the staff we met. They were described as "amazing" by one member of staff. The Matron said they were encouraged to have a strong voice and raise awareness of their unit with the nursing management. The consultants we spoke with had a high regard and respect for the Matron, the nursing team, and the allied health professionals. The nursing team was described by the lead consultant as "fantastic". All the leadership within critical care praised the support of their general manager, and the nursing team spoke highly of their relationship with the director of nursing.
- The leadership was fully supportive. We judged that the leadership of the service would defend the staff when

needed and take responsibility for any rare mistakes. The leadership ensured staff were supported at these times and took the lead on making any changes to avoid errors in future. The consultants talked of fully respecting the skills and experience of the nursing team. They looked at continually empowering the nurses to develop skills and knowledge, with close supervision, all in order to benefit safer, more effective patient care.

- The trust ran a leadership development programme called 'i-lead'. This involved all service directors (including critical care) getting together to discuss whatever they chose. In recent meetings they had been joined by some of the executive team, who had seen the value of these meetings and recognised how they could learn from them and offer support and motivation.

Culture within the service

- The team that worked in critical care had strong shared values, and there were longer-term safety, quality and performance objectives for the team. The Matron said their priorities were excellent care to patients and their relatives, a happy team with good resources and support, and an environment of which to be proud. The Matron said the general manager was aware of these priorities as were all the staff reporting to the Matron, who shared and supported the priorities. The priorities for the lead consultant were to mirror the cohesion of the nursing staff among the doctors across the two sites, maintain and allow the strong culture to flourish, respond well to the new surgical high dependency unit (HDU), and make the HDU a great success.
- There was a collaborative approach to changes and improvements. The consultant intensivists had recognised the need to use one type of ventilator for patients to improve safety and effectiveness. There had been a debate and various presentations among consultants around different options, before the group had made a decision on the equipment to move to and this had been approved by the whole team.
- Staff said they were encouraged to raise concerns and had no fear of any retribution. They said they did not feel they were or would be blamed when things went wrong, and were subsequently not discouraged from speaking up.
- A strong culture of teamwork and commitment was spoken about among staff in the critical care department. Staff spoke of being proud of their unit and the care they were able to give. Patients and relatives also commented on the positive nature of the staff they met. Staff said they felt valued, and one nurse described how they made a long car journey to work each day as it was where they wanted to be. A number of staff described the unit as a family. The matron commented on how the trust's chair had worked a clinical shift on the unit as a healthcare assistant, and on the strong impression of caring and commitment this had upon staff.
- Trainee doctors were well supported on the unit. We were told consultants were easy to contact when trainee doctors needed advice. Nurses were also supportive and helpful to trainee medical staff.
- Staff were supported at difficult times. The ward clerk described how a band 7 nurse had come to see them on the unit to offer support when there had been a sad event for the staff. Other nursing staff said their team leaders called them at home to check whether they were okay when they had worked a difficult shift or equally when something had gone particularly well. There was also a 'coaching' service for senior staff and counselling services available for all staff.

Public engagement

- Former patients were enabled to come back to the unit as part of their recovery. One former patient visited the unit each Christmas and was invited to open the new surgical HDU in January 2015. A cake with a nurse and hospital bed decoration was involved, and this was publicised in the hospital's newsletter, which was available on the trust's website.
- The unit had access to charitable funds. The unit could apply for these and had done so in the past. Funds were available for items such as education, relatives' facilities and anything relating to patient care.

Staff engagement

- Staff told us they were able to meet formally with the trust's divisional board if required or warranted. They said these meetings were well attended and they felt offered both a safe and supportive environment in

which to raise any concerns or share learning or innovation. Staff said they felt they would be listened to if they had concerns and could take these to the highest level and be heard.

- All staff felt part of the team. We spoke with two domestic workers. One said they "love working here", and the other said they "love spending time talking to patients" and "everyone is so kind and happy". Both said they felt valued and how they had been impressed with the safety walk-around by members of the executive team on a regular basis.
- There was an away-day for band 6 nurses in September 2014 and another arranged for April 2015. There was an agenda with guest speakers on various subjects including organ donation and safeguarding, and the clinical lead and Matron talking about plans for the future.

Innovation, improvement and sustainability

- There had been innovation within the nursing team. This involved trialling and then implementing a system of flexible working. Nurses were able to work across both critical care units in Gloucestershire Royal and Cheltenham General Hospitals. They could also drop shifts or part-shifts when there were sufficient staff on the unit. This meant they could be called upon at, usually, short notice to join a shift if patient need had increased the need for nursing presence or there was unplanned absence.
- The unit had achieved capacity improvements. A business case had been presented and accepted to improve patient flow. This had resulted in the opening of the surgical HDU in January 2015. There were currently four funded beds in this unit, but bed spaces had already been prepared to extend to six for future expansion.
- The unit had made consultant-led innovations. The unit was one of the first nationally to adopt the use of an extracorporeal carbon dioxide removal device and the use of oscillation as advanced ventilation strategies. The unit had a best-practice approach to patient management. All patients were therefore assessed each day against a set of goals shown to improve outcomes for critically ill patients.
- In terms of future ambitions, the unit was planning shortly to introduce the World Health Organisation (WHO) adapted surgical safety checklist into critical care in order to follow a protocol for certain complex procedures.

Maternity and gynaecology

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

Maternity and gynaecological services provided by Gloucestershire Hospitals NHS Foundation Trust are located on two hospital sites, Gloucestershire Royal Hospital and Cheltenham General Hospital. In addition, maternity services are also provided at Stroud Hospital. However, services on all sites are run by one management team (within the women's and children's division) and, as such, are largely regarded within the trust as one service. For this reason, it is inevitable that there is some duplication within the reports for the three hospitals.

Gloucestershire Royal Hospital provides maternity and gynaecological services to the local community of Gloucestershire and the surrounding areas. Gynaecological care is provided in a 20-bed gynaecological ward (Ward 2a) and a gynaecological outpatient area which also serves to provide early pregnancy assessment. At the time of the inspection, an additional two beds had been opened on Ward 2a. On-site gynaecological theatres are run and managed by the surgical division.

Midwife-led and obstetrician-led services are provided for early pregnancy, antenatal, induction of labour, delivery and postnatal care, along with community care including a home birth service. There is an antenatal clinic and a separate day assessment unit. The facilities for this consist of six reclining chairs and one couch. Inpatient care is provided on the maternity ward (46 beds providing both antenatal and postnatal care in a mixture of side rooms and four-bedded bays). The delivery suite consists of a triage area with five beds and a total of 12 birthing rooms. One room (Jasmine) is equipped with a pool and is promoted for use by high risk women requesting a more normal birth experience. Two of these rooms (Meadow Suite and Snowdrop) are used as bereavement rooms. Two rooms are also used to provide high dependency care, though can also be used as birthing rooms, and another of the rooms is used to admit women awaiting elective caesarean section (all rooms other than the latter being en suite). The theatre suite adjacent to the delivery suite comprises two dedicated obstetric operating theatres and a three-bed recovery area. In addition, midwife-led care is provided in the midwifery-led unit near the main obstetric unit (located on the floor above and adjacent to the maternity ward), and consists of six birthing rooms, two of which are equipped with pools.

Obstetric and specialist clinics are run by obstetricians and other specialist consultants, for example diabetologists and anaesthetists. Antenatal clinics are held from Monday to Friday.

Between 1 April 2013 and 31 March 2014, and for 1 April 2013 to 30 November 2014, the breakdown of births across the whole service was as below.

April 2013 – March 2014

Gloucester - 4,576

Home - 187

Birth unit – Gloucestershire Royal - 898

April 2014 – November 2014

Gloucester - 2,947

Home - 106

Maternity and gynaecology

Birth unit – Gloucestershire Royal - 667

During the inspection we spoke with 16 patients, one relative and 41 staff. These staff included senior managers, midwives, nurses, specialist nurses, consultants, junior doctors, healthcare assistants, midwifery support workers, receptionists and housekeepers. We observed one shift handover and held a variety of focus groups, including one attended by nine midwives. In addition we reviewed six patients' healthcare records and observed care being given. Before and during our inspection we reviewed the trust's performance information.

Summary of findings

We found maternity and gynaecology service at the Gloucestershire Royal Hospital to be effective, caring, responsive and well-led; however, in order for safety to be good, improvements were required.

There were insufficient medical and midwifery staff to meet the needs of the service. Infection control and emergency risks were not adequately managed, and confidential information was not appropriately stored. Medicines were not managed safely.

There were some organisational challenges to meet referral-to-treatment times in gynaecology. This was under regular review at board level. Outcomes were monitored and benchmarked against national standards, and care given in line with national guidance and delivered with kindness and compassion. Understanding and involvement promoted high levels of patient satisfaction. The services were delivered in a way that met the needs of the local population as well as individual patients and were led by a team of committed and visible individuals. Services were looking at innovative ways to move forward and develop.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We judged safety within the maternity and gynaecology service as requiring improvement.

Midwifery staffing levels were worse than the England average and meant that at times women did not receive one-to-one care in labour. Midwifery staff felt staffing levels were not sufficient for the triage unit. In addition, dedicated consultant hours on the delivery suite fell below those nationally recommended. The absence of cleaning schedules and evidence of equipment having been cleaned meant infection control processes were not effective and the risk register did not report actions to mitigate infection control risks identified. Not all staff were familiar with the location of emergency resuscitation equipment, and medicines stored on resuscitation trolleys were not securely stored or held within tamper-proof containers or, in the case of the postpartum haemorrhage emergency trolley, checked regularly. Lists of names and containing full details and safeguarding concerns were not kept confidential.

There was a good culture of incident reporting and openness, with evidence of learning. Systems were in place to manage clinical risks, which were then managed appropriately. Security risks had also been addressed. Communication systems were clear, and staff were well trained to undertake their roles.

Incidents

- All grades of staff we spoke with were aware of the incident reporting system which was available in the clinical areas though not immediately accessible to staff working in the community. Staff reported easy access to incident reporting. They were able to demonstrate the icon to press on the trust's intranet home page in order to access electronic incident reporting. Staff told us they felt confident to report incidents.
- A trust-wide list of incident categories and maternity-specific categories had been devised. This gave staff clear guidance on what constituted an incident, for example third and fourth degree tears, any unplanned admission to the neonatal unit, and postpartum haemorrhage.
- Two serious incidents had been reported within the maternity unit since April 2014. These had both been investigated, and actions were monitored through the maternity clinical governance meeting. Staff were able to describe changes that had occurred as a result, for example reviewing fetal heart traces within ten minutes of commencing the recording. This was to be supported by the use of a sticker 'aide memoire' which was shortly to be introduced.
- Unplanned admissions to the neonatal unit were reported as incidents, investigated and trends monitored via the maternity service dashboard.
- Less serious incidents were investigated at ward and department level by the midwife or nurse with lead responsibility for that area. Senior staff on the gynaecological ward described having a backlog of incidents to review, caused by the increased workload the ward was experiencing. All incidents described as moderate were reviewed by the lead nurse/midwife for quality and governance. The nurse consultant with lead responsibility for gynaecology reviewed and commissioned a root cause analysis for any moderately rated incidents. Actions identified were monitored for completion through the maternity clinical governance and the gynaecological clinical governance groups. These were fed up into the divisional board governance meetings.
- As soon as an incident was described as 'red' (that is, meeting the trust's threshold as a serious incident requiring investigation), the lead nurse/midwife for quality and governance, senior managers and clinicians undertook a rapid review and escalated the incident to trust level. Investigators were then identified, including someone external to the division, and a full investigation took place. Actions identified were monitored for completion through the maternity clinical governance and the gynaecological clinical governance groups, which fed into the divisional board and onward to the trust-wide safety experience review group, which was a subgroup of the board with overall responsibility to review safety measures in place.

- Staff received feedback following moderate and serious incidents. This occurred at ward and department meetings as well as via newsletters such as the 'Maternity and Newborn' newsletter and the Birth centre newsletter, which also detailed activity, birth outcomes and changes to practice, for example the commencement of intermittent auscultation (listening to the fetal heartbeat) stickers for use in labour, which reduced risks by providing action prompts for midwives.
- Learning from incidents was also evident in the gynaecological inpatient ward. Staff were able to describe changes to practice as a result of incidents. For example, for every vaginal pack used, a pink band was placed on the patient's wrist. Each time a pack was removed, a pink band was also taken off, providing a visual aid to ensure all vaginal packs were removed.
- Morbidity and mortality meetings were held monthly, where cases were reviewed and outcomes discussed for learning; these were attended by medical staff. A 'perinatal brief' bulletin was produced and distributed to all, sharing learning from cases reviewed. For example, we saw that the September morbidity and mortality meeting reviewed cases of unexpected admission to the neonatal unit, with the most common reason being hypoglycaemia (low blood sugar). Staff were reminded of the policy for the management of the newborn to prevent this.

Duty of Candour

- Staff were aware of the Duty of Candour and told us how women were informed of incident investigations and outcomes. Letters were sent to women at ten days in line with trust policy. Serious incident investigations detailed how patients and relatives had been informed and supported throughout the investigation. Senior staff described inviting women and their families in for face-to-face meetings and discussions of incidents.

Safety thermometer

- The gynaecology ward and the maternity unit participated in the NHS Safety Thermometer. This was a process to collect information with respect to patient-safety-related to falls, catheters, urinary tract infections and pressure sores. These rates were in line with the England average rate. Patient safety information was not displayed in clinical areas for patients, visitors or staff to see. On the gynaecological ward we were told results were kept in the sister's office.

Cleanliness, infection control and hygiene

- Some areas appeared less clean than others. We looked at curtains and the history of when they were changed. We also asked staff when curtains were changed. Staff responses varied. Some staff said they were changed "when they needed to be", and others that they were changed every two years. We noted some curtains to be stained. No dates were evident on the curtains to indicate when they had last been changed. Cleaning audits were not on display within ward areas.
- No system was in place to indicate when a piece of equipment had been cleaned and was ready for use, although staff were seen cleaning equipment after use during the inspection. Staff said the expectation was that if equipment was put back into use, it was clean.
- We reviewed the cleaning schedule on the ward and noted some gaps in its completion.
- Antibacterial hand disinfectant was available at the entrances to the wards and departments. It was also present within each birthing and examination room.
- Staff were seen to be 'bare below the elbows' in clinical areas, in accordance with the trust's infection control policy, and were observed washing their hands prior to and after carrying out patient care.
- Aprons and gloves were readily available, and we saw that staff used them when carrying out the specific duties for which they were required. However, we noted staff placing dirty linen on top of bins in one side room on Ward 2a rather than using the designated linen skips.
- Women contacting the maternity unit prior to admission were asked questions regarding their risk of exposure to Ebola, in order to provide appropriate care in the event of a potential exposure risk.
- The risk register for the gynaecology service contained one risk concerning infection control. This described infection risk areas on Ward 2a that had been identified following a case of Clostridium difficile. It was not clear from the risk register what if any actions had been put in place to address this risk. .

Maternity and gynaecology

Environment and equipment

- Patients on Ward 2a described having good access to call bells. Emergency call bells were in place and all areas were equipped with emergency resuscitation trolleys.
- It was unclear where the defibrillator was stored on the maternity ward. Staff we spoke with were uncertain but thought that, in the event of a cardiac arrest, the emergency team called would bring one.
- All rooms on the delivery suite were equipped with cardiotochograph machines for monitoring the foetal heart. The delivery suite was the first in the country to have these all wireless, which enabled greater mobility and use of the pool in labour if desired for higher risk women. In addition, these machines were linked to a central monitor point, which allowed the coordinating midwife opportunities to review traces. This also meant fetal heart traces could be stored indefinitely without losing quality, as they were stored electronically rather than the previous system which stored fetal heart traces on paper which was at risk of fading over time. However this did not extend to the triage area. Funding had been requested to allow this development during the next financial year.
- The triage area had appropriate equipment to safely monitor and evaluate pregnancy. An ultrasound machine was used to confirm the presence or absence of a fetal heartbeat, but could also be used to confirm position if there was a concern that the baby might be breech or evidence of placental abruption.
- There was good access to bariatric equipment. Staff described the process for obtaining such equipment from the equipment library, which they had done in the past.
- Birthing rooms and bed spaces on the wards were equipped with piped oxygen and suction, and staff reported sufficient resuscitaires available to support neonatal resuscitation.
- Rooms at the birth centre were spacious and calming. Birth couches were provided rather than beds, and two rooms were equipped with pools. In addition there were birthing stools, balls and mats available to facilitate mobility in labour. Most of the rooms there also had 'pull down' double beds, which meant partners were able to stay overnight. All rooms had en suite facilities, and emergency evacuation equipment was available for use in the event of a maternal collapse in the pool. Transfers out of the pool were practised, and manual handling was included in the mandatory training programme for all maternity staff.
- Partners were able to stay with women on the delivery suite, but there were no facilities for them to remain overnight after birth, with the exception of bereaved parents. The two bereavement rooms were equipped with sofa beds to allow partners to remain. In addition, they were also equipped with kitchen areas where drinks could be prepared.
- Equipment was serviced regularly by the trust's maintenance department, which held an inventory of when equipment servicing was due. We reviewed the service dates on a variety of pieces of equipment, including pumps, resuscitaires and monitors, and saw these to have been serviced within the last year. Whilst the scales within the maternity unit had been calibrated, we were unable to identify from the machine the last time the scales on Ward 2a had been serviced and calibrated.
- Ward 2a had a treatment room at one end, used for the early pregnancy assessment clinic at weekends (to prevent lone working) and also for patients referred by their GP for medical review. There was a nearby waiting area and also a small 'quiet' room that could be used for counselling or additional privacy. The treatment room was equipped with one couch but was generally cluttered and not well maintained in terms of cleanliness. Equipment was stored behind plastic curtain screens on wheels, giving the room the appearance of a storage room rather than a treatment room.
- Doors into all wards were locked, with a buzzer entry system and CCTV. Reception areas were not manned 24 hours per day; reception staff gaps were covered by other staff on duty.
- At the time of the inspection, a new baby security tagging system was being installed in order to increase the security of babies within the maternity unit.
- There was a postpartum haemorrhage emergency trolley, stored in the recovery room on the delivery suite. We were told that the checks for this trolley were the

responsibility of main theatre staff (managed within the surgical division), and that checks should be completed weekly. We noted that the trolley had only been checked three times since September 2014: 2 October 2014, 22 January 2015 and 6 March 2015. This meant there was a risk that emergency equipment would not be present on the trolley in the event of an emergency.

Medicines

- Not all medicines were securely stored. Medicine cupboards were locked on all wards and departments; however, intravenous fluids on the delivery suite were not securely locked. Medicines stored on adult and neonatal emergency resuscitation trolleys were neither securely locked nor stored within tamper-evident drawers/boxes. This meant there was a risk they could be removed or tampered with.
- The delivery suite stored two plastic boxes containing all the medicines necessary to treat a woman in the event of an eclamptic fit (an obstetric emergency requiring immediate action). Both boxes had tamper-evident seals in place; however, neither indicated the date by which medicines within the box went out of date. This meant women were at risk of medicines being administered in an emergency that were out of date, or of delay in treatment whilst in-date medicines were obtained.
- Some rooms were secured with digital keypads. However, the codes for these were rarely changed, even when staff left.
- There were processes for checking the drug fridge temperatures, and we observed that the temperature was recorded daily and fell within acceptable limits.
- Midwives were able to administer some medicines under patient group directives. Training for this was included during the midwives' preceptorship programme and included in mandatory training updates.
- Some resuscitaires were equipped with bottled air; however, most others had only bottled oxygen. Piped oxygen and piped air were available in the delivery suite and birth centre, and resuscitaires could be connected to these. Resuscitation Council (UK) guidelines (2010) recommend resuscitation with air if the baby was born at term, but with blended air and oxygen for preterm babies who are less than 32 weeks' gestation. It was not immediately clear which resuscitaires were able to administer air along with oxygen if required to work off cylinder supplies. In order to reduce this risk, priority was given to ensure resuscitaires with blended gases were available in theatres. There was also a rolling program of replacement underway.

Records

- During the inspection, we reviewed six sets of care records. These contained all relevant risk assessments, such as venous thromboembolism (VTE), falls and pressure ulcer risks within a document entitled the 'Gloucester Patient Profile'.
- Women carried their own records for the duration of the pregnancy. Once delivered, women were issued with postnatal records for their care to be documented and a child health record (red book). These were completed by the midwife or midwifery support worker at subsequent visits.
- Access to past medical records was described as good. Within the maternity service, old records were routinely obtained when the woman was booked for care.
- Pre-printed stickers were used that gave prompts for staff to complete, such as cardiotocography (CTG) stickers, which were used to record aspects of the fetal heart trace. Additional stickers were about to be launched to remind staff to review the CTG within ten minutes of commencing it. This was a recent change as a result of learning from a serious incident.
- Midwives conducted audits of record keeping as part of their annual supervisory review. Their records were audited and reviewed by their supervisor of midwives, and any remedial actions identified.

Safeguarding

- Staff received training in safeguarding vulnerable adults and children and recognising abuse. Where appropriate, staff within the maternity service were trained to safeguarding level 3. Staff on the gynaecology ward had safeguarding training to level 1 or 2, dependent upon their role. There was an 80% compliance rate within the maternity service. Robust reporting processes were in place, and midwives described systems for reporting safeguarding concerns. Staff were confident to raise any matters of concern and escalate them as appropriate if

they felt no action was taken. Information was available to staff in both areas on how to escalate safeguarding concerns, and a quarterly newsletter was produced providing information and updates to staff.

- Systems were in place to identify women and babies at risk, included at risk of domestic violence. However, we spoke to two midwives who were both unsure of where such information was recorded or could be accessed.
- Matron for the community led on all public health issues and safeguarding. The lead midwife with responsibility for the antenatal clinic was also the lead for diabetes In addition the maternity unit employed a lead midwife in safeguarding as well as midwives specialising in substance misuse and teenage pregnancy and a newly appointed midwife with an interest in mental health. Midwives described an open door culture which enabled easy access to specialist advice.
- Midwives attended safeguarding case conferences and strategy meetings in partnership with the local authority. In addition, a safeguarding forum was held; records were made to ensure communication of concerns, and plans were shared among midwives, obstetricians and paediatricians providing care. There was a database of safeguarding concerns held by the safeguarding lead, which was updated monthly. This was used to provide relevant staff with an updated list of concerns. This was printed out and held in a lever-arch file on an open shelf in the ward sister's office on the maternity ward. This was not a secure office, and at times could be left unattended. The listing included full names of the individuals for whom there were safeguarding concerns. We visited the office at the entrance to the delivery suite, adjacent to the triage area. We noted a whiteboard that contained full names of women due to give birth within the next three months for whom there were safeguarding concerns, and in some cases what the safeguarding concerns were. We raised our concerns regarding this breach of patient confidentiality to the trust's executive team at the time of the inspection.
- Babies deemed at risk were removed by social services on occasion, and this could be distressing for staff as well as mothers. There was access to a debrief service for staff involved in such cases.
- Community midwifery partnership teams worked out of areas of greater vulnerability and had a smaller caseload of women. This allowed them to have a greater input in the care of more vulnerable women.

Mandatory training

- Staff reported good access to mandatory training. Mandatory training also included a 'Prompt' skills drills training day and a one-day maternity update for staff working within the maternity unit. The trust employed practice development midwives, who monitored attendance at mandatory training. Staff were automatically booked onto mandatory training annually. Failure to attend was escalated to managers for action.
- Mandatory training attendance was noted to be an average of 89% for the skills and drills training day for midwifery staff. The attendance rate for medical staff was 60% for mandatory training and 89% for skills drills.

Assessing and responding to patient risk

- All staff used a communication tool known as RSVP, which stood for 'reason, summary, vital signs and plan'. RSVP stickers were seen on telephones, and posters were displayed explaining that "effective communication saves lives". We observed handovers following that format and saw notes that clearly indicated that RSVP was followed to assess the patient and develop an onward plan of care.
- Risk assessments were completed for place of birth at booking. These were reviewed at 36 weeks' gestation and again when the woman was admitted in labour. This ensured the protocol for low risk midwife-led care was followed.
- Where women were identified as being high risk but requested midwife-led care, they were seen by a supervisor of midwives and a complex care plan devised in agreement with the woman and in discussion with an obstetrician. These plans were stored within the woman's notes and also on the supervisor of midwives' shared computer drive to ensure each supervisor of midwives and all band 7 midwives were fully aware of the agreed plan of care. We reviewed the notes of one woman and saw such a care plan with the woman's requests clearly documented.

- Midwives practised 'fresh eyes' on the delivery suite every two hours. This was undertaken by a core midwife, usually the coordinating midwife who was not directly involved in the woman's care, and comprised a review of the foetal heart and progress in labour. In addition, a central screen that showed all foetal heart traces was in use on the delivery suite, allowing the shift coordinator general oversight.
- Where risks had been identified antenatally, appropriate care plans were developed. For example, staff described developing a plan of care in conjunction with the community psychiatric nurse for a patient known to have bipolar disorder. This meant staff were prepared to appropriately support the woman with any symptoms. The plan also contained a list of relevant mental health services' contacts to ensure good communication should such support be required.
- Few midwifery staff had undertaken additional courses in high dependency care; therefore, where high dependency care after delivery was required, women were transferred to the high dependency unit or intensive care.
- Third and fourth degree perineal tears were sutured in theatre; however, access and delays to theatre were not monitored unless reported by staff as an incident under the category 'delay in treatment'. Reported incidents or complaints did not show evidence of delay, however no clear standard was set for the time within which a perineal repair should be performed. This meant women may have experienced unnecessary delays that were not being identified by the service.
- Staff completed the modified early warning score or National Early Warning Score (NEWS) system for recording vital signs. This indicated to staff when observations required repeating or concerns required escalating. We noted escalation had occurred in most cases where a concern was indicated. However, on Ward 2a we identified one patient for whom the scoring was of concern: this should have triggered a repeat set of observations and escalation to medical staff, but this had not happened. The ward manager was notified of this at the time of our inspection.
- We saw evidence of completed World Health Organisation (WHO) surgical safety checklists in postoperative notes. Staff were able to describe the process for undertaking these within the operating theatres.

