Gloucestershire Hospitals NHS Foundation Trust

Cheltenham General Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Cheltenham General Hospital

Inspected but not rated

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services from Gloucestershire Royal Hospital and Cheltenham General Hospital. The trust employs more than 8,000 staff.

We carried out an unannounced focused inspection of Cheltenham General Hospital urgent and emergency care services (also known as accident and emergency - A&E) and medical care services (including older people's care) between 8 and 9 December 2021. We had an additional focus on the urgent and emergency care pathway across Gloucestershire and carried out a number of inspections of services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

As this was a focused inspection at Cheltenham General Hospital, we only inspected parts of five our key questions. For both core services we inspected parts of: safe, responsive, caring and well led. We included parts of effective in medical care. We did not inspect effective in emergency and urgent care at this visit but would have reported any areas of concern.

The emergency department was previously rated as good overall. Medical care was previously rated as good overall with responsive as requires improvement.

For this inspection we considered information and data on performance for the emergency department and medical care. This inspection was partly undertaken due to the concerns this raised over how the organisation was responding to patient need and risk in the department and the wider trust in times of high demand and pressure on capacity. We were concerned with waiting times for patients and delays in their onward care and treatment.

We looked at the experience for patients using urgent and emergency care and medical care services in Cheltenham General Hospital. This included the emergency department but also areas where patients were cared for while waiting for treatment or admission. We also went to wards where patients were admitted for further care. This included the emergency department, medical wards and areas where patients in that pathway were cared for while waiting for treatment or admission. We visited services and departments that patients may encounter or use during their stay. We also went to wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, was managed by the wider hospital.

A summary of CQC findings on urgent and emergency care services in Gloucestershire

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. On this occasion we did not inspect any GPs as part of this approach. However, we recognise the pressures faced by general practice during the COVID-19 pandemic and the impact on urgent and emergency care. We have summarised our findings for Gloucestershire below:

Our findings

Provision of urgent and emergency care in Gloucestershire was supported by health and social care services, stakeholders, commissioners and the local authority. Leaders we spoke with across a range of services told us of their commitment and determination to improve access and care for patients and to reduce pressure on staff. However, Gloucestershire had a significant number of patients unable to leave hospital which meant the hospitals were full and new patients had long delays waiting to be admitted.

The 111 service was generally performing well but performance had been impacted by high call volumes causing longer delays in giving clinical advice than were seen before the pandemic. Health and social care leaders had recently invested in a 24 hour a day, seven day a week Clinical Assessment Service (CAS). This was supported by GPs, advanced nurse practitioners, pharmacists and paramedics to ensure patients were appropriately signposted to the services across Gloucestershire.

At times, patients experienced long delays in a response from 999 services as well as delays in handover from the ambulance crew at hospital due to a lack of beds available and further, prolonged waits in emergency departments. Patients were also remaining in hospital for longer than they required acute medical care due to delays in their discharge home or to community care. These delays exposed people to the risk of harm especially at times of high demand. The reasons for these delays were complex and involved many different sectors and providers of health and social care.

Health and social care services had responded to the challenges across urgent and emergency care by implementing a range of same day emergency care services. While some were alleviating the pressure on the emergency department, the system had become complicated. Staff and patients were not always able to articulate and understand urgent and emergency care pathways.

The local directory of services used by staff in urgent and emergency care to direct patients to appropriate treatment and support was found to have inaccuracies and out of date information. This resulted in some patients being inappropriately referred to services or additional triage processes being implemented which delayed access to services. For example, the local directory of services had not been updated to ensure children were signposted to an emergency department with a paediatric service and an additional triage process had been implemented for patients accessing the minor illness and injury units to avoid inappropriate referrals. Staff from services across Gloucestershire were working to review how the directory of services was updated and continuing to strengthen how this would be used in the future.

We found urgent and emergency care pathways could be simplified to ensure the public and staff could better understand the services available and ensure people access the appropriate care. Health and social care leaders also welcomed this as an opportunity for improvement. We also identified opportunities to improve patient flow through community services in Gloucestershire. These were well run and could be developed further to increase the community provision of urgent care and prevent inappropriate attendance in the emergency departments.

There was also capacity reported in care homes across Gloucestershire which could also be used to support patients to leave hospital in a timely way. The local authority should be closely involved with all decision-making due to its extensive experience in admission avoidance and community-based pathways.

Summary of Gloucestershire Hospitals NHS Foundation Trust - Cheltenham General Hospital

We found:

- Staff understood how to protect patients from abuse and acted on any concerns.