Midwifery staffing

- The funded midwife-to-births ratio was 1:31.5. Whilst this had improved from 1:34.1 in October 2014, this was worse than specified in the Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007), which states there should be an average midwife-to-births ratio of 1:28. The funded midwife-to-births ratio was also worse than the England average of 1:29. A risk assessment was in place and the risk was monitored via the risk register.
- Midwives worked as core unit midwives, community midwives or rotational midwives within the main hospital. Rotational midwives moved work areas every six months, whilst core and community midwives remained in the same working area.
- Staffing for the delivery suite was set at 10 midwives per shift. This included one midwife who was assigned the role of delivery suite coordinator and, as such, worked in a supervisory position. At times of increased activity and in order to provide one-to-one care to labouring women, staff were redeployed from other areas.
- The maternity dashboard for 2014/15 showed that staff were providing one-to-one care in labour between 94.8% and 98.6% of the time. However, one-to-one care in labour on the birth centre had reduced during December 2014 to only 82%. This occurred as a result of staff being called to support the delivery suite. We saw evidence of meeting minutes communicated to all staff informing them that they should return to their original working area as soon as possible.
- Midwifery and nursing handovers occurred as staff changed shift at 08.30am and 8.30pm. During these handovers the full multidisciplinary team present on the delivery suite attended.
- Acuity was monitored using the birth rate plus acuity tool, with acuity monitored four-hourly. This meant midwifery managers were able to benchmark staffing against patient acuity.

- The delivery suite had receptionist cover provided Monday to Friday, 8.30am to 10pm, and on Saturdays from 9am to 5pm. Outside these times, all calls, administration and controlling of access to the delivery suite were undertaken by one of the midwives. This was often the only midwife working in the triage area, at times taking the midwife away from patient care.
- Midwives were allocated to work in triage from the delivery suite. Triage was staffed with one midwife at any one time and was open 24 hours a day, seven days per week in addition, midwifery care assistant cover was provided from 12.00 – 9pm. Cover for breaks was provided from delivery suite midwives when capacity and acuity allowed; however, this could be as late as 4pm when a midwife was on a 12-hour day shift, having started work at 08.30am.
- As well as providing care for the women who were present in triage, the midwife on duty received calls for telephone advice, and was required to obtain medical records and facilitate entry into and out of the delivery suite, for example whenever the midwifery care assistant was not on duty.
- When possible, a second midwife was deployed to support triage. However, senior staff recognised this was not always possible. Staff told us one midwife was not sufficient at times to staff the triage unit. On average, 815 women attended triage each month (approximately 27 per day). The triage midwife told us there had been complaints from mothers about the length of time it took to be seen. Women were reviewed according to their clinical presentation. It was not clear to women that others arriving after them could be seen first if their clinical need was greater.
- There were plans to develop a telephone triage system to be located within an ambulance service hub as an alternative, with the aim that this would reduce the volume of calls to the triage area. This initiative would aim to direct women to the most appropriate place for care.
- A clear escalation policy detailed how additional staff were to be obtained in the event of increased sickness or high activity and/or acuity within the maternity service. This included additional support from the senior midwifery team and supervisors of midwives. The on-call rota for each of these was evident within the delivery suite. When additional staff were obtained, incident forms were completed in order to monitor the frequency of such situations. Whilst staff described this as occurring frequently, a review of incidents and actions provided to us dated 1 September 2014 to 31 December 2014 included only two reports of community midwives being called in. Community staff we spoke with were aware of the immediate need within the maternity unit. However, staff also told us of the impact and difficulties this could cause, with the need to continue to provide community work the following day despite being called in during the night.
- Community midwifery caseloads were 1:80, with midwifery partnership midwives' caseloads 1:50. Partnership midwives worked in the city of Gloucester and were based in and around areas of greater vulnerability, providing antenatal and postnatal care. Partnership midwives initially held a lower caseload and provided intrapartum care; changes to caseload size and the provision of intrapartum care by the core midwives meant recruitment into the partnership teams was good.
- There were currently no whole-time-equivalent midwifery vacancies across the service. The midwifery sickness rate was 3.6% for December 2014. Sickness across the gynaecology service was also better than the national average at 3.8%, although higher among advanced nurse practitioners. It was noted, however, that this was within a small team where longer term sickness had occurred.
- Expected and actual staffing levels were displayed on Ward 2a (gynaecology) and also on the maternity ward. However, they were not displayed in the delivery suite or in the birth centre. At the time of the inspection, the safe staffing information indicated there were the expected numbers of staff on each shift on Ward 2a. However, during the inspection we noted the actual level of staff on the maternity ward to be lower than expected. For the morning and afternoon shift there should have been eight midwives, but there were seven on duty. Also, during the night a shortfall of one midwifery care assistant was reported. Interviews with staff suggested that the maternity ward was generally a busy ward but all staff enjoyed working there. There were no negative comments received regarding staffing from the staff or patients interviewed.

- As a result of opening two additional beds on Ward 2a, an additional healthcare assistant had been added to the staffing numbers for each late and night shift. These were currently unfunded posts.
- Patients being cared for on Ward 2a were often surgical and orthopaedic patients. There had been an increase in complaints on Ward 2a over quarter 2 and quarter 3 of 2014/15. Staff there felt this was as a result of the increased acuity and dependency of patients on the ward. Staff said this meant less time was available to provide care to patients requiring gynaecological care, a lot of which would have been psychological support. These issues had been added to the gynaecology risk register (November 2014) and were due for review in May 2015.
- The trust had its own bank of nursing and midwifery staff. This meant the use of agency staff were required less frequently to cover the gynaecology service. In the event of sickness among advanced nurse practitioners, additional shifts were worked and cover provided by the established team. Within midwifery, agency midwives were not used.

Medical staffing

- The maternity dashboard for December 2014 reported 75 hours of dedicated consultant cover on the delivery suite. This was below the recommended 168-hour consultant presence to meet the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance. However, staff told us consultants attended when called out of hours. Senior managers told us a business case had been submitted to the trust's board two years previously that would have allowed the service to actively work towards the recommended level. The business case had been declined by the trust's board.
- There was 24-hour consultant on-call cover. The delivery suite had 24-hour anaesthetic presence seven days per week.
- The medical rota showed there was obstetric registrar-level presence on the delivery suite 24 hours per day, seven days per week.
- Handovers occurred at 8.30am, 1.30pm, 5.30pm and 8.30pm on the delivery suite. We observed one handover and saw it to be structured, reviewing all patients and following the RSVP ('reason, summary, vital signs and plan') communication format. This gave consistency and ensured all aspects of the patients' care and planning were included in discussions.
- Medical staff from the delivery suite provided cover for the triage unit and for women who had not been discharged from the day assessment unit before it closed. At times, these women were required to wait for long periods for review. Staff told us accessing medical review could be difficult at times, particularly when the delivery suite was busy.
- Out-of-hours medical cover was provided by registrars and on-call consultants. Reduced medical cover meant, at times, a delay occurred in a non-emergency review. For example, staff described a delay in certification of death for several hours. During that time the deceased person could not be removed from the ward.

Major incident awareness and training

- Staff were aware of processes to follow in the event of a major incident. The trust-wide major incident policy was available to all staff on the intranet.
- A new process was in place to ensure service communication of status across all areas. This had been developed to fall in line with the trust-wide escalation policy. We saw evidence of the current status of the maternity service prominently displayed in staff areas to ensure all staff were aware of it.

Are maternity and gynaecology services effective?

Good

The effectiveness of maternity and gynaecological services were rated as good.

Care and treatment delivered was evidence based with policies and guidelines developed in line with national guidance. Staff encouraged normal births; however, the normal birth rate for October to December 2014 was below (worse than) the England average. The caesarean section rate was below (better than) the England average, and

women were encouraged to consider vaginal birth after caesarean section; however, the normal delivery rate after caesarean section was below (worse than) the trust's target.

A wide range of pain relief was available. Postoperative pain was managed with patient-controlled analgesia, where women could self-administer pain relief. Polices existed to support the management of pain in labour using essential oils, and women in labour had access to epidural anaesthesia at all times on the delivery suite.

Staff received training and support to maintain their competence. The supervisor of midwives to midwives ratio was 1:15, equal to the recommended ratio. There was good, supportive multidisciplinary team working.

Evidence-based care and treatment

- Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecology (RCOG) guidelines. Policies, guidelines and protocols were available for staff to access on the trust's intranet site. However, the service reported current non-compliance with NICE clinical guideline 63, Diabetes in pregnancy, although glucose tolerance tests were due to commence for all women with a booking body mass index greater than 30. These were subject to review through the Gloucestershire Obstetric Guideline Group chaired by a practice development midwife, and we observed they were maintained and up to date.
- The service promoted normal birth as much as possible and where appropriate. There were good working relationships between midwives and obstetricians in order to promote this. However, the normal birth rate reported on the service dashboard was 59.1–59.6% for the three months from October to December 2014. This was lower than the national average of 61.7%. Caesarean section rates had been as low as 20.9% but were between 24.8% and 26.8% for the same three months. This was around or above the national average rate of 25.5%. There was a working party to look at reducing the caesarean section rate.
- The induction of labour rate was in line with the national average, with the service undertaking up to eight inductions per day.
- Women who had previously had a caesarean section delivery were encouraged to consider options for vaginal birth after caesarean (VBAC). Staff felt the installation of a pool and the roll-out of wireless cardiotocography (CTG) monitoring encouraged and supported this as an option safely. The number of women who attempted VBAC was reported on the maternity dashboard, which showed approximately 60% of women eligible to attempt VBAC did so. The service's target was 70%.
- Skin-to-skin contact between mother and baby was encouraged immediately after caesarean section, in line with NICE Clinical Guideline 190, Intrapartum care: care of healthy women and their babies during childbirth. This practice regulates the baby's breathing and heart rate, maintains their body temperature and encourages bonding and breastfeeding.
- Babies born with tongue tie were seen in midwife-led clinics. Across the whole service, approximately 600 babies were treated annually.
- Regular audits were undertaken, with findings presented monthly. For example, an audit of caesarean section wound infection had occurred. This had resulted in changes to the length of time dressings stayed on, to reduce the risk of infection.
- In addition, headline findings were shared across the maternity unit in the maternity and newborn newsletter. For example, we saw an audit had been undertaken regarding substance misuse. This had highlighted a failure to obtain urine toxicology samples from newborn babies. This had been identified as a targeted action by the substance misuse midwives.
- Research had shown the first stage of labour to be shorter for women who were upright or walked around, and reduced the likelihood of medical intervention. Midwives in all areas promoted this with the Mums Up and Mobile (MUM) programme.
- Despite being recognised as good practice, there was currently no provision to administer the measles, mumps and rubella (MMR) vaccine to rubella-susceptible women on the postnatal ward. This had been identified as a risk and was on the department risk register.

Pain relief

Maternity and gynaecology

- Women in both the maternity and gynaecology service had a full range of pain relief options available. Pain scores were monitored on Ward 2a. Pain relief available ranged from simple analgesia (paracetamol) to patient controlled analgesia administered via a pump.
- Women in the maternity service were encouraged to remain mobile and active during labour to reduce pain. Essential oils were available and all midwives undertook a half-day study day in their use, with training updates covered within the mandatory study day.
- Nitrous oxide for pain relief was piped into all birthing rooms. In addition, diamorphine and epidural anaesthesia were available via a pump controlled by the patient. Often described as 'mobile epidurals', these gave pain relief whilst maintaining mobility in labour.
- Women were able to have epidural analgesia on the delivery suite. The birth centre did not provide epidurals, as it was for women of low risk requesting normal midwifery care. Information about this was provided to women when they chose their place of birth. Transfer to the delivery suite occurred if a labouring woman on the birth centre requested an epidural during labour. When a woman requested an epidural, staff aimed to have this in place within one hour. Staff told us they completed an incident report if they were unable to achieve this. Incident reports provided to us from 1 September 2014 to 31 December 2014 showed no such incidents had been reported.
- Use of water for pain relief and birthing was frequent in the birth centre. A pool had recently been installed on the delivery suite to allow higher risk women the opportunity to labour and deliver in water. Statistics from December 2014 showed a water birth rate of 21% in the birth centre. Use of the pool in the delivery suite was also monitored and had been audited. This indicated 80% of women who had used that room had achieved a normal delivery, with 35% of these women achieving a water birth.

Nutrition and hydration

- The maternity service employed an infant feeding specialist midwife and had achieved UNICEF Baby Friendly Initiative accreditation. All staff, including obstetricians and paediatricians, underwent initial training in breastfeeding followed by annual updates during the maternity training day.
- The breastfeeding induction rate was 75% against a target set by the commissioners of 78%. To support and further promote breastfeeding, all community midwives had a 'breastfeeding toolkit' and lesson plans to ensure consistency of education in the antenatal period. The local breastfeeding network came onto the maternity ward four days per week and also ran drop-in clinics at weekends in order to provide ongoing support for up to six weeks after birth. As the maternity partnership teams had lower caseloads, they were able to provide continued breastfeeding support when the woman was discharged from hospital.
- Women were supported with their method of choice for infant feeding. For example, one woman who had been unable to breastfeed for medical reasons had been supported to access expressed breast milk sourced from a milk bank.
- All babies who had a weight loss of greater than 12% were admitted for observation. The infant feeding specialist midwife was informed of these admissions and attempted to see each one. However, in the absence of the infant feeding specialist midwife, midwives had been trained to provide additional support.
- Dietetic advice was available to women both on Ward 2a and also within the multidisciplinary antenatal clinic held with the diabetologists.
- Women were encouraged to remain hydrated in labour.

Patient outcomes

- Information relating to outcomes for patients using the service was collated within performance dashboards for both gynaecology and maternity services. All maternity staff received the performance dashboard monthly via email. In addition, dashboards were presented and monitored within the clinical governance meetings and the divisional board. These fed up into the safety experience review group.
- Gynaecological performance data showed a failure to meet 18-week referral-to-treatment targets in December 2014 and January 2015. Staff felt this had occurred because of winter pressure on beds across the whole organisation.

Maternity and gynaecology

- The maternity performance dashboard for year 2014/15 showed that between 70% and 75% of all births occurred within the obstetric-led delivery suite. Overall there were approximately 10–16 home births per month.
- Transfer rates from midwife-led care were also reported within the dashboard. Transfer rates of approximately 22–25% were reported from midwife-led units into the obstetric unit, slightly below (better than) the Birthplace survey findings of 26.4%.
- Year to date figures showed that 91% of women were booked for antenatal care by 12 weeks and six days' gestation, marginally higher than the national target of 90%. (It was noted that on three months performance had fallen below 90%).
- Family of origin questionnaires were completed to identify women at higher risk of sickle cell disease and thalassemia. The percentage of these women being screened under 10 weeks' gestation was not reported on the dashboard. Staff told us that following two audits, they had identified that only 33% of high risk women were completing the family of origin questionnaire, and therefore opportunities for early screening undertaken before 10 weeks' gestation were missed.
- The maternity service employed an antenatal screening coordinator and contributed to the national antenatal screening programme.
- Midwifery partnership teams working within the community were established in November 2014. Prior to that, midwifery group practices had run in the city. Their outcomes had been evaluated, and when compared with those for a similar area, women cared for by the midwifery partnership teams had better breastfeeding rates, sustained breastfeeding for longer, reduced smoking, fewer preterm babies and fewer low birthweight babies. Midwifery partnership teams were developed to continue the public health and partnership working without the provision of intrapartum care.
- There was a detailed cycle of local and national audits, including decision-to-delivery times for emergency caesarean sections and epidural rates.
- Data for April 2014 to date showed an average of 3.7% of babies born at over 37 weeks' gestation and weighing greater than 2.5kg were admitted to the neonatal unit (and therefore unplanned) – lower (better) than the England average of 4%. Rates for postpartum haemorrhage in excess of 1.5 litres for same timeframe were recorded on the dashboard and showed an average of 0.6%, a slight increase compared with the England average of 0.5%. The rates of women experiencing a third- or fourth-degree tear was 4.6% compared with the England average of 1–7% dependent on type of delivery. Staff described the ongoing monitoring of such tears, with practices being reviewed if the monthly average fell below 3% (to ensure tears of this severity were being identified) or rose above 4% (to monitor increases in trends).
- The gynaecology dashboard showed postoperative readmissions were monitored, as were any missed diagnosis of patients attending the early pregnancy assessment clinic, patients returning to theatre and intraoperative complications.

Competent staff

- All staff received a trust induction when commencing employment, which included basic life support, health and safety and fire training.
- On arrival in the department, locum medical staff we spoke with described a comprehensive induction lasting approximately a week, during which their competencies were assessed.
- Newly qualified midwives were appointed as band 5 midwives. They then underwent a 23-month preceptorship programme during which they increased their skills and competencies. This included, for example, undertaking cannulation, episiotomies and suturing before being eligible to apply to become a band 6 midwife.
- There was also a band 6 development programme to support staff to develop into the band 7 roles in both nursing and midwifery.
- Midwives and obstetricians undertook annual skills drills training in obstetric emergencies such as postpartum haemorrhages, breach deliveries and the management of shoulder dystocia.
- Additional skills and education could be obtained, although it was recognised that funding would not always be available. All advanced nurse practitioners in

gynaecology had been supported to undertake education at master's level. There were three accredited nurse colposcopists and 2.5 whole-time-equivalent urogynaecology nurse specialists in post. Additional support and training were provided from a training budget provided from ongoing research.

- All midwives were assigned a supervisor of midwives. A supervisor of midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (rule 8, Nursing and Midwifery Council (NMC) 2012). Supervisors of midwives are referred to for advice, guidance and support. The supervisor of midwives monitors care by meeting each midwife annually (rule 9, NMC, 2012). Other supervisor of midwives roles include auditing midwives' record keeping and investigating any reports of problems or concerns in practice. All the midwives we spoke with had received an annual supervisory review.
- Data provided by the trust indicated that supervisory reviews had been conducted within the last 12 months for 81.6% of midwives. The trust's supervisor-to-midwives ratio was 1:15, which equalled the recommended ratio for supervisors of midwives. Each supervisor of midwives was allocated 7.5 hours per month in order to undertake their supervisory duties.
- A supervisor of midwives was on call at all times to support midwifery staff. The supervisor of midwives rota was evident on the ward and the delivery suite, and midwives described the supervisor of midwives attending when called for support and guidance.
- Junior medical staff at ST1/ST2 level were only allocated to work during the day (8.30am to 8.30pm) within gynaecology in order to allow for training and educational development opportunities. Night-time cover was provided by more senior medical staff. Medical staff we spoke with described being well supported with regards to workload and training.
- Junior medical staff described being well supported to attend regular training sessions on Friday afternoons, as well as having good access to clinical and educational supervision.

Multidisciplinary working

- Multidisciplinary clinics were held for pregnant women with additional healthcare needs such as diabetes. These clinics included dieticians and diabetologists working alongside obstetricians and midwives to provide appropriate care for women who were diabetic or had developed gestational diabetes. In addition, staff from the youth support and children's centre and stop smoking service were present at all consultant clinics in order to promote public health initiatives and provide support to young or vulnerable women.
- Staff described good working relationships and effective communication systems throughout the multidisciplinary team in the maternity unit. For example, handovers occurred on the delivery suite with midwives, obstetricians, junior doctors, paediatricians and anaesthetists present. Relationships with paediatricians were described by staff as being very effective.
- Theatre staff were provided and managed by the surgical division. There was good communication and team working to ensure adequate theatre and recovery care was provided.
- Midwives referred women directly for consultant advice. Staff described working relationships that demonstrated mutual respect for the others' roles.
- Colorectal specialists were involved for some complex perineal trauma as appropriate. Women were seen by the physiotherapist on the ward and received colorectal and physiotherapy follow-up postnatally.
- There was cohesive working with outside agencies such as social services and the mental health liaison team to promote the safeguarding of mothers and babies.
- We saw evidence of good working relationships with commissioners of services, with the development of midwifery pathways to include early pregnancy following a maternity services review.
- Advanced nurse practitioners in gynaecology were in post to undertake roles such the management of a nurse-led early pregnancy assessment clinic and colposcopies. Clear referral processes were in place for onward referral in line with agreed pathways, for example in the event of a miscarriage requiring surgical intervention.

Seven-day services

- A seven-day early pregnancy assessment service ran from 8.30am to 12.30pm. This meant women experiencing problems in early pregnancy could be seen in a timely manner.
- Within gynaecology, registrar reviews occurred each afternoon, seven days a week. Staff said this aimed to reduce the likelihood of admission by the GP.
- Elective caesarean section lists ran from Monday to Friday. Staff reported no problems with list capacity.
- The maternity day assessment unit was open from Monday to Friday from 9am to 4pm. Medical review during those hours was provided from the antenatal clinic, which was adjacent to the unit. Women requiring review out of these times were required to attend the delivery suite triage area. Any woman remaining in the maternity day assessment area after 4.30pm had to be transferred to the delivery suite triage area for onward care and medical review. Consultants were present during weekends, undertaking ward rounds and providing on-call support to nursing staff, midwives and junior doctors.
- There was access to an on-call pharmacist outside usual pharmacy opening hours.
- Complex diagnostic scans were only available from Monday to Friday. However, scans could be undertaken to identify the fetal presentation and placental location on the delivery suite at all times.

Access to information

- Staff had access to medical records. On booking, medical records were obtained for use during the pregnancy. Staff reported no problems with access to medical records within the gynaecological service.
- Women carried their own pregnancy records, which were provided when booking in. These were used by all clinicians who the woman had contact with during their pregnancy. When women moved onto the postnatal wards following the birth of their baby, new records were made for use in the postnatal stage. These included all information relating to the pregnancy and delivery and baby. These were then used by the midwifery and medical teams to record care.
- Medical records were created for each baby at birth so that their healthcare could be documented and linked to them rather than only being within the mother's notes. We observed staff using the RSVP ('reason, summary, vital signs and plan') communication tool when handing over from one to another to ensure effective communication occurred and plans of ongoing care were clear.
- Staff had access to up-to-date policies and guidelines on the trust's intranet site. Changes to key policies were also communicated via the maternity and newborn newsletter and email, for example as new or amended guidance was released from NICE or the RCOG.
- Staff received performance data updates on monthly basis. These were either emailed or produced in paper format and displayed in ward offices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Records reviewed showed discussions with woman and verbal consent documents. Verbal consent was obtained prior to procedures such as internal examinations and the management of the third stage of labour.
- We saw that reasons for procedures were documented and consent forms completed and signed by women prior to surgical interventions. These were stored securely within the hospital notes.
- During the inspection, no patients were subject to a deprivation of liberty application.

Are maternity and gynaecology services caring?

Good

Caring within the maternity and gynaecological services was rated as good.

Care was seen to be delivered with kindness and compassion. Women were involved in decision making, and staff ensured understanding and involvement of patients and their partners/relatives and emotional support through good communication. Friends and Family Test results showed that whilst responses were low, 93–98% of people were 'likely' or 'extremely likely' to recommend Ward 2a.

Maternity and gynaecology

Compassionate care

- Patients we spoke with described feeling well cared for. We observed care being delivered with kindness and compassion by staff at all levels.
- One woman told us, "They made me feel welcome here." We talked to seven women in the antenatal clinic, who were all happy with the care received from their midwife.
- Friends and Family Test results were displayed on the wall in the entrance to Ward 2a. Response rates were variable, with 40% of patients responding in November 2014, 32% in December 2014, but only 16% responding in January 2015. However, of those who responded, 93–98% said they were likely or extremely likely to recommend the ward to friends and family. Whilst the maternity unit collected responses, these were not displayed for members of the public to view, nor were they included on the maternity dashboard. Whilst antenatal, birth, postnatal (ward) and postnatal (community) results were variable, they were generally above the England average. Boards were displayed that stated changes made as a result of patient feedback; however, these were undated and staff were unclear how often these changed.
- Results from the CQC survey of women's experiences of maternity services (2013) reported outcomes about the same as for other trusts, with three questions scoring better than for most trusts. These all related to care during labour and birth, and were 'being spoken to in a way you could understand', 'being involved enough in decisions about care' and 'being treated with respect and dignity'.
- One patient interviewed described staff kindness, compassion and emotional support during her pregnancy following the loss of her previous baby midway through her pregnancy. She reported staff being very sensitive to her needs, concluding she "couldn't fault the care".

Understanding and involvement of patients and those close to them

- Staff were observed explaining procedures and involving patients and their relatives in decision making. Within the maternity service, women were supported in their choices through clear discussions of the risks associated with their choices, which were documented, for example when electing to deliver at home despite being deemed high risk.
- There was a structured approach to ensuring that mothers and babies were safely transferred back to community care through the discharge process. Patients left the ward with clear plans on when visits were due and how to access additional support.
- Staff were seen providing reassurance and explanations to partners and relatives. Relatives we spoke with described feeling included and involved in care.

Emotional support

- Women transferred into the delivery suite from home or one of the freestanding midwifery-led units were accompanied by the midwife who had been providing their care. This midwife remained present until care had been handed over, remaining as the woman's 'familiar face' and continuing to provide emotional support.
- The maternity service employed a bereavement specialist midwife and a midwife with an interest in mental health. Their roles were to provide specialist advice and support to women but also to midwives to build skills and confidence.
- Patients we spoke with described staff providing sensitive support during their admission.