Our findings

- The services mostly controlled infection risk well. Areas we visited were visibly clean and most staff wore personal protective equipment in line with trust policy.
- Patients had an assessment of their infection risk and other clinical risks on arrival at the emergency department and were treated according to their priority of need. Those who needed urgent care received it.
- Managers had reviewed staffing needs and increased the total number of nurses and medical staff recruited. Bank and agency staff were used to fill gaps in the rotas but some shifts could not be filled. Managers were continuing recruitment processes for new roles.
- The services mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Locums were used to fill gaps in medical rotas and managers ensured senior staff were available on each shift.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Key services were mostly available seven days a week to support timely patient care.
- Staff were empathetic and caring when treating patients in the emergency department and demonstrated an understanding of how patients may be feeling when receiving treatment. Patients felt informed of their treatment choices and praised staff for care they received.
- The services were inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.
- Managers risk assessed, adapted and rearranged services at times of extreme capacity pressures to help staff provide safe care and treatment for patients. Staff worked hard to provide care and treatment for patients who stayed in the emergency department longer than anticipated due to capacity pressures on the hospital.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid compromising the quality of care.
- Managers demonstrated the skills and abilities to run the services. They understood and managed the priorities and issues the services faced. Level of capacity pressure for the service was communicated to executive leaders and across the trust. They were supportive and caring for patients and staff.

However:

- There were risks of patients waiting a long time for treatment at the time the emergency department changed to a minor injuries and illness unit. This was particularly when patients were cared for overnight in the department because there were no available inpatient beds in the hospital. In addition to this, the lack of administration support at night sometimes took staff away from providing patients with clinical or nursing care.
- The design, maintenance and use of facilities, premises and equipment in medical care services did not always keep people safe. The use of temporary bed spaces for patients was recognised as not ideal, but in the circumstances was being as safely managed as possible.
- There was no ready clinical oversight of children who were waiting to be seen in the emergency department. Children waited in a designated area which was separate to the adult waiting area. However, they usually attended with a responsible adult and could call for assistance using an alarm bell if they needed to.
- There were not always enough nursing staff with the right qualifications and skills to cover the planned rotas for each shift in the services. However, managers regularly reviewed staffing levels and skill mix to maintain patient safety as much as possible.

Our findings

- Capacity pressures meant not all patients received treatment promptly across both services, but they were assessed quickly for risk on arrival and prioritised for treatment. A major part of the problem with access to beds for patients in the emergency department, was from the high number of patients who were medically fit to be discharged from hospital wards. They were waiting for further social care support to enable their safe discharge.
- In medical care, patients were sometimes moved between wards and sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.
- Some staff in the emergency department felt they were not always valued and supported by their managers or other colleagues across the hospital. They felt vulnerable to potential violence and aggression from patients attending the minor injuries and illness unit at night. They were aware of the protocol to request support from portering colleagues. These colleagues were not always available immediately when needed.
- Some staff felt senior and executive visibility and support was limited. Senior teams acknowledged they were not physically present at Cheltenham General Hospital as much as they would have liked and stated the extreme pressures at Gloucestershire Royal Hospital had taken priority. Staff morale in the services was low due to the immense and unrelenting pressures which had been ongoing for a number of years.

How we carried out the inspection

At Cheltenham General Hospital, we spoke with 23 patients and their families, 27 staff, who included nursing, medical, administration staff and service leads. We observed care provided, reviewed relevant policies, documents and patient records.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Medical care (including older people's care)

Inspected but not rated

Cheltenham General Hospital provides medical care (including older people's care) to patients in the Gloucestershire area. Medical care is provided at both hospitals with some specialist services in one location.

Since the start of the COVID-19 pandemic some medical care services at Cheltenham General Hospital have been reconfigured so the trust can accommodate patients who are positive to COVID-19. This was generally planned using single rooms before patients were transferred to designated wards at Gloucestershire Royal Hospital. Also, some services have been moved between the two hospitals.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas we visited were visibly clean and furnishings were well-maintained. Furnishings, such as chairs and flooring were wipeable and easy to clean. We did not find any dust in hard to reach places where we checked. However, a patient told us they had found the toilet on their ward dirty and it was not immediately cleaned by staff after it was reported.

Managers audited cleaning records and staff compliance with infection control practices as part of a wider COVID-19 assurance framework. Staff compliance was reported to infection prevention and control specialists within the trust and actions needed were fed back to staff in the relevant area. Hand hygiene audit results for the three months prior to our inspection showed good staff compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff wearing the correct PPE including surgical face masks in accordance with national guidance. All clinical staff were bare below the elbow to enable effective cleaning of their hands. Patients told us and we saw how staff cleaned their hands regularly. However, in the medical day unit there was limited sink provision. This made it difficult for staff to wash their hands near to where they were providing patient care.

The trust had designated wards for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew how to provide safe care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy. Staff told us patients who had COVID-19 symptoms or who were known to be COVID-19 positive would be cared for in single rooms in Cheltenham General Hospital prior to being transferred to Gloucestershire Royal Hospital.

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms. Most staff we spoke to told us the measures to protect staff and patients from COVID-19 were good.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Medical care (including older people's care)

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff managed clinical waste well. However, the use of temporary bed spaces for patients was recognised as not ideal, but in the circumstances was being as safely managed as possible.

Most patients could reach call bells and staff responded quickly when called. At times when no other beds were available some patients (assessed for risk) were cared for in areas where there were no call bells, piped oxygen or suction. For example, where an additional temporary bed space was created in a bay or on a ward corridor when patients were awaiting a bed space. However, these patients were cared for close to where nursing staff were based and it was possible for staff to observe them. Staff recognised patients who were being cared for in temporary beds required additional monitoring to ensure the lack of some clinical facilities did not compromise their care and treatment. Portable suction and oxygen were available in all areas where there were temporary beds.