Are maternity and gynaecology services responsive?

Good

Maternity and gynaecological services were responsive.

Women were able to make choices about where to have their babies, with the choice of home, midwife-led care alongside birth centre or obstetric-led care. Multidisciplinary clinics were held for women with complex care needs, and transitional care was provided on the maternity ward. Day assessment clinics were limited to Monday to Friday, 8am to 4pm, which meant women

requiring assessment outside that time were required to attend the triage area. This was a busy area, and at times women complained about the length of time they had to wait for review.

The provision of gynaecological care did not always occur within the 18-week referral-to-treatment target timeframe, as a result of trust-wide winter pressures and gynaecology beds being used for other specialties.

Translation services were available, although there was a delay in accessing information leaflets in other languages.

Service planning and delivery to meet the needs of local people

- The gynaecological service was experiencing difficulties in meeting referral-to-treatment times for non-cancerous surgery. This was because of the increased number of surgical and medical patients being placed on Ward 2a. As a result, weekly meetings were held with the general manager for the women's and children's division and the director of operations to monitor waiting lists and cancelled operations.
- Gynaecological referral-to-treatment times for November 2014 were 91.3%; however for December 2014 they were 86.6%, and for January 2015 86.9%, before rising marginally to about the trust's target of 90% in February 2015. Senior staff told us initiatives had been undertaken to provide routine surgery at an alternative local hospital. However, no further lists were currently planned at this location.
- Staff told us that wherever possible they tried to ensure beds were available to admit gynaecological patients for surgery onto Ward 2a, but were aware of the overall pressures in the trust to accommodate all patients in need of an admission.
- A GP referral system had been successfully devised to avoid unnecessary admissions. Women were referred to Ward 2a by their GPs in the afternoons. Gynaecology registrars then undertook a review. Of patients seen, 75% were subsequently discharged. These were women who may have been admitted in the past.
- Most routine antenatal care was carried out by community-based midwives. Antenatal clinics were held from Monday to Friday in the hospital. In addition, outreach clinics were held in Cheltenham and Stroud, where women could attend to have antenatal care or some screening tests. This meant local women could access services in a location closer to their home.
- The maternity service dashboard for 2014/15 reported that the delivery suite had not closed and the home birth service had not been suspended. However, the midwife-led birth centre had been closed on one occasion in order to provide midwifery support to the delivery suite in the hospital.
- Elective caesarean sections occurred from Monday to Friday. There were two dedicated obstetric theatres and a three-bed recovery area. One theatre was used to undertake elective cases, whilst the other was reserved for emergencies. This meant emergency caesarean sections could occur without delay.
- Bed occupancy within the maternity unit ranged from 59.3 – 70.1%. Whilst occupancy rates were not reported on the maternity performance dashboard, any closure or suspension of service was.
- The delivery suite had worked with the Stillbirth and Neonatal Death charity (Sands) to refurbish two rooms on the delivery suite as bereavement rooms. These rooms were larger and with seating areas that could accommodate partners to remain with the women overnight. These were used for women experiencing a stillbirth or for women requesting termination of pregnancy for fetal abnormality over 16 weeks' gestation.
- Ward 2a had a high turnover of patients, many of whom were from other surgical specialties. Staff told us they were concerned about the impact that time spent with patients of greater complexity and acuity from the other surgical specialties had on gynaecological patients.

Access and flow

- Staff told us some gynaecology patients had been cancelled on more than one occasion. We reviewed the gynaecology performance dashboard and figures received from the trust. This indicated that whilst some patients had been cancelled on the day of surgery because of a lack of beds, no patient had been cancelled more than once. Ten women had their surgery cancelled on the day of surgery in October 2014, one in November 2014, 16 in December 2014 and 15 in January

2015. Concerns regarding access and flow, ability to meet waiting times and to admit gynaecology patients were on the risk register. These had been escalated to divisional and board level.

- The maternity day assessment ward was open from Monday to Friday, 8am to 4pm. Patients remaining in the assessment area after that time were transferred to the triage area. This increased the activity through the triage area and on the delivery suite.
- Elective caesarean section lists ran from Monday to Friday and could accommodate a total of five cases per day. Staff felt this was sufficient to meet demand.
- A total of eight inductions of labour could be accommodated at any one time. These were booked in with the maternity ward. In addition, the maternity ward discharged on average 17–23 women per day.
- Midwives were trained to undertake the newborn screening examination. Whilst many examinations were undertaken by paediatricians, trained midwives could undertake the examination to expedite discharge if required.
- Discharge information was communicated to GPs and midwives when women were discharged from hospital services. Discharge summaries were written and sent to the GP to ensure GPs were aware of the care and treatment undertaken.

Meeting people's individual needs

- Translation services were provided by a telephone translation service. Leaflets were available in alternative languages, although these were not immediately available for midwives or nurses to give women, but had to be ordered in. We spoke to one woman on Ward 2a for whom English was not her first language. She described being unsure of her treatment and care needs despite having had them verbally explained. In addition, we saw one woman attend an outpatient clinic. It was clear that staff in the reception area had difficulty communicating with the woman as there was no translation service available.
- Staff told us documentation processes were not always correctly followed when patients were transferred to areas other than the gynaecology ward to await discharge. This was done to vacate a bed for another patient. Staff told us that at times they had been required to recall patients from the discharge waiting area to complete the correct paperwork, such as in the event of a miscarriage. This was felt to be distressing for the women and nursing staff involved.
- We spoke to one patient who had recently returned to England to have her baby. She told us she was pleased at the speed with which the scan and appointment with the consultant had been arranged.
- Woman reporting to triage having felt no foetal movements for a period of time were admitted into a single room equipped with an ultrasound scanner. This meant that, should the absence of a foetal heart be detected, women and their partners were able to receive the news in privacy rather than in an open bay area.
- Ward 2a had a recently decorated small room with comfortable seating, which was used for counselling, breaking bad news or having private discussions with patients.
- Ward 2a had no immediate access to ultrasound scanning. Therefore, women attending for registrar review to prevent unnecessary admission could not have immediate access to a scan. Staff described borrowing scanning equipment from other areas.
- Midwives had identified some high risk women wanted to be able to experience normal birth. This was part of the Mums Up and Mobile (MUM) programme. As a result, a pool had been installed on the delivery suite (Jasmine room). This meant high risk woman would be able to have the opportunity to experience care of their choice.

One of the bays on the maternity ward was used to provide transitional care to babies who might otherwise have required admission to special care. Midwives undertook frequent observations on these babies. However, the babies were required to attend the neonatal unit every 12 hours in order to receive intravenous antibiotics if required.

- Following bereavements, women were given memory boxes appropriate to the gestation of their lost baby. In addition, all women received a follow-up telephone call and were offered a home visit by the bereavement specialist midwife (in addition to any postnatal care being given by the community midwives).

Learning from complaints and concerns

Maternity and gynaecology

- The number of complaints received was monitored on the service's dashboards. Complaints were processed centrally and sent to relevant areas for investigation and the formation of a response. Staff on Ward 2a told us they were concerned that the number of complaints had increased. They felt this was as a direct result of the ward being so much busier with patients admitted from other specialties.
- Staff were able to describe changes that had occurred as a result of complaints received. For example, the infant feeding leaflet associated with tongue tie had been altered to explain that surgical division of the tongue tie was no longer required if the baby was bottle fed.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecological services were well-led.

The service had a well-defined governance structure with good communication to the board. Activity, quality and risk were monitored and reported on; however, actions to address risks were not recorded on the risk register. Specialist midwives were employed to support the governance function.

The women's and children's divisional management team had been a stable team since 2006. Staff were positive about the support from the senior staff and immediate managers. Staff described an open culture that encouraged honesty. Although there had not been maternity service liaison committee meetings with users, actions were underway to reinvigorate it. Other means of public engagement were evident.

Staff actively promoted the Mums Up and Mobile (MUM) project to promote normality in labour. This was supported by the roll-out of wireless cardiotocography (CTG) monitoring, with the delivery suite the first in country to go fully wireless. There was an outpatient induction service for pregnant women whose only complication was postmaturity, aiming to keep the woman at home until labour established.

The maternity unit had recently purchased a full pregnant-woman simulator, known as 'Victoria'. Staff were able to practise simulated emergencies and deliveries in a highly realistic way.

Vision and strategy for this service

- Staff were aware of the trust's vision for safe, effective and personalised care for every patient, every time. In addition, there was a clear vision for the maternity unit which centred on the promotion of normality in labour. Staff we spoke with were clear on that aspect, though less able to describe the remainder of the service's vision, namely to: provide evidence-based care, support, innovate, listen and improve, and to monitor practice.
- Developments within the maternity service were all working towards the vision, for example wireless cardiotocography (CTG) monitoring and mobile epidurals within the MUM project.

Governance, risk management and quality measurement

- There were clear governance processes across both services which fed into the women's and children's division. Service-wide meetings were held that oversaw activity, performance, quality, safety, audit and risk. These in turn fed into the division and onward into sub-committees of the board. There was divisional representation on these committees. Specialist midwives were employed to support the governance function of the service.
- There was a service-wide risk register. We reviewed the risk registers for both maternity and gynaecology. These contained a description of the risks, the date they were added to the risk register and the date they were due for review. The service was in the process of migrating risks from one electronic system onto another. Risk assessments were reviewed and each demonstrated actions put in place to mitigate the risk. The highest risks identified on the risk register were staffing and CTG interpretation. Senior staff told us this was a priority risk, not as a result of patient outcomes, but in order to maintain impetus on safety. Staff told us they would escalate risks identified to their managers for inclusion in the risk register.
- Practice was reviewed and learning shared. For example, we saw the 'perinatal brief' distributed to staff

following a morbidity and mortality meeting in November 2014 at which the induction of labour rate had been reviewed. This was felt to be higher than previously at 22.7%, therefore a full audit for reasons for induction of labour was planned.

Leadership of service

- Medical, nursing and midwifery staff described a visible presence by the director of nursing, who was said to be approachable and supportive.
- The nurse consultant with management responsibility for gynaecology attended or called the ward daily in order to identify and address any immediate concerns.
- Midwifery leadership was highly visible. All staff we spoke with were positive about the support they received from the senior staff and immediate managers.
- Teams were described as cohesive and supportive.
- The women's and children's divisional management team had worked together in that capacity since 2006. They described a supportive team around them that allowed them to function well.

Culture within the service

- There was an open and positive culture across both services, which promoted loyalty and teamwork among the midwives.
- Staff spoke of feeling happy and supported to raise concerns. Junior medical staff described being able to raise concerns regarding practice with the consultant. One consultant told us of concerns that had been raised with them by a midwife, which they had subsequently investigated and acted upon.
- Medical staff told us they felt there to be a right balance between supervision and freedom, allowing them to develop their clinical expertise and knowledge.
- The opening of the maternity unit in 2010 had seen the bringing together of two smaller obstetric-led units successfully into one. Staff described holding a Ball to encourage teambuilding and integration. This had proved to be a huge success, and staff felt it had been key in bringing the two teams together. As a result, the maternity service continued to hold either a Ball or to put on a Review each year. The next Ball was planned for May 2015.

Public and staff engagement

- The maternity service had lay-user representation within a number of groups. They were also in the process of reinvigorating the maternity service liaison committee meetings. There was also a trust Facebook page with links to the maternity service.
- Staff were asked to provide ideas for improvement through the maternity and newborn newsletter. The newsletter detailed actions that had occurred as a result of staff feedback; for example, skills drills were now held in the birth centre as well as on the delivery suite, following requests for training to be focused in the normal setting as well as the high risk care setting.

Innovation, improvement and sustainability

- Staff actively promoted the Mums Up and Mobile (MUM) project, which had also been presented nationally at midwifery conferences. This was supported by the roll-out of wireless cardiotocography (CTG) monitoring, with the delivery suite the first in country to go fully wireless.
- Senior staff were in discussion with commissioners for the provision of a hyperemesis (excessive vomiting in early pregnancy) day clinic to avoid unnecessary admissions.
- There was an outpatient induction service for pregnant women whose only complication was postmaturity. Treatment was administered on the ward, and providing all observations remained normal, the woman was discharged home in the evening. Midwives then made a follow-up call 12 hours later to monitor progress if the woman had not already presented in labour.
- The maternity ward had previously run a 'baby café' in the cafeteria, supported by the maternity care assistants. However, staffing issues had recently meant this could no longer be staffed.
- The maternity unit had recently purchased a pregnant-woman simulator, known as 'Victoria'. Staff were able to practise simulated emergencies and deliveries in a highly realistic way.

Services for children and young people

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

All children's inpatient services are located at Gloucestershire Royal Hospital, with the exception of specialist eye surgery day cases. These are held at Cheltenham General Hospital but staffed by nurses from the children's unit. A team of clinical nurse specialists is based on the children's unit and provides an outreach service across the county. The services provided within the children's services include oncology, surgery, medicine, neonatal intensive care units and support services such as play and education.

The trust provides 52 inpatient beds, which include a dedicated eight-bed day-case unit, a four-bed oncology unit and a four-bed high dependency unit. A six-bed paediatric admissions unit (PAU) is located in the children's unit. There are a further 28 cots on the neonatal intensive care unit. Children's and young people's outpatient services (reported under the outpatients section of the report) are located in the children's unit and a separate outpatient department at Cheltenham General Hospital.

We spoke to 34 staff, including nurses, consultants, medical staff, managers and support staff. We spoke to 20 parents and eight children and young people during our inspection. We visited all the areas within the children's unit. We observed care and looked at records and also other documents provided by the trust.

Summary of findings

Overall, services for children and young people were found to be good. Children received excellent care from dedicated, caring and well trained staff who were skilled in working and communicating with children, young people and their families. Children, young people and their families were involved in the children's and young people's care, and the comments we received were all very positive.

The arrangements for safeguarding were good and improving, although we had some concerns about the numbers of referrals being received and the lack of staff to deal with those referrals in a timely way. We also had concerns about the medical cover for middle grade doctors on both the neonatal and children's units.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We did have concerns about the medical staffing numbers, specifically relating to the middle grade doctors. Whilst the trust was aware of this issue, plans had only been put in place since December 2014.

There were systems in place for recording and learning lessons from incidents and staff told us they were encouraged to report incidents.

Systems were in place for the safe storage and administration of medicines and appropriate audit trails were in place for controlled drugs and prescription forms.

We saw that parents were fully informed prior to consent being obtained and that nursing and medical records had been completed appropriately and in line with each individuals child's needs.

Staff had completed their mandatory training and had systems in place to identity deteriorating babies, children and young people.

We saw evidence of good safeguarding processes in place. We were told that the designated and named doctors for safeguarding did not have the capacity to meet the demand of the referrals. Whilst measures had been put in place to reduce the risk to children, there were still a large number of children waiting to be seen.

Incidents

- Systems were in place to make sure that incidents were reported and investigated appropriately. Staff told us they would have no hesitation in reporting incidents and were clear on how they would report them. Staff told us they were able to get feedback on incidents they reported because there was space on the incident form to request feedback.
- Risk coordinators were in place for both the children's unit and the neonatal unit. The risk coordinators reviewed any reported incidents on a daily basis and looked at areas requiring action. Where incidents were judged to be serious, a scoping meeting was arranged with all the staff involved and an investigation started. Where the risk of the incident was judged to be lower, the incident was reviewed and investigated by the ward sisters and matrons.
- Any trends with incidents were raised via the paediatric joint medical/nursing monthly newsletters; we saw evidence that this was the case. These newsletters reiterated that individual feedback to staff was available to improve communication, keep staff updated and promote a reporting culture. These trends showed us that the biggest areas for concern with incidents in 2014 were: medicines (95 incidents); staffing, bed and system problems (70 incidents); treatment provided (70 incidents); care provided (60 incidents); and record keeping (30 incidents).
- Staff gave us examples of actions that had been taken to reduce the risk of similar incidents occurring and how patient safety had been improved. One example was the increased use of paediatric early warning scores. The risk coordinators produced a 'lessons learned' report, which was presented to staff. We saw evidence that learning was also discussed through risk management meetings, perinatal meetings, ward meetings and the newsletters.

Cleanliness, infection control and hygiene

- During our inspection we observed staff washing their hands and using hand sanitiser in accordance with the trust's policy. We observed staff advising visitors to also use the hand sanitiser when entering the children's unit. Personal protective equipment such as gloves, aprons and face shields was available for staff to use, and we observed staff using these items appropriately.
- Each of the areas we visited during our inspection looked clean and tidy. We saw that cleaning schedules were being maintained.
- Side rooms were available to isolate children and young people who might present with an infectious condition. Staff told us about the procedures in place to identify these children and when to place them in isolation.
- Systems were in place for the management of clinical waste. This included the use of clinical waste bins, cytotoxic waste disposal and sharps boxes.

Environment and equipment

- Both the children's unit and the neonatal unit had secure access to maintain the safety of the babies, children and young people. Staff were able to control access to their department via a video entry system. Staff told us that sometimes this meant that people who wanted to access the units had to wait until staff had verified their identity and reasons for visiting.
- Resuscitation equipment appropriate for babies, children and young people was in place. We saw that this equipment was consistently checked daily.
- We visited the neonatal intensive care unit and the high dependency unit and found that each bed space had the necessary equipment. Machines with internal batteries were plugged into the mains to keep them charged.
- Equipment was serviced according to the manufacturer's instructions. Equipment had labels in place to confirm its last check date.
- The environment within the children's unit was suitable for children and young people. A range of toys and activities were available. Sensory equipment was available for children with special needs. Some of the children we spoke to were excited about a new piece of equipment that projected interactive images into the floor.

Medicines

- During our inspection we found that medicines were stored securely in locked rooms that were only accessible by staff. Controlled drugs were stored in separate locked cupboards and were checked daily by two qualified nurses. Where medicine needed to be stored in a fridge, the fridge temperatures had been checked consistently during March 2015. However, the fridge within the paediatric admissions unit (PAU) had only been checked on four days during February 2015. We raised this with the nursing staff and were told it had been checked but not always documented.
- We noted that allergies had been documented on the medicine charts for children and young people where appropriate. We saw that medicines were administered as prescribed and documented on the medicine charts.
- A dedicated pharmacist visited the unit on a daily basis. They checked ward stocks and reordered as necessary. They also provided advice and support to staff regarding audits and reducing medication errors.
- The children's unit operated a policy of single nurse administration of some medicines. A policy was in place as an extension to the trust's main policy on ordering, prescribing and administering medicines. Staff had to be qualified children's nurses with a minimum of six months' experience and to have been deemed competent in the safe administration of medicines. There was an agreed list of medicines that could be administered under this policy.
- Medication errors were the top risk, accounting for 95 incidents in 2014. Of these, 46 were caused by medicines that had not been given, 25 were because of wrong or unclear doses, 20 because of wrong frequency, and 17 because of wrong quantity. Measures had been put in place to reduce the number of incidents recurring, including a process for education of staff in reducing medicine errors.
- Children's and young people's services used a process known as DRAINS to make staff more aware of medication errors. DRAINS stood for: Drug and dose, staff should be checking they are legible, correct and patient appropriate; Route, staff should be aware whether the route is correct, because multiple routes have been shown to be unsafe and to be avoided; Allergies, staff must make sure the allergy section is completed, dated and signed; Identification, staff should be checking the child's name, address, date of birth and hospital numbers before administering any medicines; Nursing and Midwifery Council, are staff adhering to their professional standards for medicines management?; and Signatures, staff needed to check there is a prescriber's signature and that all medicines are signed for when given or changes made to the dose.
- We saw evidence of where action had been taken to reduce errors. For example, there were some medicines that, whilst they were different strengths, they were in very similar packaging. By storing these medicines separately it reduced the chances of staff administering the wrong strength.
- The children's unit carried stocks of some medicines that could be prescribed to children and young people

to take home on their discharge. This meant patients were not delayed, especially out of normal pharmacy hours. There was a clear audit trail for these medicines, and staff were able to respond quickly to any queries about what medicines the children and young people had been discharged with. With the PAU, the doctors were able to issue prescription forms to parents. We found that the PAU had a clear audit trail in place for these prescription forms to make sure they were accounted for.

- We found an emergency grab bag of medicines for use in emergencies locked in a cupboard in the treatment room on the children's unit. On checking this grab bag, we found eight of these medicines were out of date. We raised this at the time with the manager, who informed us that the bag was not used and should have been removed from the ward. It was subsequently destroyed during our inspection. We checked other emergency drug bags that were in use and found them to be all in date.

Records

- We looked at 15 combined medical and nursing records in all the areas we visited. These records contained clear and detailed information and reflected the care each baby, child and young person needed. We saw that entries were signed and dated in accordance with trust's record-keeping procedures. We noted that core screening had been completed in each case. Care plans were in place and, where necessary, risk assessments had been completed.
- Observation and monitoring charts were used. Overall we found these had been completed appropriately and according to the needs of the individual child or young person and the care plan. We did, however, find some inconsistencies with the fluid monitoring charts. In three sets of notes we saw that the fluid monitoring charts had not been totalled at midnight, and therefore staff were unable to ascertain whether those children had received the appropriate amount of fluids. We raised this with the senior nurse and were told that the staff should total them after each 24-hour period at midnight.
- The senior nurse on duty completed a daily record-keeping audit by randomly selecting five sets of nursing records. We saw that these checks were completed consistently and action taken where errors had been identified. Where persistent errors were shown by the same staff, it was raised through the individual staff performance management process. We observed that these record-keeping audits did not look to see whether the fluid monitoring charts had been totalled.

Consent

- Staff were aware of the principles of Gillick competencies and used these where appropriate.
- We saw from the records that consent was obtained from parents for each baby, child or young person who was undergoing any procedure or surgery. We saw that the consent forms included details of the specific procedure together with the potential risks or complications.
- The parents that we spoke to during this inspection all told us that the consultant staff had explained any procedures to them fully before asking for a consent form to be signed. The children we spoke to during this inspection also told us that the doctors had explained things to them directly in a way they could understand.
- Where the parent's first language was not English, interpreters were used during the consent process to make sure parents fully understood the risks and benefits before signing the consent form. We noted that the interpreter was asked to sign the consent form to confirm that the translation was true and accurate.

Safeguarding

- Records showed us that all staff had been trained to level 3 in children's safeguarding. The staff we spoke to during our inspection told us that their training was up to date and that they had completed their yearly updates. Senior nursing and medical staff had also gone on to complete the enhanced level 3 multi-agency training.
- A safeguarding policy was in place across the trust, and staff knew how to access this policy. Staff were able to explain the different types of abuse, including child sexual exploitation and female genital mutilation. Staff were able to explain their role in the recognition and prevention of child abuse and what actions they would take if they had safeguarding concerns about a child.

- We spoke to the designated doctor and named doctor for safeguarding within the trust. They told us that regular peer review and supervision took place for medical and nursing staff. They told us that the designated nurse was in place and named leads and link workers were in place on both the neonatal and children's units. We were told that there had been teething problems with the trust's information system communicating with the local authority safeguarding system, and that this was being investigated. It was felt that it was vital to have systems that communicated freely with each other to promote interagency and professional communication for the safeguarding of children. It was hoped that the new IT system would automatically notify social services when a child was admitted who had a social worker.
- A safeguarding children newsletter was produced every three months, highlighting key areas to improve staff awareness, such as female genital mutilation and child sexual exploitation. It provided updates on accident prevention and any child safety alerts from Public Health England. Details of training were listed and what was new in the local area on safeguarding children.
- A leaflet was given to parents who might be involved in a safeguarding process. This explained what would happen and was used as a support to the verbal explanations given by staff.
- When any baby, child or young person was admitted, a safeguarding assessment was completed. We saw evidence that these were completed appropriately.
- We spoke to the health visitor liaison nurse who visited the emergency department and children's unit on a daily basis. Where any concerns were raised by staff, contact forms were completed which were reviewed each day by the health visitor liaison nurses. They were able to check to see whether the children concerned were subject to a safeguarding plan and make decisions on follow up referrals and any action that needed to be taken. Outcome boxes on the contact sheets were then completed either at the time or following decisions or actions from the local authority.
- Staff told us that improvements had been made to children's safeguarding, and gave examples such as a new administration worker who had been employed to support the designated doctor. Social services notify the staff of the outcomes of case conferences on the same day, whereas previously this could take several months. Further improvements included asking all children on admission whether they had a social worker.
- We saw there were good links with the local police and the sexual assault and referral centre (SARC). The medical staff would use SARC's facilities to undertake safeguarding examinations.
- Any safeguarding referral requiring medical examination was referred to the medical staff on the children's unit, with the community paediatricians taking over on the next working day. The switchboard made contact with the SARC and the on-call paediatrician as necessary. The designated and named doctors were always available for advice as necessary.
- We were told that a medical legal group was starting, chaired by a judge. We were told that this was to help staff to fine-tune giving evidence in court, breaking down barriers between the Criminal Prosecution Service (CPS), police and doctors. We understood that this was a unique group, with the only other local one being in Bristol.
- We were told that while safeguarding was given a high importance within the trust, it required additional funding to match the demand. For example, we were told that the designated doctor had 12 slots each month to see new children, however between 12 and 16 children were referred each week. This increase has caused a 'pending list' for follow up appointments, which meant delays for children being seen. This could potentially put children at risk. We were told that the risks had been reduced by prioritising those to be seen and making sure that both the parents and the children on the pending list could contact the designated doctor at any time. Additional posts had been advertised but there had been no applicants. Since our inspection the trust has provided us with the risk assessment and action plan which shows the trust is aware of the risk and had plans in place to manage this risk and to resolve as quickly as possible.

Mandatory training

- The trust held mandatory training records for all wards and departments including the children's unit. We looked at the training records for children's and young people's services and they showed that all the staff were

either up to date with their training or had dates booked to attend the next available mandatory training day. The key performance indicator for children's services was for 90% of their staff to have completed their mandatory training. The unit had achieved this between August 2014 and November 2014. All the staff we spoke to during this inspection told us they were up to date with their mandatory training.

- A dedicated study day was run for all staff within children's and young people's services. This day included safeguarding, mentorship, resuscitation, manual handling, learning from incidents and mental health training.

Assessing and responding to patient risk

- Each baby, child and young person had a comprehensive nursing assessment completed on admission. This included risk assessments such as pressure ulcer prevention, where necessary and appropriate. We saw that these assessments were present in all the notes we looked at during this inspection.
- Clear processes were in place to deal with deteriorating children. The Paediatric Early Warning Score (PEWS) system was in place. Details of the escalation required, depending on the scores, was in place on each PEWS chart. Four different PEWS charts were used for different children of different age ranges. Each chart recorded the necessary observations such as pulse, temperature and respirations. The charts also recorded pain scores.
- We observed the multidisciplinary handover that took place every morning. Information was included on how any individual child was progressing and any areas of concern that staff had regarding the child's condition. In addition, the nursing staff held a ward handover every morning. The ward coordinators then allocated staffing depending on the needs of each child and the skills of the staff available. This showed appropriate communication was in place to assist staff in responding to children's individual needs.
- All staff within the children's and neonatal units had been trained in paediatric life support. Staff working in high dependency areas had also been trained in advanced paediatric life support.
- When children were admitted for surgery or procedures, checklists were used. Staff completed these checklists with the child and parent on admission. The details were double-checked when the children were collected on the ward before their trip to theatre and also by the theatre staff in the anaesthetic room. This meant systems were in place to make sure the correct child or young person was having the correct procedure. If surgery was to be performed, the area was marked and this was confirmed and double-checked by staff at each step. This reduced the chances of wrong-site surgery being performed.
- The paediatric admissions unit took GP and A&E referrals for all children from birth to 16 years of age 24 hours a day. All referrals were discussed with a paediatric consultant. When children were seen within the paediatric admissions unit (PAU), depending on their individual needs, they could be observed in the six-bed observation unit, admitted to the children's unit if necessary, seen in rapid-access clinics for follow-up, or discharged home.

Nursing staffing

- The staff we spoke to during our inspection told us that there never seemed to be enough staff on duty. These comments were also made by parents.
- We were told that whilst both the children's and neonatal units had difficulty in recruiting experienced staff, they did not seem to have the same difficulty in recruiting junior staff. We were told that recruitment was an ongoing issue, but plans have been put in place to resolve it. These plans including recruiting nurses from overseas. We asked to see the nursing workforce action plan and were provided with a copy from January 2015. This did not show any updates since January or the status of each action.
- Where there were shortages in nursing staff, gaps were filled using the hospital nurse bank system or, as a last resort, via a nursing agency. Escalation plans were in place should staffing vacancies remain unfilled.
- The nurse manager told us they were able to achieve a nurse-to-children ratio that adhered to the Royal College of Nursing guidelines. These ratios were one nurse to four children on the main ward, increasing to one nurse to two children in the high dependency area. A matron was always on duty and had an overview of

the whole service. Each shift was coordinated by a sister or a charge nurse. A sister or charge nurse was always present in the paediatric admissions unit (PAU) and the day-case unit, which meant senior nursing advice was always available. We did not see any evidence during this inspection that suggested staffing ratio guidelines were not being followed.

- Qualified staff on both the children's and neonatal units were complemented by healthcare assistants and a team of play specialists.
- On the neonatal unit, three of the four advanced neonatal nurse practitioners (ANNPs) were due to retire in 2015.
- The matron for the neonatal unit told us they were able to adhere to the British Association of Perinatal Medicine (BAPM) guidelines for the ratio of staff to babies. We saw that in the special care unit a ratio of one nurse to four cots existed; this rose to one nurse for every two cots in the high dependency area and one nurse to one cot in the intensive care unit. We saw evidence that these ratios were being achieved for the majority of shifts.

Medical staffing

- At the time of our inspection, the children's unit had nine consultants whilst the neonatal had five consultants. The consultants worked predominantly between 9am and 5pm with on-call commitments to make sure the units had 24-hour cover. Some consultants were also required to cover from 5pm to 8.30pm because of the lack of middle grade cover, specifically in the paediatric admissions unit (PAU).
- We had concerns regarding the middle grade medical cover. The medical staff shared their concerns about this with us during our inspection. We noted that it also featured on the divisional risk register and trust risk register.
- The middle grade medical rota was supposed to have 15 doctors to fully cover the children's unit and the neonatal unit. This number was made up of 12 medical staff and the other three posts were covered by four advanced neonatal nurse practitioners (ANNPs). From March 2015, it had reduced to a 12-person rota because of the retirement of three ANNPs. Within this 12-person rota, one was on sick leave and two were just about to start maternity leave. This left nine doctors to cover a rota for 15. These doctors covered the children's unit and neonatal unit 24 hours a day and in the PAU from 10am to 10pm.
- The trust had been aware of the retirement of the three ANNPs for more than a year and had not supported ANNP training until recently. A middle grade working group was established which involved managers, consultants and medical staffing. This working group met every four to six weeks and an action plan was drawn up to resolve the shortage of middle grade cover. This action plan included an agreement to look at a new post for an advanced paediatric nurse practitioner (APAP). However, how this post would work had yet to be addressed. The actions that had been agreed included funding for ANNP training, using existing money to fund a one-year medical fellowship post, and two medical staff had been appointed from overseas. At the time of our inspection, despite the urgency to resolve the middle grade cover, the job description for the fellowship had not been produced and the overseas staff had yet to achieve registration with the General Medical Council.
- We looked at the gaps in the rota for middle grade doctors and saw from March 2015 to September 2015 that 105 shifts (either night duty or long day shifts) were unable to be covered with the rota in place.
- In the meantime, consultants had been asked to cover gaps in the rota and 'act down'. We saw that a policy had been put in place for this but were told that no agreement had been reached for a change in the consultant's job plans.
- We were told that because of the middle grade reduction, there was no registrar in the PAU until 10am, and only one registrar to cover the children's unit and the PAU over the weekend. The medical staff told us that there had been difficulty with the rotas for last three years but the loss of more staff had made the situation worse. Some of the medical staff told us that the divisional managers had helped to rewrite the rota, but that goodwill from medical staff had been negatively affected.

Services for children and young people

- We looked at the action plan that had been put in place, and whilst we found this to be comprehensive, we noted that it had only started in December 2014, whereas the problems appear to have been known about for longer than that.
- We looked at the paediatric dashboard, which showed medical staffing had been rated as a red risk every month from April 2013 to March 2015 with the exception of November 2014. This lack of middle grade medical cover potentially put children at risk because of the lack of experienced doctors providing a 24-hour service to the neonatal unit and children's unit.

Major incident awareness and training

- The staff we spoke to were aware of the trust's major incident policy and understood their roles and responsibilities.

Are services for children and young people effective?

Good

Babies, children and young people were cared for by competent staff who had received the necessary training.

A selection of food was available, including special diets, halal meat, and milk for babies. We saw inconsistencies in the recording of fluid intake on fluid monitoring charts on the children's unit. We saw that daily record-keeping audits were completed by senior nursing staff but that they did not contain checks on fluid monitoring charts.

Clinical pathways were present for the most common conditions children presented with, including high temperature, head injury and abdominal pain. These pathways were shared across the health community in Gloucestershire to support consistent treatment for children who presented with these issues.

We observed excellent team working both within the services for children and young people and externally with other wards and departments that children had contact with.

Evidence-based care and treatment

- Policies, procedures, guidelines and protocols were developed in line with national best practice where appropriate. For example, the 'Big 6' document aimed to standardise treatment protocols for the six most common problems children present with.
- Policies were available to all staff via the trust's intranet system. We saw evidence of this, although some staff did tell us that it could sometimes be difficult to find exactly what they were looking for.

Pain relief

- Pain scores were an integral part of the observation charts. We saw evidence that, when appropriate, pain scores were completed and analgesia was administered. Parents confirmed that if their child needed pain relief, it was given without delay.
- The play specialist team provided distraction therapy, as necessary, for all children undergoing procedures and tests.

Nutrition and hydration

- We looked at the fluid monitoring charts, and in three sets of notes we saw that the charts had not been totalled at midnight and therefore staff were unable to ascertain whether those children had received the appropriate amount of fluids. We raised this with the senior nurse and were told that the staff should total the charts after each 24-hour period at midnight. We observed that the charts were completed in the neonatal unit.
- Guidelines were in place for children and young people who were unable to eat and drink because of surgery. This meant they were not fasting for long periods.

Patient outcomes

- The hospital play specialists were available seven days a week to support children and young people. The play team was also available for play and distraction therapy. Team members were able to visit children and young people at home and at their school to help prepare them for coming into hospital. They could help with needle phobias, insulin injection and oncology treatment.
- Information obtained prior to our inspection showed that the multiple readmission rate was worse than the England average for asthma in children of one to 17

years of age. The England average was 16.8%, however on the children's unit it was 22.7%. We raised this with the nursing and medical staff within the children's unit, but they told us they were not aware of this until we raised it.

- From April 2013 to March 2014, the children's unit saw an average of 214 children per month admitted from the emergency department.
- We asked the trust for the results of the latest neonatal audit, but received information from 2013. This showed that the neonatal unit had not achieved some of the standards set by the Royal College of Paediatrics and Child Health. These included not taking temperatures of babies less than 29 weeks gestation within an hour of birth (the trust scored 82% compared with a standard of 98% and a national average of 93%) and lack of documented consultation by a senior member of the neonatal team within 24 hours of admission (the trust scored 65% compared to a standard of 100% and a national average of 84%. However, the trust had scored well in other areas such as retinopathy screening where the trust achieved 100% against a national average of 94%. We were not shown more up to date results, however, an action plan was in place.

Competent staff

- We saw examples of senior nursing staff who rotated every six months between the day-case unit and paediatric assessment unit (PAU) to maintain their competencies. The staff told us this helped to maintain their skills in each area and that rotating every six months felt about the right length of time. The staff also rotated from days to nights.
- Staff told us they were encouraged and supported with training and that there was good teamwork. They told us they had their performance reviewed and received face-to-face feedback.
- The children's unit had seen an increase in admissions of children and young people with mental health issues. Additional training had been made available to staff in caring for these children and young people. At the time of our inspection, all staff were working towards completing the two-day training.
- The trust kept a list of all mandatory training, and in addition the children's unit kept a list of all staff competences. These were kept updated and staff were reminded when they needed to update specific competencies. All neonatal staff had completed mandatory training, and those who had not completed it on the children's unit had a date on which to attend.
- 'Motivational Mondays' for the band 5 nurses had been running for 18 months and encouraged them to look at problems and to think about how they would manage and resolve them. It got them to think about what they could do to help resolve problems rather than just relying on a senior member of staff. The initiative only existed on the children's unit, and staff told us it gave them an advantage because they were aware of problems and would think out of the box to resolve them. They gave us several examples of issues that had arisen that they had resolved themselves, and compared this with the action taken by staff in other ward areas that had not had the benefit of 'motivational Mondays'. As an example, where there was a shortage of linen and pillows, staff told us that on other wards the staff would contact the senior nurse on duty to resolve the issue. However, the staff within the children's unit would resolve the problem directly, because they understood the processes involved and who to contact.
- Staff on the children's unit told us that they had received a comprehensive induction, both to the trust and the children's unit. This included spending up to a month being supernumerary under the supervision of a mentor.
- The induction for the neonatal intensive care unit was similar and included a period of eight weeks' supernumerary status whilst the new staff worked through their induction packs and competencies in areas such as heel pricks and nasogastric tubes. For the first six weeks, the new staff were supervised by more experienced staff, and for the final two weeks they were integrated more into the ward team and expected to take on more responsibilities.
- Both on the children's ward and the neonatal unit, new staff could have their induction extended if they hadn't achieved their expected competencies. New staff in both units were expected to gain experience before they were able to administer drugs, and had to complete additional training and competencies to administer intravenous drugs.

- On the neonatal unit, 70% of staff had completed the neonatal qualification. The nurse manager told us it was important to "grow their own" staff, and funding had been secured via a local charity, the trust and the local neonatal network to fund additional nurses to gain the neonatal qualification.
- Staff on both units told us that they received regular access to supervision and appraisals.

Multidisciplinary working

- We saw examples of multidisciplinary team working across all the areas within children's and young people's services. This team working also existed across other departments such as the emergency department, theatres and radiology. Several working groups had been established, particularly between children's services and the emergency department and general surgery. These groups contained staff from those particular areas, who worked together to improve the care children received when being seen in the emergency department, and to improve the process of transferring to the children's unit and then, where necessary, the transfer to theatres.
- The play specialists were a part of the wider team. They supported children, young people and staff on the ward, but could also be bleeped by other departments such as radiology and the emergency department to provide distraction therapy.
- Handovers were multidisciplinary in the morning to ensure all staff had up-to-date information about the needs of children within the service. At other times of the day, handovers took place between nursing and medical staff. We observed two handovers and found them to be very comprehensive.
- There was access 24 hours a day, seven days a week, to psychiatric support for children using this service. We saw good working relationships with the local children's and young people's mental health services.

Transition

- The senior nursing staff within the children's unit told us that transition was still a challenge that needed to be overcome. They told us that in certain areas such as learning disability and epilepsy there were transition policies in place. However, at the time of our inspection, discussions were being held with the clinical commissioning group, who agreed that transition needed to be addressed and would potentially be a key target for the coming year.
- On the neonatal ward, a four-bed transition ward was available for women and their babies, for women to get used to the additional care their babies might need whilst having the reassurance that a qualified nurse was on hand to advise and support and help prepare for the babies' discharge home.

Seven-day services

- The services for children and young people were available seven days a week, with the exception of the day-case unit, outpatients and the school. The play therapy team provided a service seven days a week.
- Staff were able to obtain mental health and safeguarding advice 24 hours a day.
- Consultants were available seven days a week via an on-call system.

Are services for children and young people caring?

Good

The feedback we received from children, young people and their parents was all positive. They praised the staff for the care they received, they praised the environment and the food, and they praised the way the staff really understood the needs of children but involved the whole family in caring for the needs of individual children.

Parents were encouraged to be involved in the care of their children as much as they wanted to be, whilst young people were encourage to be as independent as possible.

Staff were skilled to be able to communicate well with children and young people to reduce their anxieties, and keep them informed of what was happening and involved in their care.

We observed that where a parent's first language was not English, interpreters were provided to make sure the parents fully understood what was happening and, where necessary, could give informed consent.

Services for children and young people

Compassionate care

- The NHS Friends and Family Test was not carried out in the children's and young people's service at the time of our inspection, but was to be rolled out in line with the national programme later in 2015.
- During our inspection, we observed excellent interactions between staff, children, young people and their families. We saw that these interactions were very caring, respectful and compassionate. The staff were skilled in talking to and caring for children and young people. Parents were encouraged to provide as much care for their children as they felt able to, whilst young people were encouraged to be as independent as possible.
- Parents were able to stay with their children on the ward or in separate accommodation close to the children's unit and neonatal unit.
- We observed staff on both the children's and neonatal units were very sensitive to the needs of parents. As an example, one parent had some anxieties about an open ward, and these could have been relayed to their child. The nursing staff intervened and offered coping strategies to the parent and arranged different accommodation for them and their child. This meant the parent was better able to support their child.
- The day-case unit had a file on display in its reception area that contained lots of thank you cards from both parents and children. This reinforced the feedback that was given to us during our inspection.
- All the feedback we received from the parents we spoke to was unanimous in its praise for the care their children received. The comments we received included, "The staff have been brilliant," "Very happy with the care given to my child," "The staff are very responsive to both our and our daughter's needs," "We are kept well informed," "Can't fault the service; nurses are very helpful, always answer our bell quickly," and "It's like my second home; they are all very welcoming and the ward is always clean."
- The children and young people we spoke to told us how good the staff had been in looking after them. Comments from children and young people included, "It's been a good experience," "The staff help me when I need them," "The staff always tell me who they are," and "There is lots to do; the staff are good and explain things to me."
- Comments from parents in the paediatric admissions unit (PAU) included, "We were seen within 15 minutes; I (the parent) have also been well looked after, offered something to eat and drink," "The care is good," "I brought my child in via the GP; we have been offered food and drink, they are monitoring my child and I feel very reassured," and "The area is a bit cramped, and that is my only negative comment."
- All the parents, children and young people we spoke with told us that staff respected their privacy. This included knocking on doors before entering, and ensuring curtains were closed when personal care was being provided.
- Parents were able to accompany their children to the theatres. We followed a child and their parents to theatre and observed excellent interaction and communication between the theatre staff, child and parents. Once their child had been anaesthetised, the parents were advised they would be called on their mobile phone when their child was in recovery, and they would be able to wait with their child until they were ready to go back to the ward.

Patient understanding and involvement

- We observed staff explaining things to parents, children and young people in a way they could understand. For example, we saw a nurse explaining to a child what would happen before their surgery. Time was allowed for either the child or their parents to ask whatever questions they wanted to. We also observed staff using technology to help children understand what was happening, especially for admission onto the ward and for surgery. iPads were used which had interactive presentations that the children could watch, showing them every step of the process and using photographs from the unit. This proved especially useful for younger children.
- Children admitted for day surgery were seen by the play specialist before admission. This helped the child and parents to understand what was going to happen, and allowed the play specialist to answer any questions they might have.

Services for children and young people

- If a child was coming into the day-case unit for orthopaedic or ear, nose and throat (ENT) surgery, the adult teams phoned the parents the night before to check things were okay and they were ready for the operation. However, the staff on the day-case unit also did this for all of their children coming in, and this could lead to confusion. We were told that the children's unit had offered to phone all children so as to avoid duplication and confusion, but the specialties were not willing to give this up. Parents told us they preferred it when the children's unit called, because the staff were able to answer specific questions.
- Where necessary, interpreters were booked, usually by the booking clerk if the child was a planned admission. We saw evidence of this during our inspection and spoke to two interpreters who had been booked to attend the ward with the parents to make sure communications were accurate and appropriate so the parents could understand.
- Parents were encouraged to be involved in the care of their children as much as they felt able to be. We observed that children and young people were also involved in their own care. Children, young people and parents that we spoke to all confirmed this was the case.
- A range of information on particular procedures and conditions was available for parents. These were used to support the verbal information provided by staff. We did not, however, see any information available specifically for children and young people.
- Parents, children and young people told us the nurse who was looking after them on any particular shift always introduced themselves.

Emotional support

- Children and young people who needed surgery were able to have one of their parents or carers accompany them into the anaesthetic room and then be with them after the operation when they went into the recovery room. This meant the parent was able to continue to provide emotional support for their child. We observed ward staff and theatre staff providing emotional support for the parents and the children and young people as they visited the department.
- The trust's chaplaincy department was available to parents, babies, children and young people on the children's unit and neonatal unit to support their emotional and spiritual needs. The service was open to people of all faiths and of no faith.

Are services for children and young people responsive?

Good

All inpatient children's services had been centralised at the Gloucestershire Royal Hospital, with the exception of outpatient clinics, which were held on both hospital sites. Specialist eye day surgery was still undertaken at Cheltenham General Hospital but with staff travelling over from the children's unit to care for the children.

Systems were in place to allow children to be seen in the paediatric admissions unit (PAU) without having to wait for long periods in the emergency department.

Members of the play specialist team were able to see children who were booked for surgery. They were able to tell the children what would happen, and the children could see for themselves using a special presentation on an iPad.

A wide range of clinical nurse specialists were available to advise staff, parents, children and young people on a variety of specialist conditions such as diabetes and epilepsy. These specialist nurses also provided an outreach service to the children's homes, as necessary, to help prevent admission to hospital.

Service planning and delivery to meet the needs of local people

- Children's and neonatal services had all been centralised at the Gloucestershire Royal Hospital, with the exception of children's outpatient clinics, which were held on both hospital sites. Specialist day case eye surgery was performed at Cheltenham General Hospital. We asked the managers about these specialist lists and were told the children were looked after in separate bays away from the adult patients and cared for by children's nurses from the children's unit.
- Both the children's unit and the neonatal unit had escalation plans in place for a lack of capacity or

shortages of staff. These escalation plans included the use of other areas when necessary. For example, if the children's unit was full, strict guidelines were available for staff to decide which children could be cared for in the dedicated oncology suite or the day-case unit.

- The children's unit had a four-bed high dependency unit which, because of the increase in demand, had been funded to provide a full service all year round.
- Figures were maintained for paediatric admissions detailing the times children and young people attend the unit. This allowed for staffing to be flexed as necessary to cope with demand. The figures showed that the quietest times were between 1am and 9am.
- Allergy services had been developed over two years in light of the needs of the children, young people and parents. The clinics changed from consultant-led to nurse-led clinics. The consultant reviewed referral letters and decided which clinic the child would be best seen in, and set up health visitor and school nurse allergy champions to get information into schools. GP events were also held to increase training and awareness within the health economy.
- The children's unit provided a wide range of age-appropriate toys and activities for children and young people in an environment suitable for this age group.
- It had been identified that from July to December 2014, the neonatal unit had been forced to send 34 babies to other units because of the lack of high dependency and intensive care cots. A proposal had been put forward to increase the number of intensive care cots together with the associated staffing, with an anticipated completion date of April 2015.
- Cheltenham General Hospital no longer had children's inpatient beds, and therefore all children went to the emergency department at Gloucestershire Royal Hospital. This had resulted in an increase in the workload for the emergency department. There was an agreement in place that after 8pm all babies up to the age of one year went straight to the PAU.
- Before February 2014, children undergoing surgery as day cases were admitted to another unit away from the children's ward. The opening of the dedicated day-case unit on the children's inpatient ward meant children and young people were now cared for in a more suitable environment.
- Respiratory nurses cared for the children with cystic fibrosis and provided an outreach service that worked well. They linked with the Bristol Royal Hospital for Children and presented the lowest infection rates at the quality board. They were now looking to include psychological support at the clinics.
- Clinical pathways were in place for the most common reasons why children present to hospital, including head injury, abdominal pain and fever. These pathways gave clear and consistent guidance about how to treat these conditions. These pathways were shared across the health community, including GPs, to promote consistency and best practice.
- Adult and paediatric clinical nurse specialists were available to support children, young people and their families with conditions such as diabetes or asthma. In addition, continence, oncology and respiratory nurses were also available for help and support, both in hospital and in the child's home.

Access and flow

- To try and reduce unnecessary admissions and to help GPs in decision making, a document was compiled in conjunction with the Gloucestershire clinical commissioning group. 'The Big 6' promoted the use of standard assessment tools for the six most common conditions/symptoms that can cause children and young people to use A&E. These included bronchiolitis/ croup, fever, gastroenteritis, head injury, wheezy child/ asthma and abdominal pain.
- When children and young people where admitted for surgery, they were seen by the play specialists and prepared for coming into hospital. Children would attend preadmission clinics where the procedure would be explained to them and their parents and the consent would be signed. The day before surgery, the staff on the day-case unit would phone the parents to make sure everything was okay and answer any further questions they or their child might have. The day after the surgery, when the child had been discharged home,

the staff from the day-case unit would again phone the parents to check on the child's condition and progress, answer any questions the parents might have and offer any reassurance that might be necessary.

- The children's unit kept stocks of certain medicines to avoid delays in discharge waiting for medicines to take home. The medical staff would agree which children could be discharged during the ward rounds. These decisions were made in conjunction with the nursing staff, the parents and, where possible, the children themselves. The staff told us that nurse-led discharge did happen when the medical staff had specifically documented the requirements for discharge.
- Agreements had been made with the emergency department that any baby under one year of age would automatically be transferred to the paediatric admissions unit (PAU). We also observed that unless a child required critical treatment, for instance in the resuscitation room, children would be sent from the emergency room straight to the PAU so they could be seen by specialist children's nurses and doctors.
- Guidelines were in place for some babies, children and young people to have direct access to the ward. This meant that, should any problem arise with their children's condition, the parents can bring the children back to the ward directly without having to go to their GP or the emergency department first.

Meeting people's individual needs

- The school room operated from Monday to Friday and provided education support for all children, in the school room or at their bedside. The teachers told us how they liaised with the nursing and medical staff, and if a child had been in hospital for longer than three days they also liaised with the child's individual school. Yoga and music therapy were also offered to children.
- There were a number of clinical nurse specialists as part of the children's unit. They advised children, young people, parents and staff on the unit and provided an outreach service when the children were discharged. This was particularly evident for children with cancer. We were told that whilst the workload had increased for the oncology nurse, the aim of the service was to keep the children at home where possible. Other specialist nurses working were for epilepsy, diabetes and, more recently, neuro disability.
- There had been an increase in children and young people being admitted with mental health issues. Staff were being trained in basic child and adolescent mental health needs, and two side rooms were being turned into more suitable accommodation so children and young people requiring mental health support were cared for in a safe environment. This included reviewing and assessing ligature points. There were close working relationships with the mental health trust. A liaison nurse was provided to support staff on the ward in caring appropriately for children with mental health issues. Bespoke training had been provided for staff, including safe handling and de-escalation training. These had been added to the mandatory training requirements. The paperwork had been revamped, including risk assessments, and two rooms had been made safer for children admitted with deliberate self-harm. Mental health advice was always available 24 hours a day, and support was obtained from specialist mental health nurses for high risk children or young people.
- The respiratory nurse specialists had set up a shared care system with Southampton Hospital for children with a specific condition for which Southampton was the nearest specialist centre.
- The oncology unit had four dedicated rooms for treating children with cancer. There were shared care arrangements with Bristol Royal Hospital for Children, Birmingham Children's Hospital and the Children's Hospital in Oxford.
- We saw that support mechanisms were in place for parents of babies in the neonatal unit. We saw thank you cards from parents in appreciation of the support given. Staff told us that parents would often bring their babies back to see them to show the staff how well they were doing.
- Children and young people were able to choose what they wanted to eat from the menu. We saw that a variety of diets were available, including soft, easy to eat and puree for younger children. Halal diets and an a la carte menu were also available if the children and young people didn't like what was on the usual menu. The ward always had bread for toast, beans, soup and sandwiches if the children wanted snacks. The staff

could phone the hospital kitchen, which would accommodate anything the child asked for, where possible. For babies, a variety of milks were also available.

- Overall, parents and children and young people told us they liked the food that was on offer. One parent told us that they did not feel the food was suitable because it was too adult orientated.
- Any mothers who were breast feeding were automatically given meals, and any parent who was resident with their child overnight was offered breakfast on the ward.

Learning from complaints and concerns

- Information was displayed in both the children's and neonatal units on how to raise concerns and to get feedback.
- The staff we spoke to were all aware of the complaints system within the trust and the service provided by the Patient Advice and Liaison Service (PALS). They were able to explain what they would do when concerns were raised by parents. Staff told us that they would always try to resolve any concerns as soon as they were raised, but should the family remain unhappy they would be directed to the trust's complaints process.
- Staff were aware of complaints that had been made and any learning that had resulted.
- Complaints were sent to the divisional management team and then distributed to the senior nursing or medical staff for investigation.
- We saw that the children's unit got very few complaints, and these mainly resulted from delays in the paediatric admissions unit (PAU).

Are services for children and young people well-led?

Good

Children and young people's services had good governance arrangements in place. All the staff were complimentary about the nursing and medical leadership on both the neonatal and children's wards. Staff also told us they received support from the divisional management team and the trust's director of nursing.

The staff told us that they were proud to work on both the children's and neonatal units and they were proud of the care they gave to babies, children, young people and their families.

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

Discussions had been held with the local clinical commissioning group about improving services for children and young people with mental health issues, and we saw evidence of the improvements that had been made.

Vision and strategy for this service

- The staff were aware of the trust's values and the philosophy of care within children's and young people's services.
- The children's and neonatal nurses had their own objectives as part of the overall trust's nursing and midwifery strategy.

Governance, risk management and quality measurement

- Regular governance meetings were held. We saw minutes from these meetings which showed that issues affecting the service were discussed and actions taken. Specialist governance meetings were held, such as the paediatric surgical governance group, with an aim of improving the care for children undergoing surgical procedures.
- We saw that regular auditing took place and every two months there was an audit improvement meeting for medical staff, to which nurses were invited. However, the staff we spoke to seemed unclear as to the actions taken as a result of those audits, and a governance lead told us that no overall compliance data had been collected and there was no evidence of improvement or trends.
- Clinical policies and guidelines were available for all staff via the trust's intranet system; however, staff told us that the system was not easy to navigate.

- A risk register was in place, and we noted that this had been kept up to date. The risk register had the main areas of concern as staffing, high dependency beds, bed occupancy rate and transferring children out of county.
- We observed one issue that was discussed at a handover, whereby medical staff stated that a particular blood form had the wrong collection bottle listed. This resulted in the blood having to be taken from a child twice. The issue was discussed at the handover meeting and measures put in place on the ward to make sure the medical staff were aware and to make sure they used the correct bottle. However, no discussions were held about looking at the root cause of the issue and the arrangements made to get the actual form changed so it had the correct information printed.

Leadership of service

- The staff we spoke to were able to tell us who their unit managers and divisional managers were. We were told that they were very supportive and approachable. The matrons were visible on both the children's and neonatal units, and staff told us they appreciated this.
- Staff told us that the trust's director of nursing was very visible. Members of the executive team visited the wards as part of their safety walk-around, and the chief executive held regular listening events that staff at all levels could attend and where they could raise any issues directly with a trust executive.
- Senior nursing staff within the children's unit told us that they felt very supported by the trust as a whole. They also told us they had always felt listened to. However, on the neonatal unit they didn't feel the trust recognised them for the work they did.

Culture within the service

- The staff we spoke to during this inspection told us that they were proud to work on the unit and proud of the care they provided to babies, children and young people. The staff said there was an open reporting culture within the trust. All staff felt comfortable with raising any concerns with their line manager or the divisional management team.
- It was apparent during our inspection that all the staff had the baby, child, young person and their families at the centre of everything they did.

Public and staff engagement

- Staff told us about different newsletters that were available to them, both from the neonatal and children's units but also from the trust. These kept them up to date and engaged with what was happening. Staff also completed the annual NHS staff survey.
- Comment cards were available on the ward for parents and children to complete. Results of these cards were displayed on the ward. Staff seemed unclear about actions that had been taken as a result of this feedback.
- A pilot engagement project was run on the paediatric admissions unit (PAU) during February 2015, in which staff, parents, children and young people participated. It looked at what people liked about the environment of PAU, what would they would like to improve, and actions they would suggest. Following this pilot, three groups were established looking at the specific environment issues, improving the nurse processes and support patient pathway.
- The allergy service was looking at introducing a patient satisfaction survey about clinics and the service, but this had not been started at the time of our inspection.

Innovation, improvement and sustainability

- We were told about discussions with the local clinical commissioning group about improving the facilities for children and adolescents with mental health problems. At the time of our inspection, two side rooms were being made safer to accommodate these children and young people.
- The manager for the children's unit told us that the numbers of children needing admission were increasing year on year. Because of this, work was being undertaken about how best to use the space within the children's unit, specifically to increase the space for the high dependency unit and the paediatric admissions unit (PAU).
- An area of innovation that we noted was an evidence-based programme that had attracted funding from the Macmillan Cancer Support charity. The programme was linked to a university and would look at the resilience of staff looking after children with cancer.

End of life care

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

End of life care is led by a specialist palliative care team and delivered, where required, by staff throughout the hospital. The specialist team provides end of life services at both Gloucestershire Royal and Cheltenham General Hospitals, with approximately half the team based at each site. For this reason, duplication in some parts of the two hospital reports is unavoidable.

The specialist palliative care team provides support and advice for any adult patients who have complex care and/or complex symptom management needs throughout the hospital at the request of clinical staff. Support is also provided to relatives of end of life patients. The core specialist palliative care team consists of a specialist consultant, specialist nurses, a psychologist and a social worker. The team had also has administrative support.

We visited 11 wards and three specialist departments. We met two patients, spoke with six relatives and reviewed eight care records. We talked to 37 staff about end of life care. These included the specialist palliative care team, ward nurses and doctors, the chaplaincy team and bereavement and mortuary staff. We observed care being provided to patients and relatives. Before and during our inspection we reviewed the trust's performance information. The trust reported just under 2000 deaths occurred in the year 2013/04.

Summary of findings

We found end of life care was caring and responsive to individual patients' needs, particularly in the last days and hours of life. Patients were prescribed appropriate medicines to manage end of life symptoms and pain. The relatives of patients we spoke with told us they had been involved in decisions, that care was good and staff were respectful and kind. It was, however, unclear how patients' mental capacity had been assessed, particularly in relation to documentation in the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms.

Staff throughout the trust demonstrated an understanding that the end of life pathway was for use with patients diagnosed with any life-threatening condition approaching the last few days of life.

Improvements were needed to identify patients who were potentially in their last year of life in order to plan care better. Discharge procedures needed to be evaluated to identify whether patients achieved their preferred place of care. Specialist face to face palliative care was not available seven days a week; due to the demands on the service the team were not able to provider a wider service. There was no end of life strategy, and governance processes were inconsistent. The priorities for the service were not fully understood or articulated at trust board level. The continuing rise in referrals was threatening the sustainability of the service and it ability to innovate and improve as it was only able to react and focus upon short term issues.

End of life care

The specialist palliative care team were highly valued and respected by colleagues, and they worked collaboratively and effectively with other palliative services in the community and with the local clinical commissioning group.

Are end of life care services safe?

Requires improvement

The specialist palliative care team regularly reviewed incidents and demonstrated how it learned from them. Guidance was followed by ward staff in order to provide medicines safely to manage end of life pain and symptoms. Other risk and comfort assessments were appropriately completed and reviewed by staff.

We reviewed 14 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. These should demonstrate or link to a reference of patients' mental capacity, and this was not obvious or easily accessible in other records. Explanations for the reason for the decision to withhold resuscitation were not always clear, and records of discussions with patients and their next of kin, or of reasons why decisions to withhold resuscitation were not discussed, were not documented in five of the records we reviewed.

The specialist palliative care team was concerned that staffing levels were not sufficient to manage the ongoing demands of complex referrals, staff training needs and planned work. The team was concerned that its lack of capacity had contributed to the poor organisational and clinical key performance indicator outcomes identified in the National Care of the Dying Audit 2014.

Incidents

- Staff understood their responsibilities with regard to reporting incidents and were familiar with the processes to follow. This was demonstrated with clear explanations of what constituted an incident and what had to be done to comply with the reporting procedures.
- The specialist palliative care team discussed incidents relating to end of life care as a standing agenda item at their bimonthly clinical governance meeting and within the monthly specialist palliative care leads' meeting. Staff said this ensured feedback and learning were shared and understood by the whole team. Meeting minutes identified actions taken, and staff said issues were escalated when required to the divisional quality committee. For example, the contraindication (reasons not to use a treatment because of harmful risks) of a

specific medicine were discussed following identification of a safety issue. This resulted in teaching sessions for junior doctors and awareness-raising with the heads of medical, surgical and unscheduled care divisions.

- Records dated August to December 2014 identified 11 incidents relating to end of life care. Of these, nine were reviewed as causing no harm to patients and no or minimal risks. These incidents instead noted the potential for causing harm and resulting from issues related to communication and record keeping. The remaining two incidents each recorded minor harm and minor risk to patients. Actions taken were recorded. These aimed to improve standards of care and prevent further similar incidents recurring.

Environment and equipment

- The National Patient Safety Agency recommended in 2011 that all Graseby syringe drivers (a device for delivering medicines continuously under the skin) should be withdrawn by the end of 2015. Nursing staff throughout the trust had been trained by the specialist palliative care team to use the alternative syringe driver. Staff on ward areas confirmed they were trained and had adequate supplies of the syringe drivers for use with patients.

Medicines

- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance to promptly manage any changes in patients' pain or symptoms. Staff on wards said they kept stocks of commonly used end of life medicines so they were available for prompt use.
- Guidance for staff on end of life medicines was included as part of patients' care plans. Staff said this supported the assessment, management and review of a range of end of life symptoms.
- An anticipatory prescribing medication chart was available for use and linked to the trust's shared care record for the expected last days of life. This chart was prepopulated with four of the most common symptom- and pain-relieving medicines, with guidance for dose and frequency. There was additional space on the chart for other specific medicines to be added to meet individual patients' needs as required.

Records

- We reviewed eight sets of patients' records. We saw that discussions between clinical staff and patients and relatives were recorded legibly and sensitively.
- Patients' records reviewed by the specialist palliative care team included detailed conversations noting explicitly what patients and relatives understood or wanted to be informed of, and their concerns and wishes. Action for staff to take in accordance with these wishes and advice for ward staff were clearly documented and reviewed by the specialist team.
- Most clinical staff we spoke with were familiar with the trust's shared care record for the expected last days of life. This document was re-launched trust-wide during January 2015. The record provided prompts for clinicians which emphasised supporting patients' comfort and dignity. For example, in addition to guidance to manage pain and other symptoms, the document included actions to maintain mouth care and provide spiritual support.
- The shared care record included risk assessments of patients' nutrition, mobility and skin integrity. We saw that risk assessments were documented and were reviewed appropriately.
- For those patients who did not yet have a shared care record in place, we observed that pressure care, mobility and nutritional risks had been assessed and reviewed appropriately within nursing records.
- When we spoke with staff they were able to describe the processes they would follow in relation to a patient's mental capacity and ability to consent. However, we reviewed 14 Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) forms on five wards. These were all attached to the trust's 'Unwell/Potentially Deteriorating Patient Plan', known as UP forms. The UP/DNA CPR records did not document or link references to patients' mental capacity, and this was not obvious or easily accessible in other medical or nursing records. The Mental Capacity Act 2005 Code of Professional Practice states the following: "It is good practice for

professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record findings in the relevant professional documents." The General Medical Council (2010) advises clinicians to follow one of two DNA CPR decision-making models based upon whether a patient is assessed as having mental capacity or not having mental capacity to make their own valid decisions. For patients who have mental capacity, this involved, where possible, the patient being included in discussions and the decision regarding the appropriateness of resuscitation. For patients assessed as lacking mental capacity, this involves checking whether there is any legal proxy or legally binding advance directive for healthcare decisions, and/or consulting the patient's main carers. As it was not evident which patients had or did not have mental capacity regarding making decisions around resuscitation, it was not possible to audit how decisions had been made, whether advance decisions had been respected, whether legal proxies had been consulted or whether national guidance had been followed.

- There was trust guidance on completion of the UP form but staff were not familiar with this. All the medical staff we spoke with referred to the UP advice within the trust's DNA CPR policy. This simply states the UP form is a "Document which clarifies decision making in the acutely unwell inpatient through the timely definition of ceilings (limits) of treatment", and that these decisions should be recorded. We observed 10 of the 14 UP/DNA CPR forms noted the patient's diagnosis rather than an explanation of the decision. For example, the following were used as the only reasoning or explanations on the forms for limits of treatment and withholding resuscitation: "breast cancer", "stroke", "frailty" and "infective carditis". Whilst the benefits and risks of CPR may have been reviewed by the doctor in line with national guidance, this was not recorded on the UP/DNA CPR form or within the patients' records we reviewed.
- We observed in five of the 14 UP/DNA CPR forms, no discussion had been recorded as taking place with either the patient or their relatives. Whilst there may have been appropriate reasons for not having discussions, no explanations for this were documented.
- The trust had completed a retrospective audit and review of the UP/DNA CPR forms during August 2014 using 69 randomly selected patients' records from 14 specialties across both hospital sites, Gloucestershire Royal and Cheltenham General Hospitals. This identified some improvements on the previous two years' evaluations. For example, consultant involvement with the UP/DNA CPR decisions was 65% in 2014 compared with 58% in 2013 and 21% in 2012. In addition, for all patients who had died, a UP form was completed by staff that documented the limits of care that should have been provided. The audit showed that further work was required, as only 51% of the forms reviewed in the audit were completed 100% accurately. The action plan included feedback of the audit findings to a number of committees, teams and within mandatory training, with continued annual re-audit to monitor progress. No confirmation was provided of actions taken to date.

Consent, Mental Capacity Act

- Staff were knowledgeable regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt. General decisions such as about personal and pressure care were made by clinical staff and often involved the patients' relatives when the patient was no longer able to give informed consent. Staff said if they had doubts regarding a patient's capacity to give informed consent they would ask a doctor to assess this. Staff demonstrated they understood that more complex decisions needed to include best interests' discussions in accordance with the Mental Capacity Act 2005.
- The relatives we spoke with told us they had been involved by staff in decisions when their relative who was a patient was no longer able to make decisions independently.

Safeguarding

- The specialist palliative care team and other ward staff were knowledgeable regarding processes to follow if they had any vulnerable adult safeguarding concerns. Staff were able to explain what signs and symptoms might alert them to safeguarding issues, how to escalate these concerns and who to escalate them to.
- Records showed that the majority of members of the specialist palliative care team were up to date with the trust's mandatory safeguarding vulnerable adults and safeguarding children training.

Mandatory training

End of life care

- The specialist palliative care team members confirmed they were all up to date with the majority of the trust's mandatory training. This included health and safety, infection control and safeguarding training. We saw training records to corroborate this.

Assessing and responding to patient risk

- The shared care record incorporated regular reassessments of patients' needs to minimise risks and maximise symptom control. The regularity of assessments was based on the impact of symptoms on patients. We saw that risk documents had been reviewed appropriately, detailed outcomes and recorded further actions.
- The trust's 'unwell/potentially deteriorating patient plan' (UP) form documented ceilings of patient care or limits of treatment plans. Each plan stated the maximum level of interventions a patient would or would not have in the event of deterioration in their condition, for example whether to refer a patient to the department of critical care or give active ward care such as treatment for infections.

Medical and nursing staffing

- The specialist palliative care consultant divided their time equally between work in the hospital and the community. The core specialist palliative care team at Gloucestershire Royal Hospital consisted of 0.5 whole-time-equivalent (WTE) specialist consultant, one WTE specialty doctor, 0.8 WTE acting heads of nursing (covering both hospital sites), one WTE advanced nurse practitioner and one WTE clinical nurse specialist. In addition, there were 0.8 WTE consultant clinical psychology hours (with a 0.2 WTE clinical psychology vacancy), 0.8 WTE social worker hours and 1.7 WTE administrative support.
- The specialist palliative care team said that while it kept the skill mix of the team under review, staffing levels were not sufficient to manage the ongoing demands of complex referrals, staff training needs and planned work. The team was concerned its lack of capacity had contributed to the poor organisational and clinical key performance indicator outcomes identified in the National Care of the Dying Audit 2014.

Major incident awareness and training

- In the event of a major incident, the lead chaplain would have responsibility for coordinating any additional support requirements identified within the hospital and, as required, briefing and responding to requests from the hospital control rooms.
- The bereavement services had procedures to follow in the event of a major incident that could involve a large number of casualties or deaths. This would be led by the senior bereavement officer and included accessing additional trained bereavement staff and extra patient property storage. If required, the chaplains would become involved by providing spiritual, pastoral and religious care and support for casualties. Where possible, existing chaplaincy volunteers would continue their regular work of supporting patients on wards, but could also be called upon to assist the chaplains.
- The chaplains would provide counselling support to staff as required.

Are end of life care services effective?

Requires improvement

Patients with long-term conditions who might have been in the last year of life were not consistently recognised by staff throughout the trust. However where patients were identified with end of life care needs had their needs assessed and reviewed and had pain and other symptoms managed effectively. The shared care record for the expected last days of life was developed in line with national guidance.

The hospital had performed poorly against both the organisational and clinical key performance indicator outcomes identified in the National Care of the Dying Audit 2014. Specialist face to face palliative care was not available seven days a week; due to the demands on the service the team were not able to provider a wider service.

The specialist palliative care team had a good profile throughout the hospital and was highly regarded by colleagues. Ward staff recognised that end of life care was not exclusive to patients with cancer but related to a range of conditions. This was reflected in the type of referrals to the specialist palliative care team.

Evidence-based care and treatment

End of life care

- The specialist palliative care team followed principles from national guidance including the National Institute for Health and Care Excellence (NICE) quality standard for end of life care for adults (2011, updated 2013). For example, records showed patients approaching the expected last days of life were given opportunities to discuss psychological, physical and spiritual needs and were supported appropriately to meet individual needs.
- The Liverpool Care Pathway tool for end of life care had been withdrawn in line national guidance. The trust had launched, as a replacement, the 'shared care record for the expected last days of life' in January 2015. Staff said this also followed the five core recommendations for care of patients in the last few days and hours of life in the Department of Health's End of Life Care Strategy 2008 and One chance to get it right published by the Leadership Alliance for the Care of Dying People 2014, for example ceasing unnecessary investigations such as blood tests and reviewing the continued use of routine medicines. Staff on the wards we visited demonstrated an understanding of the shared care record. We reviewed two patients' care plans and saw that the guidance was being followed appropriately.
- End of life care within the hospital was focused on the recognition of patients who might be approaching the last few days and hours of life. The Department of Health's End of Life Care Strategy (2008) and NICE quality standards for end of life care (2011) included recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. Clinical staff on the wards we visited did not demonstrate this understanding that end of life could cover an extended period, or that patients might have benefited from early discussions and care planning.

Pain relief

- The relatives of a patient told us that nurses regularly checked that medicines had been effective for pain relief. Relatives said the patient experienced some discomfort when personal care was given. Staff had responded by giving additional top-up doses of pain-relieving medicines 20 minutes prior to giving any necessary care such as changing the patient's position. The relatives said this ensured the patient's comfort levels were maintained.
- Relatives said staff reviewed equipment used to relieve pain, such as pressure-relieving mattresses, and checked the comfort of patients. Relatives told us staff explained medicines and equipment to relieve pain and other symptoms and how these might impact on the patient, for example that some medicines could induce nausea so additional medicines were prescribed to counteract this.
- Patients and relatives were offered support with emotional and psychological pain through the specialist palliative care team, which included a specialist psychology service, and through the chaplaincy service, ward staff and the bereavement offices. Relatives confirmed how they had been offered or received support, and we saw this was documented in care records.
- Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them, and trained staff to set up this equipment. Staff said that if a patient was provided with a syringe driver and was subsequently discharged, the syringe driver was replaced by the community palliative care team, who returned the original syringe driver to the ward. Staff said this ensured that any patient's pain and symptoms were managed in a continuous and consistent way.
- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance of need to be available to promptly manage any changes in patients' pain or symptoms.
- Guidance on medicines was provided for clinical staff, and records showed pain was regularly assessed and reviewed. Staff demonstrated an understanding of how to assess patients' pain when they were not able to articulate their needs, by assessing body language or using a recognised assessment tool called the Abbey Pain Scale.
- Pain management guidance tools for clinical staff were included as part of the shared care record. Pain

medicine information leaflets for patients and relatives were provided on wards or accessible via the trust's website. These had been developed by the specialist palliative care team.

Nutrition and hydration

- The patients' records we reviewed showed that nutrition and hydration needs had been evaluated and appropriate actions followed. These records documented subsequent discussions with relatives around what to expect with the dying process. One relative of a patient we spoke with confirmed that ward staff had clearly explained all changes in care, including those relating to nutrition and hydration.
- The shared care record for the expected last days of life included ongoing review of patients' nutrition and hydration needs. We looked at eight patients' care records and saw their nutrition and hydration needs had been assessed and reviewed and subsequent actions clearly recorded.
- We observed that patients had drinks available, which relatives said were replenished throughout the day.

Patient outcomes

- The specialist palliative care team provided support, advice, training and care to patients and staff within the hospital. Referrals were accepted for adults who had complex support and/or complex symptom management needs during end of life. This included support to the families and/or carers of patients referred, which ensured care was safe and effective.
- The hospital contributed to the Royal College of Physicians National Care of the Dying Audit 2014. This scored participating trusts against seven organisational and 10 clinical key performance indicators. The hospital achieved compliance with only one of the seven key organisational performance targets; this was for having protocols in place for the prescription of medicines for the five key symptoms at end of life. The trust also scored poorly for the clinical targets. The specialist palliative care team was working towards achieving improvements in patient outcomes.
- One of the organisational outcomes not achieved in the national audit was the trust having a board representative for end of life care. Since the audit, this role had been filled for approximately the past nine months. Senior staff expressed concern regarding how the other organisational and clinical improvements could be achieved, because of the limited resources of the specialist palliative care service. Another view was expressed, suggesting that the shared care record for the expected last days of life would promote sufficient improvements to achieve improved compliance with all the key performance indicators.
- Staff throughout the trust demonstrated an understanding that the end of life pathway was for use with patients diagnosed with any life-threatening condition and not solely related to patients' with cancer. This was also reflected in the specialist palliative care team's referral audit information. The specialist team provided a trust-wide service and, as such, the monitoring systems were set to analyse data combined from both hospital sites, Gloucestershire Royal and Cheltenham General Hospitals. Analysis of data for the past six months identified the primary diagnosis within three categories: cancer, non-cancer, and not known or not recorded. The percentage of referrals to the specialist team from October 2014 to January 2015 for whom the primary diagnosis was cancer showed the following, which confirms that referrals were not made exclusively for patients with cancer:

Date

% of referrals for cancer

August 2014

56%

September 2014

57%

October 2014

47%

November 2014

52%

December 2014

62%

January 2015

53%

Competent staff

End of life care

- We saw evidence that the specialist palliative care team provided regular and ongoing training to different professional groups. These included qualified pharmacy staff, medical and nursing staff, pharmacy and medical students, and healthcare assistants. Training subjects included end of life care, organ donation, advanced communication, and care and management of patients who have had a stroke or cancer.
- During 2008, Macmillan Cancer Support offered finances for developmental (nurse educator) palliative care posts. The trust's board preferred alternative arrangements that were led by the specialist palliative care team, who developed an education package supported and facilitated by a local university. This enabled 36 nurses selected from the 40 different wards throughout the trust's two hospitals (Gloucestershire Royal and Cheltenham General Hospitals) to be trained as end of life ward champions. The modular course provided successful candidates with either 60 academic credits at level 2 or level 3. These credits could be used at a later date as part of an associated diploma or degree course at the university. At the time of our inspection, there were 32 university-trained ward champions who remained in posts on the wards, across both hospitals. Their role was to act as a key link between the specialist palliative care team and ward areas, providing advice, support and policy updates, and to cascade training updates. There was, however, no further funding available to train additional nurses for the wards where there was no identified champion.
- Staff on the wards we visited knew who their end of life champion was, and said the additional advice and support given by this person helped to maximise patient care and gave staff increased confidence in sensitive situations.
- We spoke with one nurse end of life champion, and they explained how the training and continuing links with the specialist palliative care team had positively enhanced their knowledge, skills and confidence to support end of life patients and their relatives. We saw laminated resources and information flow charts that this nurse had developed to support team colleagues, and meeting minutes documenting updates on end of life care.
- One of the chaplains supported the specialist palliative care team by arranging and chairing bimonthly palliative care update sessions for the ward champions. Staff said these meetings ensured all new end of life practice and policy from the specialist palliative care team was disseminated. Staff said the chaplain was supportive, sending email updates, and was available to provide additional advice between meetings.
- The specialist palliative care team members said they took all opportunities to educate staff in practice by providing micro (short or brief) teaching sessions. This was done when any of the team attended any multidisciplinary team meeting or ward visit. Staff said recent micro teaching sessions had included symptom management and setting up syringe drivers.
- The bereavement service staff had appropriate training to support grieving visitors appropriately. This included counselling, bereavement care and conflict resolution training.
- The specialist palliative care team had developed a range of educational resources for staff, which were available via the trust's intranet or website. For example, these included decision charts to manage complex symptoms and an end of life diabetes care management pathway. Ward staff said the resources supported effective and safe end of life practice.

Multidisciplinary working

- The specialist palliative care team met every morning to discuss current work and new allocations. Work was allocated based on patients' need and urgency. The team worked closely with the community palliative care team, transferring clinical management and follow-up reviews of patients when they were discharged from hospital.
- The specialist end of life team had a weekly multidisciplinary meeting to discuss end of life patients in more detail and review care and treatment plans. The consultant completed ward rounds every week to review patients' care with other hospital staff.
- The specialist palliative care consultant worked half time in the hospital and half time in the trust's community services. Another specialist consultant worked the same hours but was based at the other trust hospital (Cheltenham General Hospital). The local hospice consultant also worked within the trust's community services. All the consultants met every

month to review clinical and governance issues, and covered for each other when necessary. This enabled the consultants to input clinical expertise within a range of multidisciplinary teams, in different care settings, and provide consistent coordinated care.

- The team had extended multidisciplinary input from other specialties and services that attended the specialist team meetings when available and when required. These included: the consultant hospice medical director, the lead chaplain, and consultants from the pain service, respiratory and renal and general medicine, neurology, haematology and oncology. There were nurse specialists from 14 site- or condition-specific services, for example heart failure, Parkinson's disease, multiple sclerosis and the MIND (mental health) link. Staff said this ensured patients received holistic end of life care and support.
- The specialist palliative care consultants and nurses had been attending a range of condition- or site-specific multidisciplinary meetings when possible, to advise on end of life care during patient reviews. The team said that, because of the ongoing demands of their own clinical caseloads, they would not be able to continue to attend these meetings.

Seven-day services

- The specialist palliative care team was available from 9am to 5pm, Monday to Friday. The specialist nurses provided an out-of-hours telephone advice service for clinicians. The Royal College of Physicians (2014) recommends that hospitals should provide a face-to-face specialist palliative care service between at least 9am to 5pm, seven days a week, to support the care of dying patients and their families or carers. The team said it was not able to provide any further out-of-hours support without this impacting on their current clinical workload. Records showed that referrals to the specialist palliative care team had steadily and significantly increased. During 2010, the team had 584 referrals at Gloucestershire Royal Hospital. During 2014, referrals totalled 1,006, an increase of 72%. Staff said the workload was maintained by the goodwill of the team, who regularly worked in excess of their contractual hours.
- The chaplaincy service was integrated within the specialist palliative care team and other services in order to provide and promote good end of life care. The team had an established group of volunteers and links with other faith groups. Staff said this ensured most patients' religious or spiritual needs could be met. The chaplaincy service operated seven days a week, 24 hours a day, in order to be responsive to patients' needs.
- A radiology service was available out of hours for palliative treatments, but this was limited because of staff providing an on-call service only.
- All the wards we visited said they kept stocks of common palliative medicines. The dispensing pharmacy was open from Monday to Friday during the week, and during the mornings on Saturday and Sunday. If wards required additional or alternative palliative medicines out of hours, clinicians could access a computer database and identify other areas that had stocks. These medicines were then obtained elsewhere until the pharmacy reopened. These systems supported end of life patients' fast-track discharge home or into community services out of hours, and ensured adequate pain relief was available at all times.

Access to information

- The specialist palliative care team had full access to medical records and the IT patient-recording systems. We saw that patients' records were updated by the team at the time of consultation.

Consent and Mental Capacity Act

- Staff were knowledgeable regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt. General decisions such as about personal and pressure care were made by clinical staff and often involved the patients' relatives when the patient was no longer able to give informed consent. Staff demonstrated that they understood that more complex decisions needed to include best interests' discussions and meetings in accordance with the Mental Capacity Act 2005.
- The relatives we spoke with told us they had been involved by staff in decisions when their relative who was a patient was no longer able to make decisions independently.

Are end of life care services caring?

End of life care

Good

Compassionate and sensitive end of life care was provided to patients by a range of staff and services. The relatives of end of life patients we spoke with told us they felt involved with care and were treated with dignity and respect. However, relatives said they were given limited practical support when visiting end of life patients for extended periods.

Compassionate care

- The six relatives we spoke with said staff had been kind and compassionate and they had no complaints about care provided to their relatives who were patients.
- Ward staff told us that, where possible, end of life patients were accommodated in side rooms to increase dignity and privacy for them and those visiting.
- Relatives of end of life patients told us ward visiting restrictions had been lifted and drinks were frequently offered to them, but there was no provision of snacks or meals. One family we spoke with said they ensured they had supplies of food so they did not have to leave their relative's bedside.
- The hospital had limited accommodation for relatives. All the relatives we spoke with said they would not choose to use these facilities, as they wanted to stay close to the patient. Alternative practical support was limited but available when people were visiting for long periods. For example, relatives were offered a pillow and a blanket but slept in high backed chairs.
- We observed nursing care to a patient was given emphasising dignity and compassion. The patient was not conscious, but staff spoke softly, explaining everything they were going to do and why. Staff ensured the patient's personal appearance remained similar to how they had previously chosen to look.
- Grieving relatives had found it difficult in the past to navigate from the bereavement office to the mortuary. Staff recognised that distressed relatives found it difficult to follow navigation instructions between the two services. To improve this, the mortuary staff had designed a white rose symbol used with arrows that marked an easy-to-follow route from the bereavement office to the mortuary. Relatives had since reported they appreciated these signs.

Understanding and involvement of patients and those close to them

- We spoke with six relatives of two end of life patients, who told us they felt they had been consulted about decisions and care and understood what was currently happening and why.
- We reviewed six care records and saw that clinicians had made recordings of discussions with patients and relatives. These included discussions relating to how certain medical treatments might improve symptoms or why they might not be appropriate. We saw records of actions staff should take in response to patients' and relatives' wishes. These included requests to speak with a member of the chaplaincy and to have specific personal possessions placed close by.

Emotional support

- Emotional support for patients and relatives was available through the specialist palliative care team, through clinical psychology and social worker, ward-based nurse specialists, the chaplaincy team and bereavement services.
- The bereavement service provided a follow-up service, contacting next of kin within a few days of a patient dying to offer further support and/or information to support relatives with grieving. Condolence letters were sent, depending upon individual circumstances. For example, if care had been provided long term in the community prior to admission, the hospital liaised with community services to agree who would, or whether it was appropriate to, provide further follow-up. The critical care department maintained a record of all deaths in the department and sent a personalised card to families one year following death. Staff said they often received letters and cards in return thanking staff for the contact.

End of life care

Are end of life care services responsive?

Good

The specialist palliative care team was responsive to requests to support patients with complex end of life symptoms and care needs. They had good working relationships with community end of life care services. There were fast-track discharge process (to enable patients to go to the place they wanted to be at the end of their life) in place to respond to patients' needs, but these processes had not been audited. The specialist palliative care team demonstrated how it made changes to practice in response to patient feedback.

Service planning and delivery to meet the needs of local people

- The specialist palliative care team had established links with community palliative care services and the clinical commissioning group (CCG), meeting regularly to share learning and expertise. Staff said this also enabled patients with complex needs who switched between services to receive consistent, coordinated care.
- The specialist palliative care consultant was part of the end of life strategy group for the local CCG. A key function of this group was to develop service planning and delivery to meet the needs of local people. This was demonstrated with the development of the trust's shared care record for the expected last days of life, which was produced and piloted in partnership with the community palliative care services, the CCG and the local hospice.
- The trust had been conducting feedback surveys since December 2014 to review families' and carers' experiences of the delivery of end of life care within the hospital. This was due to be analysed later in the year. Staff said information from this would be used to plan how future care was provided to patients and their families.

Meeting people's individual needs

- The specialist palliative care team was available from 9am to 5pm, Monday to Friday, to provide support and advice for patients who had complex care and or complex symptom management needs. A nurse-led telephone advice was available to clinicians out of hours.
- Translation services were available for end of life patients and relatives. Staff who had used these services said they were prompt and efficient in responding to needs.
- The specialist palliative care team provided written resources for patients and families, which were also accessible via the trust's website. This included information about a range of end of life medicines and symptom management.
- The specialist palliative care team was available to ward staff to provide advice and training regarding communication and end of life care; this included regarding communicating and breaking bad news to patients and carers. This information was also available on the trust's website. This ensured patients received sensitive information appropriately.
- We saw that patients and relatives had been consulted and their individual wishes had been clearly recorded in care plans.
- We spoke with two of a patient's relatives who expressed concern that the level of care and attention required to provide consistent end of life care was not possible during busy periods or when wards were short staffed. Whilst these relatives felt staff were doing their best, they had felt it had been necessary to stay at the patient's bedside at all times to ensure all care was fully maintained during the patient's last days.
- There was no audit information to confirm whether patients achieved their preferred place of care. This had been included as an item for staff to document within the shared care record for the expected last days of life. The relatives we spoke with told us the preferred place of care had been discussed and appropriate actions were being taken to enable the patients' wishes to be accommodated. We saw that these discussions had been recorded in care records.
- We spoke with an end of life patient's relatives who told us they valued the patient being in a side room. This afforded the patient increased dignity and respect and gave the family privacy to grieve. It was not always

possible for end of life patients and their relatives to be accommodated in side rooms, as these were limited on wards and patients with infection control risks were given priority. We observed one end of life patient being cared for on a busy ward with family close by who were distressed. While the family and other patients understood the situation, it was difficult for staff to give the optimum dignified care and support.

- No systems were in place for end of life patients known to specialists in the hospital to be flagged up during unplanned or emergency admissions. End of life patients used the same triage systems as other patients but may have benefited from more prompt access to specialist services known to them. This would have facilitated continued coordinated care and swift and effective symptom management.

Access and flow

- Referrals to the specialist palliative care team were made by clinical staff using the trust's computer-based system or by telephone. Ward staff demonstrated they understood how to make a referral to the specialist team and consistently reported that the team responded promptly, usually seeing patients the same day as referral or the following day.
- The specialist palliative care team responded promptly to referrals, usually within one working day. This information was documented in the main medical notes. One of the specialist palliative care consultants reviewed the medical notes for 44 patients referred during an approximately two-week period during February 2015. Of these, 71% were seen on the same day of referral and 95.6% were seen within one working day of referral.
- Evidence suggested end of life patients identified for fast-track discharge who wished to transfer their care to their home or to an alternative service had their funding assessments and care packages completed promptly. However, no records or audit information were available to confirm this. Responding to patients' choice for their preferred place of care is part of national best practice guidance. This guidance includes: One chance to get it right, Department of Health (2014), and the National Institute for Health and Care Excellence (NICE) quality standards for end of life care (2011, updated 2013). Ward staff and the rapid discharge team said that most end of life discharges were achieved within 24 and 48 hours, although there were sometimes delays for patients who lived in rural areas.
- A policy was in place for the rapid release of a deceased patient from the mortuary, ensuring the cultural wishes of deceased patients were respected. Medical and mortuary staff demonstrated an understanding of the processes to follow, and we saw documentation confirming this.

Learning from complaints and concerns

- End of life complaints were reviewed as part of the specialist palliative care governance and specialist palliative care leads' meetings. Minutes from the last meeting, dated 8 January 2015, showed that two patients' complaints had been discussed. This included discussions regarding the care of a young patient with learning disabilities, and bereavement letters. Records documented discussions and actions planned to make improvements to end of life services.
- The specialist palliative care team said any patient concerns or issues were dealt with at the time they were reported. Staff said concerns were also discussed during the team's daily morning meeting and if necessary were discussed in more depth at the team's multidisciplinary meeting. Staff said they learned how to improve practice by sharing experiences.
- Records showed how the analysis of one complaint had led to an audit during October 2014 of unplanned transfers between community hospitals and the trust's hospitals. This led to additional training for medical staff and improved documentation of decision making.

Are end of life care services well-led?

Requires improvement

The specialist palliative care team was highly regarded by its colleagues. The team demonstrated a commitment and passion to deliver good end of life care and to develop end of life care provision by reinforcing the skills of others.

However, there was no strategy for end of life care, and governance processes were inconsistent. The priorities for the service were not fully understood or articulated at trust

board level. The specialist palliative care team was concerned about its ability to sustain the service and work proactively on end of life standards and innovation because of a steady and increased rise in referrals and teaching commitments without a corresponding increase in its staffing.

Vision and strategy for this service

- The specialist palliative care team demonstrated an understanding of national policy and priorities for end of life care. The team recognised end of life care was "everybody's business", as in the Department of Health's End of Life Care Strategy 2008 and One chance to get it right from the Leadership Alliance for the Care of Dying People 2014. The team worked closely with community palliative care services and the clinical commissioning group (CCG) to reduce duplication and provide seamless care and services for patients who used both hospital and community services.
- The specialist palliative care team had not developed a written strategy for the hospital with defined work plan priorities for the present and future. Therefore, it was difficult for the team to demonstrate how it was driving forward actions in a consistent way to deliver continued improvements in line with national policy. Consequently, other clinical staff in the hospital we talked with could not demonstrate an understanding of the vision of the service.
- Insufficient assurance was given to the board on matters relating to end of life care. While one view was that the shared care record would result in improved outcomes, no action plan was in place to systematically monitor, audit and evaluate this. No annual report or equivalent suite of governance information was produced. The approach to the service was reactive and focused upon short term issues. The issues and priorities for the service were not fully understood or articulated at senior level. This had impacted on the profile of end of life care and was reflected in the poor organisational and clinical key performance indicators in the National Care of the Dying Audit 2014.

Governance, risk management and quality measurement

- Governance, risk management and quality measures were inconsistent. The National Care of the Dying Audit report made a number of recommendations to improve compliance with organisational and clinical key performance indicators. The specialist palliative care team held regular governance meetings, and these produced actions. However, the minutes lacked detail on how actions had been completed, how further actions would be achieved, who would be responsible for them, and timescales. National strategy promoted supporting patients to achieve their preferred place of care at the end of life, but no performance data was collected to monitor whether this was achieved. However, there was evidence of good quality measures thorough regular audit activity relating to end of life practice. For example, patients with an implantable cardioverter defibrillator (a device that electronically regulates the heart rhythm) were audited during 2014. This was to review whether information and discussions were completed regarding the option for deactivation when nearing the end of life. This audit resulted in a number of further action plans to improve patient care. The annual audit plan for 2015/16 included documented plans for re-audits and new audits linked to national guidance.
- Risk management processes were followed. Priorities identified at the specialist palliative care team's governance meeting were fed into divisional meetings and on through to the trust's quality committee.

Leadership of service

- One of the organisational outcomes not achieved in the National Care of the Dying Audit 2014 was the trust having a board representative for end of life care. Since the audit, this role had been filled for approximately the past nine months. The team had recently met with the newly appointed executive director, who was responsible for representing end of life at board level. This person had been appointed approximately nine months ago in response to the National Care of the Dying Audit. We were told further regular meetings were to be scheduled.
- The senior specialist palliative care staff were held in high regard by colleagues and described as experienced, supportive and knowledgeable about end of life practice.

End of life care

- The specialist palliative care team had regular informal and formal supervision during daily and weekly meetings and regularly met with other specialists in the hospital and in the community.

Culture within the service

- The specialist palliative care team was dedicated to and passionate about the quality of end of life care provision in the hospital however end of life was not yet fully recognised at board level.
- The specialist palliative care team was committed to sharing knowledge and developing the skills of others. The team regularly held training events within the community and local hospice and in return, these services supported the education of hospital staff by facilitating training which hospital staff were invited to attend. The specialist palliative care team routinely provided teaching for other staff when they were requested to provide clinical advice. For example, the team explained rather than completing clinical tasks for others, they often suggested completing tasks jointly. In addition, the team provided opportunities for other staff to spend time shadowing clinical work to give individuals further opportunities for more in-depth learning and confidence.
- Members of the specialist palliative care team said they had established good working relationships with other clinical staff throughout the hospital. All staff we spoke with on wards had high regard for the specialist palliative care team, valuing its professionalism and expertise and stating that the team was responsive, supportive and very helpful.

Public and staff engagement

- Public opinion had been sought through the development of the shared care record. The service was currently completing a patient survey of views and experiences that had not yet been analysed.
- We saw records which showed that the majority of staff who attended training courses facilitated by the specialist palliative care team gave positive feedback. Staff said this was used to plan and improve future training sessions.

Innovation, improvement and sustainability

- The specialist palliative care team worked collaboratively with other services to improve end of life care for patients. This included working with colleagues in different departments and specialties throughout the hospital, and working in partnership with community palliative care services and the local clinical commissioning group (CCG).
- The specialist palliative care team was concerned regarding team members' ability to sustain the current service and work proactively on end of life standards and innovation. The rate of referrals to the team had steadily and significantly increased. During 2010, the team accepted 584 referrals, and during 2014 the team accepted 1,006 referrals. This was an increase of 72%.
- The specialist palliative care team prioritised providing a responsive, effective and safe service to meet the needs of patients with complex needs, and teaching colleagues. In order to maintain these priorities, the skill mix of the team was kept under review when any staff vacancies arose. This resulted in some adjustments to hours and grades of staff in order to most effectively respond to service demands. However, commitments to supporting other colleagues and achieving some national standards could not be met. This included stopping attendance at condition-specific ward rounds and the development of seven-day face-to-face services. The team was further concerned regarding its ability to meet the needs of young adults with very complex end of life care needs during transition into adult services, as doing so often required increased clinical time.

Outpatients and diagnostic imaging

Safe	Requires improvement
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Requires improvement
Well-led	Good
Overall	Requires improvement

Information about the service

Gloucestershire Hospitals NHS Foundation Trust provides outpatient services for a population of more than 612,000 people. These services are provided in outpatient departments in Gloucestershire Royal Hospital and Cheltenham General Hospital. The general outpatient departments at both hospitals are managed by the same team of senior staff, and staff work between the two sites. Some outpatient departments are managed by the specialties themselves, for example orthopaedics, audiology and ophthalmology. Outpatient and diagnostic services at Cheltenham General Hospital are reported on in a separate report. This report focuses on our inspection of the outpatient department at Gloucestershire Royal Hospital. However, where the same team manages the outpatient and diagnostic services across both sites there will be duplication between the two reports.

The outpatients and diagnostic services are located in a modern building attached to the main hospital, and also within other areas of the hospital. The clinics have a main reception area, with a number of waiting areas in the general outpatient department. Outpatient clinics run in other areas of the hospital have their own reception staff and waiting areas for patients.

During our inspection we visited a range of outpatient clinics including surgical, medical, dermatology and pain clinics, orthopaedic and ear nose and throat (ENT) clinics, the lung function laboratory, cardiology department including cardiac investigations, phlebotomy, and the therapies department. In radiology, we visited x-ray and imaging departments, including magnetic resonance imaging (MRI) and computerised tomography (CT) scanning. We also visited the booking office.

During our visits we spoke with 39 members of staff including specialist managers, sisters, nurses, healthcare assistants, apprentices, phlebotomists, consultants, registrars, junior doctors, radiographers, cardiographers, physiotherapists, technicians, receptionists, secretaries and the booking team.

We met and spoke with 31 patients to seek their views of the service provided to them.

Outpatients and diagnostic imaging

Summary of findings

During our inspection we found concerns and a lack of assurance that people were safe and protected from harm.

Staff had raised concerns about the cleanliness of the general and orthopaedic outpatient departments, because of the busy departments and insufficient cleaning time. Systems were not in place in all departments to check that medication was in date and safe to use. This had resulted in out-of-date medication being stored in the medication cupboard in the computerised tomography (CT) department. Patients' confidential and personal information was not securely stored at all times.

Patients were protected from the risk of infection by the practice of the staff, who demonstrated understanding of and compliance with the trust's policies and procedures.

We found patients' care, treatment and support achieved good outcomes and were based on national guidance and legislation. Staff were trained and competent to carry out their roles effectively and in line with best practice.

Records inspected showed patients had consented to care and treatment. Staff demonstrated a good understanding of the Mental Capacity Act 2005 and their responsibilities within this legislation.

Systems were in place for staff to request and track and trace notes for individual patients' appointments at clinics. Action was taken when notes did not arrive at the clinic in time, to ensure the patient was seen with as much prior history and information as possible.

Staff involved patients and treated them with compassion, kindness, dignity and respect, providing them with a caring service.

We observed that staff were polite and respectful in all interactions with patients. Feedback from patients who used the service and their relatives/representatives was positive about the way staff treated them.

We had concerns regarding the privacy and dignity of patients in two clinical areas, where opportunities arose for other people to observe patients during their care and treatment.

Outpatient services were not organised in a manner that ensured patients' needs were met promptly or responsively.

We found that referral-to-treatment times exceeded national targets, with services not delivered in a way that focused on patients' holistic needs. Some patients experienced long delays in receiving their first outpatient appointment. The booking team was taking action to address waiting times and monitored patients who did not attend for appointments.

Patients did not always know how to make a complaint, there was no consistency within clinics regarding the complaints process. When patients had made a complaint, the hospital had responded promptly and thoroughly, with staff being informed of the outcomes to enable learning to be taken forward.

The leadership and management of the outpatient and diagnostic services ensured the provision of person-centred care and supported the staff to deliver the care. Staff found their local management teams were approachable, but not all staff were aware of senior management, for example the trust's board of directors.

Potential risks within the delivery of the service were assessed, and the action taken to mitigate the risk was recorded. In some instances the action was not in accordance with other guidance.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found that safety required improvement for outpatients and diagnostic imaging.

The orthopaedics outpatient department did not have a resuscitation trolley located within the department, and there was no risk assessment to identify how the risk to patients was mitigated. Emergency equipment in the department was not ready for use, as part of the necessary equipment was missing, which could have caused a delay in the treatment provided to patients.

Patients were at risk of receiving unsafe treatment, as systems had not been effective in the computerised tomography (CT) department to ensure medication was in date and safe to use.

Patients' personal and confidential information was not stored securely while in some outpatient departments, as records were accessible to members of the public at times.

Patients were not always visible to staff while waiting in sub-waiting areas in the outpatient department, and therefore if they became unwell might not have received prompt assistance.

Staff reported incidents, felt confident in doing so and gave examples of learning that had occurred as a result of specific incidents. Patients were provided with apologies when necessary and were informed of action that had been taken to reduce the likelihood of the same thing happening again. Staff promoted the control of infection through their practice and through the attention they paid to the trust's policies and procedures. Medication was stored securely in all areas we inspected. Local rules and guidance regarding exposure times to radiation were available to staff in the departments in which they worked, to ensure the safety of patients and staff.

Children and vulnerable adults were protected against harm, and staff took a proactive approach to safeguarding and to preventing abuse.

Incidents

- Staff in all outpatient areas we visited advised us they were encouraged to report incidents that occurred in their working areas. They understood that reported incidents were monitored, but they did not consistently receive feedback on the outcomes and action taken as a result of their reports. All the staff we spoke with were confident to report incidents via the trust's electronic reporting system.
- We were given examples of incidents that had been reported by various outpatient departments. For some, staff were able to inform us of the changes that had happened as a result of their report.
- The diagnostic and screening department had implemented changes in practice as a result of reported incidents. The incidents had resulted in the wrong patient being x-rayed and another patient having the wrong site x-rayed. Additional checks had been put into action to ensure these mistakes did not recur.
- An incident reported in the paediatric outpatient department had resulted in additional security measures being implemented regarding the storage of cleaning materials, in order to protect children.

Duty of Candour

- Information regarding Duty of Candour had been cascaded from the divisional managers' meeting to all staff teams. Staff we spoke with demonstrated an understanding of the principals of Duty of Candour.
- A communication folder was kept for staff in the general outpatient department to refer to, and Duty of Candour information had been included in this following its implementation.

Cleanliness, infection control and hygiene

- The trust's policy was for all patients who were due for a surgical procedure to be screened for methicillin-resistant Staphylococcus aureus (MRSA) at their outpatient appointment. Monitoring of compliance with the policy had identified that 100% of patients due for surgery or admission through the outpatient department were screened for MRSA over the seven months in 2014 for which we were provided with data.
- Hand hygiene audits were carried out on one day each month and monitored the percentage of staff who washed their hands and applied antibacterial gel before

and after providing care and treatment to a patient. The audits carried out in 2014/15 for the general outpatient department showed that compliance was below 85% on one audit and between 85% and 100% on two out of the six months recorded, although the two months immediately prior to our inspection showed 100% compliance during the hand hygiene audit.

- Protective personal equipment, for example gloves and aprons, antibacterial hand gel and hand washing facilities were available in all clinical areas. We observed staff using the gel frequently and between patients. A daily check was carried out and signed for to demonstrate that the hand gel dispenser was functioning correctly, was clean and contained sufficient quantities of gel. All staff in the departments and areas we visited worked in line with the trust's policy and were 'bare below the elbows' when in clinical areas.
- Single-use equipment was in place. Where equipment such as blood pressure monitoring equipment was used for more than one patient, we observed it was cleaned after use. Staff could use disposable cuffs to measure blood pressure if the patient's condition warranted this. If the multi-use cuff was used, it was cleaned between each patient.
- Cleaning schedules were visible within the outpatient department. The schedules identified which areas needed cleaning and the frequency, for example whether certain areas required daily, weekly or monthly cleaning.
- Cleaning staff arrived in the department at 4.30pm each day, which was prior to the afternoon clinic's finishing time. This impacted on their access to all areas, as some were still being used by patients and clinicians. The recent cleanliness audit carried out in the department showed 85% compliance, which indicated that some areas were below standard. Staff told us this had been escalated to the senior managers' meeting and reported through the trust's electronic reporting system as an incident. We were not provided with any information regarding the action that had been taken as a result.
- The orthopaedic outpatient area was a busy environment throughout the day and was used by the out-of-hours GP service in the evenings. Concerns were raised by staff that insufficient time was allocated for cleaning the patients' and visitors' toilets during the day, and that only one member of the domestic staff was allocated to this area in the evening. The toilets were also shared with the x-ray departments, and staff reported they had observed and patients had reported that at times cleanliness had not been up to the required standard. Staff were able to call the domestic staff during the day if additional cleaning was required. We were told by staff that on occasions the domestic staff had not been able to respond promptly, as they were carrying out duties in other parts of the hospital.
- All the patients we spoke with said the outpatient areas were clean and tidy, and some commented on the hygienic appearance of the department. All the areas we visited were clean, tidy and hygienic in appearance.

Environment and equipment

- The general outpatient department was in a new building in the style of an atrium. Because of the amount of glass, staff had found problems in regulating the temperature, and often the clinics and waiting areas on the first floor were said to be too hot or too cold. This was uncomfortable for both patients and staff, as when the first floor was cold and the heating temperature increased; this affected the clinics held on the ground floor in that they became too hot. This was recorded on the department's local risk register, and the matter had been referred to the landlord for the building.
- Resuscitation trolleys were available in the medical, surgical and dermatology outpatient areas and within the x-ray department. We saw from records attached to the emergency trolleys that staff checked these on a weekly basis to ensure the medication was in date and the equipment was available and fit to use. The frequency of the checks had been discussed with the resuscitation team and agreed.
- In the orthopaedic outpatient department, we observed that there was no oxygen mask or tubing attached to the cylinder in the treatment area, which could have delayed treatment in the event of an emergency.
- Equipment was available to staff in all outpatient departments, and was serviced and maintained by the medical electronics department. Staff told us that any assistance with equipment was received promptly. Equipment displayed dates that identified when the next service was due.

- The stores department carried out routine stocking-up visits to ensure the department had plentiful supplies of equipment such as gloves, aprons and dressing packs.
- The diagnostic and imaging equipment was serviced on a regular programme by the manufacturers. When equipment was due to be serviced, notification was received by the manufacturer in advance and clinics were cancelled to allow access to the machine.
- Equipment was available in the department for bariatric patients, for example a wheelchair and scales that enabled a person to be weighed while in a wheelchair.

Medicines

- The trust provided nursing staff with medication training that included completion of a workbook. Policies and procedures were in place to provide guidance and information to staff regarding medication ordering, storage, administration, prescribing and disposal.
- Staff were knowledgeable about the medication used in the department in which they worked. Processes were in place to check stocks and reorder as necessary on a weekly basis, which meant the department did not have large stocks of medication. Medication stored in the general outpatient department that was nearing its expiry date was marked in red to ensure that all staff were aware of this. Systems were not fully effective in all departments to check that medication was in date and safe to use. This had resulted in out-of-date medication being stored in the medication cupboard in the computerised tomography (CT) department. We fed this back to the nurse on duty, who informed us that this would be dealt with. The pharmacist had checked the stock recently, but it was not clear why these out-of-date stock items had not been removed and replaced.
- Medication was stored securely in locked cupboards in clinical rooms that were not open to patients or the public.
- Medication that required storage below room temperature was stored in designated fridges, the temperatures of which were recorded on a daily basis to ensure they were within the required limits. The exception to this was in the orthopaedic outpatient department. The staff used one medication that was required to be stored in a fridge. This was ordered the day before the specific clinic, but the fridge temperatures had not been recorded. This did not ensure that the medication was stored at the correct temperature.
- Oxygen was available in specific areas in the department. All resuscitation trolleys had oxygen stored with them for prompt use during an emergency.
- Medication that was administered during the clinic was prescribed by a doctor and written into the patient's medical notes with clear instructions regarding the dose and method of administration, and with the signature of the person who administered it.
- Doctors were able to prescribe medications for patients attending the outpatient department. There was an option to provide a prescription that could be used to collect medication in any chemist or one for medication for use only within the hospital. In the general outpatient department, we saw that the prescriptions were stored securely in locked cupboards and were signed out to each doctor and then signed in on return. The prescriptions for use in any chemist were numbered, and the used prescription numbers were also recorded following each clinic. This enabled staff to monitor and ensure the safety of prescriptions.
- Controlled drugs in the imaging departments were stored securely and recorded appropriately.

Records

- In the general outpatient department, we observed that patients' notes were placed in three empty consulting rooms until they were required by the doctor or nurse holding the clinic. At times these rooms were unattended, unlocked and in some cases the door was wide open. These were areas that members of the public had access to, and therefore this did not protect people's personal and confidential information.
- Records we inspected showed information relating to the patients' visits to the outpatient department and the care and treatment they had received.

Safeguarding

- Safeguarding training was provided electronically for staff. Training data provided by the trust identified that staff within the phlebotomy, occupational therapy, physiotherapy and diagnostic and imaging departments

were within the targets set by the trust for completing safeguarding training. The level of training provided was role specific, and we found that where staff had not completed mandatory training at the appropriate level, a safeguarding awareness course had always been completed, which reduced the risk to patients. Staff we spoke with were aware of their responsibilities regarding safeguarding, and we were given examples of concerns that had been raised and how and to whom staff had raised the concerns.

- Staff in the orthopaedic and paediatric outpatient department provided us with examples of how child safeguarding procedures had been put into operation and incidents escalated in order to protect a child who had attended for an appointment. This demonstrated staff awareness of and proficiency with safeguarding.
- Staff who worked in the orthopaedic outpatient department told us they completed incident reports when patients attended with no notes or their medical notes were unable to be found. We were informed this happened several times a week. Staff expressed concern to us as some, but not all, consultants would not see patients if their correct notes were not available. Staff also advised us that on occasions the misfiling of patients' medical records was observed, and on these occasions they completed an incident report.

Mandatory training

- Corporate induction training was provided for all staff, and additional role-specific induction training for clinical staff. The quality dashboard identified that 100% of all staff had completed their induction within the general and orthopaedic outpatient departments.
- Mandatory training was monitored on the quality dashboard. A target of 90% for completion of mandatory training had been set by the trust, and completion of mandatory training was rated as red, amber or green risk level. From December 2013 to December 2014, over 90% of outpatient and 100% of diagnostic and imaging staff had achieved their mandatory training. The matron for the outpatient department carried out a biannual audit of the mandatory training completed by staff. The audit completed in January 2015 identified that 98% of staff had completed their mandatory training. The training matrix showed that the remaining 2% of staff had dates booked to complete their mandatory training.
- Staff we spoke with were positive about the standard and relevance of the training provided and were confident they would be supported to attend additional training if requested.

Assessing and responding to patient risk

- Key performance indicators relating to the quality of care provided to patients were monitored each month. These included privacy and dignity, communication and patient safety while in the department. It had been identified that patient safety had been compromised on more than one occasion as the identity of a patient had not been checked at reception and/or when they were called into the clinical area or prior to their procedure. This provided a risk of the wrong patient receiving care and/or treatment. Reminders had been sent out to all staff regarding the importance of checking each patient's identity.
- Waiting areas were divided into sub-waiting areas nearer to the clinic where the patient was due to be seen. Not all of these areas were in line of sight of the reception staff, and staff running the clinics were not always in the area. For example, dermatology and surgical outpatients had waiting areas outside the clinic suite, separated by closed doors. This was a risk to patients if they became unwell and were not seen.
- Resuscitation trolleys were available in medical, surgical and dermatology outpatient clinics for use in the event that a patient collapsed and required emergency assistance. The orthopaedics outpatient department did not have a resuscitation trolley within the department. Staff told us this had been agreed with the resuscitation officer for the trust as the department was located next to the emergency department. We were told that if any patient required emergency assistance they would be taken to the emergency department for treatment. No risk assessment was in place to provide assurance that risks had been considered and action taken to reduce the risks to patients.
- Daily handovers took place in the outpatient department each morning. The purpose of the handovers was to review the clinics planned for the day and identify any associated concerns or risks, for example regarding any specific equipment required and ensuring it was available and in working order.

Outpatients and diagnostic imaging

- Every employer who undertakes work with ionising radiation is required to produce local rules. The purpose of such rules is to set out the key arrangements for restricting exposure in a particular area and the responsibilities (in relation to the safe use of radiation) of the individuals who work there. The Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) protect staff and set out that doses given to patients should be as low as reasonably practicable and as low as reasonable possible. When asked, all staff we spoke with in the imaging and diagnostic departments knew who their radiation protection advisor and supervisor was. Staff were aware of the local rules for each area and where copies of IRMER 2000 could be found.
- Safety information was available in the computerised tomography (CT) department, including on the Ionising Radiations Regulations 1999 (IRR99) (IRR99 requires employers to keep exposure to ionising radiations as low as reasonably practicable; exposures must not exceed specified dose limits) and diagnostic reference levels (the objective of which is to help avoid giving a radiation dose to the patient that does not contribute to the clinical purpose of a medical imaging task).

Nursing staffing

- Staff worked across all areas of general outpatients and worked additional hours, through the hospital bank nurse system, to cover gaps in the duty rota. The sister, band 6 nurses and the matron all had authority to organise bank staff hours when required. Rotas we reviewed showed that no agency staff were required within the department.
- The outpatient department had a vacancy for one healthcare assistant, which was being advertised at the time of our inspection. The full complement of trained nurses were in post. The skill mix of trained nurses and healthcare assistants had been monitored, and the views of consultants had been sought regarding the staffing requirements of their specific clinics through a survey. Following the results of the survey, additional healthcare assistants had been appointed to run some clinics.
- Specialist clinics were run in the department by nurse practitioners and other professionals, for example a dietician or psychologist. The outpatient department provided reception but not nursing staff for these clinics.
- The phlebotomy department was located in the general outpatient department and provided a service to approximately 50,000 patients per year. Because of an increase in numbers of patients attending the department, an audit of the service provided had been completed. As a result, an additional three members of staff had been recruited over the past two years.
- The diagnostic and imaging team had 11 vacancies in the radiology team. The team worked across both the Gloucestershire Royal Hospital site and Cheltenham General Hospital, depending on the identified staffing need. Assistant practitioners were in post to help fill the gaps in rotas whilst they were awaiting their registration as qualified radiologists. This meant they were limited in the work they could carry out prior to registration. We were told that new recruits were to start work in three to four months. Staff advised us that they were concerned about the turnover of staff and that many experienced staff were leaving the department to work in other organisations. They also commented that there were few internal promotional opportunities.

Medical staffing

- The consultant-led clinics were staffed from the medical division that they were managed from. Consultants arranged for registrar grade doctors to cover for clinics when necessary. We saw that some GP trainee doctors also covered clinics.
- Additional clinics were arranged at times to address waiting times, and we were told these could be during weekdays, evenings or at weekends at the decision of the medical staff leading the clinics.
- Consultants, whenever possible, arranged cover for each other, for example for annual leave or sickness.
- Because of a shortage of radiologists, reporting times on diagnostic and imaging tests varied. However, at the weekends reports were completed as soon as patients were seen.

Major incident awareness and training

Outpatients and diagnostic imaging

- The trust had a major incident plan that had been updated in June 2014 and was available on the intranet. Senior staff we spoke with were aware of this document and how they would be informed if a major incident was declared requiring them to put the plan into action.
- Information was displayed to advise patients where to meet if it became necessary to evacuate the building.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We found patients' care, treatment and support achieved good outcomes and was based on national guidance and legislation. Staff were trained and competent to carry out their roles effectively and in line with best practice. Staff were supported to maintain and develop their professional skills and experience.

Appraisals took place annually and were completed on time.

Consent to care and treatment was obtained for patients whose care and treatment was pathway tracked during our inspection.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 and their responsibilities within this legislation.

Systems were in place for staff to request and track and trace notes for individual patients' appointments at clinics. Action was taken when notes did not arrive at the clinic in time, to ensure the patient was seen with as much prior history and information as possible.

Evidence-based care and treatment

- The diagnostic and imaging department was currently reviewing its systems and associated policies and procedures. Changes had been implemented as a result of the review, for example to the system for requesting an x-ray. The previous system used a small sticker that did not provide all necessary information and was not always signed. Following an audit of the use of the stickers, the system changed and a request card had been implemented to ensure the full patient details were provided by the referring health professional. Information was sent to all staff regarding this change and the use of the request card.
- The outpatient departments had access to policies and procedures that were stored on the trust's intranet. Staff were knowledgeable about which policies and procedures were accessible to them and how to access them. We reviewed a number of policies and procedures and identified references to national guidelines and good practice. Staff we spoke with were aware of the National Institute of for Health and Care Excellence (NICE) guidelines and were made aware of changes to the NICE guidelines through the management teams, for example at team meetings.

Patient outcomes

- The general outpatient department conducted audits to monitor that clinic appointments were on time and that, if there was delay, the patient had been informed. This ensured patients were kept informed throughout their visit to the department. We saw an audit ongoing in the general outpatient department during our inspection which showed that the clinic on that day had run late but the patients affected had been informed.
- The orthopaedic outpatient department provided surveys for patients to fill in regarding their care and treatment in the department.
- Three patients we spoke with who were attending the ophthalmology clinic said they were satisfied with their appointment times, notice given of their appointments, and that they had not experienced previous appointments running late. Four people who were attending the audiology clinic said they were pleased with the appointment system and the running of the clinic, although one other person told us their appointment was running 20 minutes late. We had received information from external organisations regarding clinics running late for patients. Staff confirmed this did happen, but during our inspection clinics were not running more than 30 minutes late.

Competent staff

- Completion of staff appraisals was monitored on the quality dashboard. The trust set a target of 90% for completion. In December 2014, 95.6% of all appraisals

had been completed for staff working in the outpatient department. The February 2015 results from the matron's biannual audit of the general outpatient department showed that 100% of staff appraisals had been completed. The orthopaedic outpatient staff records showed that 100% of appraisals had been completed. The completion of appraisals for phlebotomy staff was monitored, and we saw evidence that demonstrated that 96% of appraisals had been completed up until November 2014.

- Healthcare assistants in post were supported by trained nurses to run clinics, with additional training provided to them where necessary. For example, the healthcare assistant running the pain clinic had received training in methods of pain control. Healthcare assistants were supported to work with a trained nurse and doctor to observe all aspects of the clinic prior to running it themselves. One healthcare assistant told us this had been helpful as they had observed and identified what the patients would experience, and therefore were able to offer advice and reassurance to patients prior to their consultation and treatment.
- Staff attended national conferences for outpatient and diagnostic and imaging departments, during which networking with other trusts took place and information was gathered on national guidelines.
- Practical training had been provided to staff in the outpatient department following on from mandatory moving and handling training, to ensure all staff demonstrated competency. We were provided with an example of practical training based on a scenario that had been set up by the moving and handling link nurse, in which staff participated.
- In the general outpatient department there was a quiet work area where staff, including student nurses, could spend time writing notes or studying. This area had a supply of learning materials and policies and procedures.
- We spoke with a healthcare assistant apprentice who was positive regarding the training and support provided to them. Part of their apprenticeship training included one day a month in the education centre undertaking formal theoretical study.
- External training was available for diagnostic and imaging staff. On return to the department, staff cascaded learning to the whole team – the staff member was required to prepare a presentation and teaching session on their return.
- Staff told us there had been limited teaching sessions from the radiologist recently, because of time constraints.
- Radiographers worked in both the magnetic resonance imaging (MRI) and computed tomography (CT). **This test uses x-rays and a computer to create detailed images of the inside of the body.**
- Plaster technicians were provided with a six-week residential course with an external organisation to achieve competencies and skills in plaster room treatments.

Multidisciplinary working

- We observed that the cardiology outpatient team demonstrated multidisciplinary working within the trust, referring patients to different departments for specific tests and care, for example to the physiotherapy department. The team also worked as part of a wider multidisciplinary team and referred patients to other trusts, for example North Bristol NHS Trust, when necessary, for additional or more specialised treatment.
- The phlebotomy service worked with local GP services, visiting housebound patients, as part of the commissioning arrangements. Staff told us this worked well and communication was effective to ensure patients were seen appropriately and promptly.
- Test request forms received in the phlebotomy clinic did not always provide specific or clear information on the test required. Staff liaised with internal and external health professionals to ensure the correct blood test was completed.
- The phlebotomy teams at Gloucestershire Royal Hospital and Cheltenham General Hospital attended team meetings for which joint minutes were provided to staff. This ensured the departments worked well together and staff worked between the departments when necessary.

Seven-day services

Outpatients and diagnostic imaging

- The diagnostic and imaging team provided 24-hour cover seven days a week for emergency referrals.
- Outpatient clinics were generally run from Monday through to Friday. Additional clinics were added at times to reduce the waiting times for patients. These clinics were arranged at the discretion of the consultant and were often on Saturday mornings.

Access to information

- Staff attended a daily handover in the general outpatient department to ensure they were aware of any specific information regarding the day's clinics, for example changes to the running times or specific information regarding individual patients attending.
- Information from the trust informed us that a recent audit carried out in the outpatient department had found that the full medical records for 0.96% of patients were not available in time for their appointments. We spoke with two consultants, who told us this had not caused them to experience difficulties when seeing patients.
- The trust had an electronic system in place for staff to request and track notes. Records for patients attending clinics were requested six days in advance to enable staff to have time to track any missing records. Tracking and requesting of notes continued up until the day of the clinic. If notes were not received by the day of the appointment, a temporary set of notes was put in place that provided the clinician with a copy of the referral letter, discharge summary or letter from a previous appointment, depending on the patient pathway. Clinicians were able to access test results electronically.
- Concerns had been raised by the staff during a previous executive board members' visit to the outpatient department. This had been regarding poor completion by the clinician of forms requesting diagnostic tests. Changes to the electronic patient record system in use by the trust had not resulted in an improvement of this, and staff advised us that they often needed longer with the patient to complete administration.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up-to-date policy and procedure in place relating to consent to care and treatment. The policy and procedure informed staff that valid consent had to be obtained before treatment or examination and set out how the consent was to be obtained and recorded.
- Written consent was obtained from patients prior to having a computerised tomography (**CT) scan. (This test uses x-rays and a computer to create detailed images of the inside of the body.)**
- **Written consent for Xyopex injections was obtained prior to their administration in the orthopaedic outpatient department. (Xyopex is a medication given to correct a Dupuytrens's contracture of the finger(s).)**
- Consent provided by or for children was sought in accordance with legislation. Staff in the orthopaedic outpatient department knew the legal guidelines which meant that children under the age of 16 were able to give their own consent if they demonstrated sufficient maturity and intelligence to do so (often called 'Gillick competence'). Otherwise, consent would be sought from the child's parent or guardian, with input from the child. If a child attended without a person who was able to provide consent, staff would attempt to contact an appropriate adult.

Are outpatient and diagnostic imaging services caring?

Good

We found the service to be caring. Staff involved and treated patients with compassion, kindness, dignity and respect, providing them with a caring service.

We observed that staff were polite and respectful in all interactions with patients. Feedback from patients who used the service and their relatives/representatives was positive about the way staff treated them. We had concerns regarding the privacy and dignity of patients in two clinical areas where opportunities arose for other people to observe them during care and treatment.

Outpatients and diagnostic imaging

Staff provided information to patients, both verbally and in writing, regarding their care and treatment, to enable them to have a full understanding and make informed choices where necessary. Information regarding external support organisations was available from outpatient departments.

Compassionate care

- Positive feedback received from patients was recorded on the quality dashboard. The number of compliments received in 2014 had increased in number month on month, with seven compliments received in December 2014.
- We observed staff in polite and kind interactions with patients. One example was a patient in a wheelchair who asked for assistance. We saw that a staff member knelt down on the same level as the patient and responded to their request immediately. We observed that reception staff treated patients with dignity and respected their privacy when booking them into clinics. When health professionals called patients into the clinics, this was done in person and assistance was given with mobilising patients when necessary.
- Patient confidentiality was respected at the booking-in desks, with ropes placed for people to wait in turn a distance away from the desk to allow patients privacy when speaking with the receptionist. We observed receptions speaking to patients kindly and patiently and listening carefully to their responses. We saw that notices clearly displayed information regarding the availability of private areas if patients wanted to have a more confidential conversation away from the desk.
- During our tour of the outpatient department, we saw a clinic room was being used for a minor surgical procedure. The door to the clinic room had a window that was not occluded, enabling people passing to see what was going on in the room. There was no sign on the door advising that the room was occupied and not to enter. This did not ensure that patients' privacy and dignity were promoted and respected.
- Patients had raised concerns to the phlebotomy staff that they felt their privacy was not respected as they had been able to observe other patients having blood taken in the same clinical area. A directive had been issued to staff to ensure curtains were pulled between patients, and staff we spoke with were aware of this. However, we observed that while the curtains were drawn between patients so that they could not see each other, people (including patients, representatives and children) sitting in the waiting room could view patients in two of the areas used for taking blood. This did not respect the patients' privacy and dignity.
- We spoke with 39 patients and/or their representatives during our inspection, and all made positive comments about the staff. Specific comments included, "They [the staff] are kind and helpful," "friendly welcoming staff", "excellent staff" and "I can't complain about anything, I've been looked after well."

Understanding and involvement of patients and those close to them

- We spent time in the reception area of the outpatient department, observing patients being greeted and booked into the department. We saw that patients were greeted in a warm and welcoming manner and given clear instructions by the receptionist about which waiting area to sit in and any delays there were in the clinics.
- We observed that staff provides patients with information regarding their care and treatment, both verbally and within information leaflets which were explained to patients during their visit to the clinic. Patients we spoke with said that they had been provided with information.
- Relatives/representatives we spoke with said they were able to attend the clinic with their loved one and had been included in the explanations and information-sharing by the clinician.

Emotional support

- The quality of nursing care and treatment was monitored on a monthly basis against performance indicators, for example regarding communication with patients, clinic delays and privacy and dignity, including the use of chaperones. The outpatient department evidenced good outcomes for patients from the performance indicators.
- Patients we spoke with told us staff were kind and considerate to them during their visit to the outpatient department.

Outpatients and diagnostic imaging

- Information was available to patients regarding support groups they could contact for specific conditions. We saw information relating to a support group for the visually impaired and for dermatology conditions.
- Clinical nurse specialists were available throughout the trust to support patients with specific conditions and illnesses, for example learning disabilities and dementia.

Are outpatient and diagnostic imaging services responsive?

Requires improvement 

Outpatient services required improvement to ensure clinics were organised in a manner that ensured patients' needs were met promptly and responsively.

We found that referral-to-treatment times exceeded national targets, with services not delivered in a way that focused on patients' holistic needs. Some patients experienced long delays in receiving their first outpatient appointment. The booking team was taking action to address waiting times and monitored patients who did not attend for appointments.

Staff were responsive to patients' individualised care needs and made reasonable adjustments to support patients to be seen promptly on arrival at the clinic if their medical conditions required this.

Patients did not always know how to make a complaint, there was not consistency within clinics regarding the complaints process available. When patients had made a complaint, the hospital had responded promptly and thoroughly, with staff informed of the outcomes to enable learning to be taken forward.

Service planning and delivery to meet the needs of local people

- Staff working within the outpatient department told us patients could use the 'choose and book' system to enable them to choose an appointment in a hospital location close to their home. A booking team was available to assist patients, with the provision of letters to inform them of their appointment date and time. Text reminders and telephone calls were in operation to serve as a reminder to the patient.
- We were told some specialties booked additional patients into the clinic as they expected some patients to not attend. At times, this made the clinics run late and had a considerable impact on subsequent clinics using the same consulting rooms, making those clinics run late too. When it was known that certain clinics regularly overran their allotted time, action had been taken to start afternoon clinics later to accommodate for this.
- Nurse specialists provided clinics for patients in different locations to provide accessibility for local people, for example for neurology and breast care. We spoke with two specialist nurses who were providing clinics at Gloucestershire Royal Hospital outpatient department, and they were satisfied with the support they received from the department in order to run their clinics smoothly and efficiently.
- Rapid-access outpatient services were available each day for patients who required chest pain assessment, urgent care and treatment for ophthalmology, ear nose and throat (ENT) appointments, or access to fracture clinics and plaster room clinics.

Access and flow

- Information from national data showed the trust had regularly performed worse than the England average for the referral-to-treatment time standard since December 2013. The diagnostic waiting times for people waiting more than six weeks were consistently better than the England average for 2013 and 2014.
- Booking for outpatient clinics, including the orthopaedic outpatient department, was done through the trust's booking office with the exception of booking for some specialist clinics, where appointments were booked by the consultant. The system for booking was the same for all clinics covered by the booking team, apart from some small differences which were usually consultant-specific. Differences included where some types of appointment should not be after a certain time of day, such as if an x-ray was needed, or where new patients were not booked later in the clinics, because they may need more time.
- There were long waiting times of up to 45 weeks for new patients who required a cardiology appointment, and

up to 25 weeks for rheumatology. Staff informed us this was because the number of clinics there was limited, with some only being available for half a day a week or month.

- Additional clinics had been opened following an audit of the waiting times of patients with acute knee pain, to ensure such patients were provided with an appointment within three weeks of referral.
- The bookings team set an internal target of 11 weeks from referral to treatment, to meet the 18-week referral-to-treatment target. A weekly report regarding the referral-to-treatment time was produced by the booking team and provided to the manager of the specialty team for the individual clinic.
- If a patient required a follow-up appointment within six weeks, the clinic receptionist booked the appointment. If the appointment was to be more than six weeks later, the patient was referred to a 'pending' list that was then managed by the booking office. If no appointments were available, the booking team liaised with the consultant, adding more patients to the clinic list. This could result in overbooking of clinics, although some consultants would hold an extra clinic.
- Delays had been experienced by patients who required an annual review, which had extended their wait to three or four months more than a year. This meant there was a risk that the delay could lead to a missed recurrence of the patient's disease, such as of cancer. This had been raised and was recorded on the risk register.
- For patients who did not attend, another appointment was booked. A second missed appointment was not rebooked. The booking team monitored rates of non-attendance and found that rates within the trust were similar to the national average.
- The booking office reminded patients of their forthcoming appointments by telephone calls and text messages in a bid to reduce non-attendance. We saw receptionists checking telephone numbers when booking patients in to ensure hospital records were kept up to date. Patients were complimentary about the reminder system and made positive comments about the letters sent out initially and about appointments made at the last visit to the clinic and the reminders.
- Two patients were positive about the flexibility of the booking office. For one patient, an appointment had been made for when they would have been on holiday, and for the other patient, unforeseen circumstances had meant they would be unable to attend an appointment. Both appointments had been rearranged with earlier appointments that suited the patients.
- On occasions, clinics were cancelled at short notice, for example because of sickness. When this happened, the booking team focused on making contact with patients to tell them before they attended. During the week of our inspection, there had been four short-notice clinic cancellations across both hospitals, which we were told was a higher number than usual. Before a clinic was cancelled, the booking team always checked with the relevant division to see whether it could be covered by another consultant, doctor or specialist nurse.
- Waiting times in clinics were written on whiteboards or on electronic displays so that patients were aware of any delays. Receptionists advised patients when they were booking in of any delays in their clinic. During our inspection, the longest delay of 45 minutes was observed in the phlebotomy clinic, at the end of the morning. When we returned to this clinic in the afternoon, fewer patients were in attendance and the service was prompt.
- The cardiology clinic provided a 'one-stop shop' for patients who attended following sudden onset of chest pain. The clinics were run by a specialist nurse and provided the opportunity for patients to receive tests such as an echocardiogram, electrocardiogram or exercise test. Once the tests had been completed, the patient returned to the specialist nurse for the results and an ongoing plan of treatment. This reduced the number of times the patient had to attend hospital for medical tests, and reduced the waiting time for results.
- Patients who had attended the orthopaedic outpatient department had experienced waiting times of up to one and a half hours. New patients were allocated 20-minute slots, while patients returning for follow-up appointments were allocated 10 minutes. Patients who required treatment following an x-ray or removal of plaster often experienced delays that extended the running time of the clinic. The arrival and departure times of patients were recorded. However, the time

patients spent in x-ray, in the treatment room (for example, for removal of plaster) or at phlebotomy was not recorded, so a full picture was not recorded of the patient's journey and where delays had occurred.

- One patient praised the booking office staff as being helpful, as on the day of their appointment their arrival had been delayed by 20 minutes. They said they had telephoned the booking office and been reassured that they would not miss their appointment.
- One patient had attended the clinic every month for the past nine months, and they told us they had always got an appointment booked before they left.

Meeting people's individual needs

- Patients who lived with dementia or who had a learning disability were provided with additional support from staff. Staff were alerted to these patients by the use of stickers placed on their booking form within their medical records. We observed that staff provided additional support to one patient who had learning disabilities by spending time with them and their carer in the waiting areas. Link nurses were available within the departments to provide additional support when patients attended for their appointment. Learning disability nurses worked with patients in their own homes prior to their appointment. The trust had implemented a dementia strategy which was in operation within the outpatient department to improve the experiences of patients living with dementia. Biannual monitoring took place, and the report from July 2014 showed positive awareness among staff of their actions regarding the care and treatment of patients with dementia.
- Phlebotomy outpatient staff made arrangements so that patients with learning disabilities were supported by the learning disability liaison nurse if necessary and were seen promptly when arriving in the clinic. Children over the age of six attended the general phlebotomy outpatient clinic rather than the paediatric clinic, and were responded to promptly on arrival in the clinic.
- A document for people with additional needs, for example learning disabilities, was in use and was known as 'tell us about you'. These documents were held by the patients and included information that outlined their needs during hospital visits. Patients were supported by their representatives and/or the staff to complete these booklets.
- Signs were displayed clearly in waiting areas and treatment and consulting rooms regarding the availability of chaperones. Monitoring by the trust demonstrated that 100% of patients who requested chaperoning during clinical care and treatment were provided with this service.
- Consulting rooms had notices on the outside of the door to identify if they were in use. Red 'do not disturb' signs were used when patients were having intimate examinations or difficult or private conversations were taking place. We saw these signs in operation during our inspection, and staff we spoke with were all aware of the importance of the signs.
- Hearing loop systems were in operation within the outpatient departments, and signage advised patients of the availability if required.
- Magazines were available in waiting areas for the patients to read. In some waiting areas where children might be attending clinics, there were toys and children's books available. However, we did not see these in all clinics to provide entertainment for children attending the hospital with an adult for their appointment. We observed two children waiting with adults where there were no toys available. One member of staff brought some books for the child to look at, but we did not see this happen for the other child.
- The paediatric outpatient department was well equipped with toys and games to entertain children waiting for their appointments and to provide a distraction during tests and examinations.
- The dermatology outpatient department had access to a WII electronic games console, which had been provided by the dermatology specialist paediatric nurse and was used when the department was operating a clinic. It was not used at other times, as the console was locked.
- Children were provided with care and treatment in the orthopaedic outpatient department by an orthopaedic

paediatric consultant. No paediatric nurses worked in this department, so nursing care was provided by general nurses. A small but separate child-friendly waiting area was available.

- We observed the process that was followed when a patient who was seen in the orthopaedics outpatient department required admission to a ward. The process was efficient, and assessment of the patient for admission took place in outpatients.
- Volunteers were available in the outpatient department to direct patients to the appropriate reception desk in the clinical areas. However, one patient we spoke with had not been booked into the clinic but had been advised to wait in one particular area by an administrator. The reception staff were not aware that the patient was in the department, as the patient's attendance had not been communicated to them. The patient was delayed as the clinic staff had not realised they were present. Once the reception staff were made aware of this patient, they took prompt and effective action.
- We observed that staff provided individualised care to one person with a disability. The patient told us they felt well cared for and had found the department had good accessibility, including access to appropriate toilet facilities.

Learning from complaints and concerns

- Numbers of complaints received in the outpatient departments were monitored within the trust's quality dashboard. From December 2013 to December 2014, a total of 19 complaints were recorded. There was a risk rating based on the numbers of complaints received. For two months, the numbers of complaints identified a red/high risk, with four and five complaints received. Two months rated as amber/medium risk, with three complaints, and the remaining months were green.
- Information on how to make a complaint was not consistently displayed within all waiting rooms to inform patients of how to contact the Patient Advice and Liaison Service (PALS) to raise issues. Ten patients we spoke with in the general outpatient department were not aware of how to make a complaint, although they all said they had never needed to do so.
- We reviewed the complaints received in the general outpatient department. The department's electronic quality dashboard identified that one complaint had been received regarding the service provided by the general outpatient department. An investigation had been carried out into the issues raised, and feedback provided to staff regarding the findings of the investigation.

Are outpatient and diagnostic imaging services well-led?

Good

The leadership and management of the outpatient and diagnostic services ensured the provision of person-centred care and supported the staff to deliver the care. Staff found their local management teams approachable, but not all staff were aware of senior management, for example the trust's board of directors.

Potential risks within the delivery of the service were assessed, and the action taken to mitigate the risk was recorded.

Vision and strategy for this service

- The trust's vision of safe effective and personalised care for every patient, every time, all the time, was displayed in the outpatient department. Staff were aware of the national vision and strategy called Compassion in Practice. Compassion in Practice is based around six values: care, compassion, courage, communication, competence and commitment. Information was displayed within the department for patients and staff.
- The surgical, medical and dermatology outpatient departments were managed by the matron and department manager. These had previously been run as individual departments, and staff confirmed that the running of the clinics and bookings for clinics had improved since they had been managed as one division.

Governance, risk management and quality measurement

- Key performance indicators were monitored to demonstrate the quality of nursing care provided. These were discussed at departmental and divisional governance meetings.

Outpatients and diagnostic imaging

- Risk registers were in place in the outpatient department and provided information regarding identified risks to staff and patients, for example about the potential risks from using sharps (needles) and from fire, violence and aggression from patients and representatives, stress and lone working. The risk registers were up to date and provided guidance for staff on how to reduce the perceived risk.
- We were provided with an example of when staff in the general outpatient department had felt at risk from the behaviour of one patient who regularly attended the department. Staff told us they had been supported by the trust and a planned course of action based on a comprehensive risk assessment had been put into place.
- The environment within the general outpatient department had been recorded as a risk on the register because of the fluctuating temperatures caused by large amounts of glass in the structure of the building.
- The x-ray department had identified a problem with passing through fire doors with heavy equipment. This was because the doors did not have automatic release openers in place, and staff found it difficult to hold the door open while passing through. Staff used up-turned hooks to keep the doors open, and had recorded this practice on the local risk assessment. The fire officer was recorded as having being consulted and having agreed to this practice.
- The orthopaedic outpatient service had a departmental risk assessment. Staff had confidence that the risk assessment process led to a change in practice. For example, a risk had been identified that the plaster saws were old and very noisy to use. Following remedial action to protect staff from hearing damage, new saws were purchased by the trust.
- The imaging department held local risk registers that were reviewed regularly and were up to date. The risks identified included theatre radiographer access after midnight for orthopaedics, computerised tomography (CT) equipment replacement, work environment for ultrasound and availability of safe couches for ultrasound, which were all classed as ongoing.
- Local risk registers were reviewed at the monthly outpatient and diagnostic monthly meetings attended by senior staff from all departments. Any significant risks identified were escalated to the trust-wide risk register. At the time of our inspection, the environment of the general outpatient department was registered on the trust-wide risk register.
- The phlebotomy service told us that it did not carry out quality surveys for its patients but did review complaints and incident reports to ensure there were no themes or patterns identified that resulted in a risk to patients and required addressing.
- The outpatient department manager went to the outpatient department board meeting and cascaded information back to the staff team.

Leadership of service

- Staff who worked in the radiology department made positive comments regarding the support provided by the superintendent radiographer. This included clinical, management and educational support to staff.
- Staff commented that they felt supported by their line managers and departmental managers within all outpatient areas we visited. We were told managers were visible in the departments and were approachable and supportive.
- Specialist clinics were managed by the division leads, for example in orthopaedics and phlebotomy.
- The physiotherapy management team held a monthly meeting, attended by both Gloucestershire Royal Hospital and Cheltenham General Hospital staff. Minutes of the meeting were available and emailed to relevant staff. The meeting had developed an action plan that evidenced each issue and who was delegated responsibility for ensuring the action was met. Weekly staff meetings were held for staff who worked in the physiotherapy department, and minutes were taken to communicate issues to staff who were not able to attend.
- Feedback from the last board meeting was provided to staff within the monthly newsletter.

Culture within the service

- Nursing staff we spoke with told us they were proud to work at the hospital and were confident their departments provided safe and effective care.

Outpatients and diagnostic imaging

- Some staff in the diagnostic and imaging teams did not feel listened to regarding their workload and the current level of vacancies among radiographers. We were told they had reported their concerns regarding the staffing levels and skill mix of staff but had not experienced any changes to improve the situation.

Public and staff engagement

- The trust's newsletter for staff included information on changes taking place trust wide, such as in how complaints were managed and information was made available to patients, and on significant events occurring within the trust. Information was also provided regarding specific departmental changes.
- The outpatient department held a monthly team meeting over a lunchtime so that the maximum number of staff could attend. Information relating to the outpatient department and the wider trust was disseminated at this meeting. For any staff who could not attend the meeting, the information was cascaded electronically.
- Executive board members attended departments to enable staff to speak with them and review the services provided. The phlebotomy clinic provided us with evidence regarding an executive visit that had taken place in 2014, and we were informed that staff had been listened to and action had taken place following this visit regarding concerns that had been raised.
- We observed that patients were encouraged by staff to complete the Friends and Family Test within clinic waiting areas. In some clinics, surveys were available for patients to take and complete, whilst in others they were not visible.

Innovation, improvement and sustainability

- Staff had completed an incident report following the resignation of a skin psychologist; this was because the staff understood that this position was not going to be filled, and they were concerned this would result in a decreased service for patients. This had also been placed on the risk register but staff were not aware of any action that had been taken by the trust in response to this.

Outstanding practice and areas for improvement

Outstanding practice

- Patients living with dementia on Ward 9b were able to take part in an activity group that had been organised by one of the healthcare assistants. The activity group enabled the patients to become involved in activities and encouraged them to maintain their skills and independence. The group was held weekly, and patients were able to play bingo, watch films, take part in reminiscence, paint, sing and eat lunch together. Activities were tailored to individual preferences, and relatives were encouraged to be involved.
- The trust had a mobile chemotherapy unit, which enabled patients to receive chemotherapy treatment closer to their home to prevent frequent travel to hospital.
- Patient record-keeping in critical care was outstanding. All the patients' records we saw were completed with high levels of detail. There were all the essential details to keep patients safe and ensure all staff working with them had the right information to provide safe care and treatment at all times.
- There was an outstanding holistic and multidisciplinary approach to assessing and planning care in the department of critical care. All the staff involved with the patients worked with one another to ensure that the care given to the patient followed an agreed treatment plan and team approach. Each aspect of the care and treatment had the patient at its centre.
- In critical care, there was an outstanding commitment to education and training of both nurses and trainee doctors. Nurses and trainee doctors followed comprehensive induction programmes that were designed by experienced clinical staff over many years. All the staff we met who discussed their training and development spoke very highly of the programmes on offer and of there being no barriers to continuous learning.
- There was outstanding care for bereavement in critical care. All staff spoke highly of how they were enabled to care for and support patients and relatives at this time. Bereavement care had been created with input from patients, carers, relatives and friends, and staff were particularly proud of the positive impact it had on bereaved people and on patients nearing or reaching the end of their life.
- The outstanding arrangements for governance and performance management in critical care drove continuous improvement and reflected best practice. There was a serious commitment to leadership, governance and driving improvements through audits, reviews and staff honesty and openness. All staff had a role to play in this area and understood and respected the importance of their work.
- Mobility in labour was promotion through the Mums Up and Mobile (MUM) programme, which included wireless cardiotocography (CTG) monitoring across the whole delivery suite.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

- Improve its performance in relation to the time patients spend in the emergency department to ensure that patients are assessed and treated within appropriate timescales.
- Continue to take steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced consultants and middle grade doctors to provide senior medical presence in the emergency department 24 hours a day, seven days a week, and to reduce reliance on locum medical staff.
- Continue to reduce ambulance handover delays and take steps to ensure that patients arriving at the emergency department by ambulance do not have to queue in the corridor because there is no capacity to accommodate them in clinical areas.

Outstanding practice and areas for improvement

- Develop clear protocols with regard to the care of patients queuing in the corridor. This should include risk assessment and the identification of safe levels of staffing and competence of staff deployed to undertake this care.
- Work with healthcare partners to ensure that patients with mental health needs who attend the emergency department out of hours receive prompt and effective support from appropriately trained mental health practitioners.
- Take immediate steps to address infection control risks in the ambulatory emergency care unit.
- Ensure that systems to safeguard children from abuse are strengthened by ensuring that children's safeguarding assessments are consistently carried out, and safeguarding referral rates are audited to ensure they are appropriate.
- Ensure that senior medical staff in the emergency department are trained in level 3 safeguarding.
- Ensure that patients in the emergency department have an assessment of their pain and prompt pain relief administered when necessary.
- Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.
- Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.
- Ensure that patients' records across the hospital are stored securely to prevent unauthorised access.
- Ensure that the premises for the medical day unit are suitable to protect patients' privacy, dignity and safety.
- Ensure patients' mental capacity is clearly documented in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) and 'unwell/potentially deteriorating patient plan' (UP) forms. Improvements in record keeping must include documented explanations of the reasoning behind decisions to withhold resuscitation, and documented discussions with patients and their next of kin, or reasons why decisions to withhold resuscitation were not discussed.
- Ensure that where emergency equipment in the form of resuscitation trolleys is not available, the decision to not supply is based on a thorough risk assessment. Where emergency equipment is available, this should be ready to use at all times.
- Ensure all patients' referral-to-treatment times do not exceed national targets, and that services are delivered in a way that focuses on patients' holistic needs and does not mean patients experience long delays receiving their first outpatient appointment.

Review communication methods within maternity services to ensure sensitive and confidential information is appropriately stored and handled whilst being available to all appropriate staff providing care for the patient concerned.

Action the hospital SHOULD take to improve

Action the hospital MUST take to improve

- Improve its performance in relation to the time patients spend in the emergency department to ensure that patients are assessed and treated within appropriate timescales.
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- Review communication methods within maternity services to ensure sensitive and confidential information is appropriately stored and handled whilst being available to all appropriate staff providing care for the patient concerned.

Action the trust SHOULD take to improve

- Review how staff perceive the feedback they get from incident reporting and the level of detail received.
- Ensure that patients, including children, are adequately monitored in the emergency department waiting room to ensure that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Take steps to improve the experience for patients and visitors in the emergency department waiting room. This should include the provision of drinking water, a TV, and appropriate reading material and information about waiting times.
- Review the emergency department's nursing staff mix and training to ensure adequate numbers of staff are trained to identify, care for and treat seriously ill children.
- Continue to improve hospital-wide ownership of the emergency department's four-hour target, to ensure that delays in admission are minimised.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.
- Ensure all staff in surgery services are able to demonstrate and understanding of the requirements of the Mental Capacity Act and Deprivation of Liberty

Outstanding practice and areas for improvement

Safeguards, so patients are not put at unnecessary risk of staff not acting legally in their best interests. Ensure there is appropriate documentation in place to support decisions.

- Ensure that the ambulatory emergency care unit is sited in an appropriately equipped area that is conducive to ensuring patients' comfort and dignity.
- Consider displaying feedback from patients and relatives for each individual medical ward.
- Consider a system to identify when patient equipment has been cleaned.
- Ensure all areas are clean and free from litter.
- Store all medicines in critical care in a way that meets requirements for their security.
- For safety of the medicines and equipment inside, ensure resuscitation trolleys are secured in such a way so there is clear evidence if they have been opened between checks.
- Capture and report safety thermometer data in the department of critical care alongside the other data on patient harm that the department collects.
- Ensure all items are within their expiry date.
- Ensure all staff in the medical wards follow the trust's infection control policies and procedures.
- Maintain continuity of care for patients on the day surgical unit to ensure their needs are met when it is open 24 hours a day, seven days a week.
- Review the medical and surgical cover at weekends for the day surgery unit to make sure patients are reviewed and discharges not held up.
- Ensure patients who are admitted to the surgical day surgery unit can have their needs met by the staff team.
- Reduce the number of times patients are moved between wards for continuity of care.
- Review the staffing levels of physiotherapists against the requirements of the Faculty of Intensive Care Medicine Core Standards.
- Ensure the specialist palliative care team can be sustained and are able to remain responsive to the evidenced increased demands of complex referrals, provide a face-to-face seven-day service and ongoing staff training in line with national policy, and make improvements to inconsistent governance, risk management and quality measures.
- Ensure a strategy for end of life care is developed.
- Ensure all patients who are referred by their GP with suspected cancer are seen with two weeks of referral, and treatment is started within 62 days of referral.
- Ensure the cleaning arrangements for all outpatient areas are appropriate to maintain a high standard at all times.
- Ensure that where medication is required to be stored at refrigeration temperatures, there are systems are in place to monitor the correct temperature.
- Ensure that systems are in place in outpatients to identify in a timely manner and replace medication that is approaching its expiry date, to prevent potential harm to patients.
- Ensure patients' privacy and dignity is consistently respected in the outpatient department and medical unit.
- Ensure patients in outpatients have access to information on the trust's complaints procedure, and that this is readily available in all areas.
- Ensure staffing levels and the skill mix of staff in the diagnostic and imaging teams meet the needs of patients at all times and support staff to deliver a quality service.
- Review, in the maternity services, the midwifery and support staffing to ensure there are sufficient staff to meet patients' needs at all times in all areas.
- Ensure that in maternity services, both service risk registers detail actions underway to mitigate risks.
- Review cleaning schedules in maternity services and devise systems to ensure staff know when equipment has been cleaned and is ready for use.
- Within gynaecology, review recalibration schedules for weighing scales.

Outstanding practice and areas for improvement

- Within maternity services, review the provision of oxygen and air on resuscitaires to ensure that the correct gases are administered during resuscitation, in line with the Resuscitation Council guidelines.
- Review the location of the maternity services' registrar clinic and early pregnancy assessment clinic (at weekends) to ensure facilities are appropriate to provide care, assessment and treatment.
- Review the processes to ensure early screening (pre 10 weeks' gestation) can occur where the need for such screening is indicated.
- Within maternity services, work with the wider organisation to ensure overall patient flow is effective to prevent the need for cancellation of gynaecology patients because of the need to accommodate other patients on Ward 2a.
- Review the timeliness of access to patient information in alternative languages.
- Ensure staff in all areas of maternity services are aware of the procedures to follow in the event of early discharge ahead of the completion of all bereavement processes.
- Ensure all patients' referral-to-treatment times do not exceed national targets, and that services are delivered in a way that focuses on patients' holistic needs and does not mean patients experience long delays receiving their first outpatient appointment.
- Review staffing levels for the provision of services within the specialist palliative care team.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services Regulation 9 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services. The provider had not taken proper steps to ensure that each patient was protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of: (a) the carrying out of an assessment of the needs of the service user; and (b) the planning and delivery of care and, where appropriate, treatment in such a way as to: (i) meet the service user's individual needs, (ii) ensure the welfare and safety of the service user. [Now Regulation 9 including Regulation 9(3)(a) and 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] Patients spent too long in the emergency department. Too many patients who arrived at the emergency department by ambulance waited too long to be handed over to emergency department staff. This posed the risk that their assessment, care and treatment might be delayed. Too many patients arriving at the emergency department by ambulance were cared for in the corridor because there were insufficient available cubicles. This impacted on their safety, privacy and dignity. Patients with mental health needs attending the emergency department out of hours waited too long for assessment and support from appropriately qualified mental health practitioners.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 10 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.** **The provider had failed to protect service users against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the provider to:** 1. regularly assess and monitor the quality of services provided. **[Now Regulation 17 including Regulation 17(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]** **The provider had not taken appropriate steps to improve care and treatment in the emergency department in response to national clinical audits.**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Regulation 11 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse.** 1. The provider did not have suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of: 1. Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; 2. Responding appropriately to any allegation of abuse. **[Now Regulation 13 including Regulation 13(1), 13(2), and 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]**

This section is primarily information for the provider

Requirement notices

Children's safeguarding assessments were not consistently carried out.

There was a lack of any system to ensure all appropriate child safeguarding referrals were made.

Not all senior medical staff in the emergency department were trained in safeguarding level 3.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control. [Now Regulation 12 including Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] The provider had not, so far as reasonably practical, ensured that ensure service users were protected against identifiable risks of acquiring a healthcare-associated infection. Appropriate standards of cleanliness and hygiene in relation to equipment and materials used in the treatment of service users were not maintained. The assessment/treatment room in the ambulatory emergency care department was not suitably maintained or equipped to ensure that it provided a suitable and hygienic area in which clinical interventions could be carried out.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

This section is primarily information for the provider

Requirement notices

Regulation 15(1)(a) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Safety and suitability of premises.

The provider had not ensured that service users and others having access to premises were protected against the risks associated with unsafe or unsuitable premises by means of:

1. Suitable design and layout.

[Now Regulation 15 including Regulation 15(1)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

The medical day unit was not suitable to protect patients' dignity, privacy and safety.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Consent to care and treatment. [Now Regulation 11 including Regulation 11(1), and 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] The provider did not have suitable arrangements in place for the obtaining, and acting in accordance with, the consent, of patients in relation to the care and treatment provided to them. In one surgical ward it was documented that a patient had early signs of dementia and confusion, no assessment was evidence of their capacity to make certain decisions.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records.

1. The provider had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of:

1. an accurate record in respect of each

service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

[Now Regulation 17 including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

Documentation relating to patients' mental capacity was not obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records. Explanations for the reason for the decision to withhold resuscitation were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation were not discussed were not documented.

1. the provider must ensure that the records referred to in paragraph one are:

1. kept securely and can be located promptly when required.

[Now Regulation 17 including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

People who use services were not protected against the risks associated with unauthorised access to confidential patients' records. Patients' records were not securely kept.

Lists of patients' names and safeguarding concerns were not kept confidential in an area of the maternity service.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Regulation 22 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing.

[Now Regulation 18 including Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

The provider had not taken appropriate steps to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed for the purposes of carrying on the regulated activity.

There were not always sufficient numbers of suitably qualified, skilled and experienced staff in the emergency department.

Safe levels of staffing and a safe skill mix had not been defined in relation to caring for patients in the emergency department corridor.