When patients were cared for in temporary beds staff assessed patients to make sure they were well enough to be cared for in these areas. The hospital had a policy for using these beds and criteria for staff to follow. Staff told us how they would care for those patients and this followed the principles of the policy in identifying who should be cared for in these areas and assessing their risk. It was nevertheless recognised the environment was not suitable for patients remaining for long periods or for treatment.

As part of the trust's response to the COVID-19 pandemic, the medical day unit had been moved from Gloucestershire Royal Hospital to Cheltenham General Hospital, sharing the area with the ambulatory emergency care unit. We found staff in the unit had to use extension leads to power medical devices delivering medication, owing to a lack of sockets in the area. The area lacked piped oxygen and suction and the call bells were linked to the emergency department making it difficult to distinguish which patients required assistance. Staff prepared intravenous medications for patients in an alcove that was part of a corridor used by staff and patients within the unit. This posed a potential health and safety and infection control risk. However, we saw the area where intravenous medications were prepared was kept clean and tidy, had a suitable work surface, lockable cupboards to store medications and portable oxygen and suction was available. Staff told us there were plans to improve this area.

Due to environmental restrictions caused by the COVID-19 pandemic and the medical day unit and the ambulatory emergency care unit sharing the same environment, both units had limited space for a waiting area. This prevented social distancing for patients and also sometimes patients having to wait on the corridor outside the unit where they were then not routinely observed by staff. However, these patients were assessed as being of lower risk.

Staff carried out daily safety checks of specialist equipment. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure with tamper seals. We found all checks we reviewed were completed daily with the name of the staff member, date and their signature.

The service had enough suitable equipment to help staff safely care for patients and staff we spoke with did not report any shortages of equipment. We saw equipment used to safely lift patients had dates of the last and next service displayed and these were in date.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Medical care (including older people's care)

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, when handing over care to other providers sometimes documentation was delayed or not available.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. This included tools to record vital observations for patients and early warning scores were used to identify patients at risk of deterioration. The use of an electronic system meant senior nursing staff and medical staff had an oversight of the clinical risk of unwell patients. The acute care response team (a team who reviewed unwell patients when it was urgent) could also access this electronic system.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed five patient records and saw risk assessments were completed on admission and reviewed regularly and when a change occurred. Risk assessments were recorded using the same electronic system used to record vital observations. This meant risks were assessed and recorded in one place and more visible in a timely way for clinical staff.

Staff knew about and dealt with any specific risk issues for patients. Staff showed us additional assessments that would be made for patients if a risk was identified and told us of the action they would take to manage the risk.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). This was provided through another NHS trust and was accessible through referral.

Staff shared key information to keep patients safe when handing over their care to others, although staff said there were delays in sending some discharge paperwork. During our inspections of adult social care services at the same time, providers told us they had concerns about delayed paperwork or missing information. This was difficult for providers to follow-up on with wards particularly at weekends and out of hours.

Shift changes and handovers included all necessary key information to keep patients safe. Handover documentation was clear and contained the latest updates on patient condition, plan of care and any outstanding actions to be completed.

Nurse staffing

It was recognised by senior management that shortages of staff trained in nursing care meant the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.

Due to national shortages of nursing and support staff and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe. There were continuous advertisements for nursing and healthcare assistant vacancies. Managers of the service told us they had increased nurse staffing establishment to allow for absences and vacancies so they could provide continual safe care as much as possible. In some areas where it was difficult to recruit and retain staff, recruitment and retention payments were offered to try and increase staff numbers. However, staff in the areas we visited told us they were often short of nursing staff.

Medical care (including older people's care)

We reviewed nurse staffing rosters for two wards and found the number of nurses and healthcare assistants did not always match the planned numbers. For example, in the four weeks prior to our inspection on at least 23 out of 28 days registered nurse staffing levels for Woodmancote ward were below the planned numbers by at least one day or night shift. However, our inspection took place during a peak of the COVID-19 pandemic and nationally there was an increase in absence across the care sector particularly due to short term sickness.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff told us this was done when they had patients with additional care needs. However, staff also told us that often, additional staff would not be provided as no staff were available to fill gaps in shifts.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. A senior nurse was allocated to manage staffing and respond to requests for support from wards. Additional staffing requirements were discussed with the wider management team throughout the day at site meetings. The team discussed whether these shifts should be escalated to non-framework agencies (an agency beyond nationally agreed funding limits).

The medical care wards often had to use bank and agency staff to fill shifts. Some of these were staff who were familiar with the wards, but not always. Staff who were unfamiliar with the ward required induction and familiarisation with systems and processes, which were provided, but put additional strain on the regular staff.

Medical staffing

The service mostly had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff told us the service mostly had enough medical staff to keep patients safe. We saw rosters that showed the medical staff matched the planned number. There had been an increase in establishment for the number of doctors, many of whom had been recruited and there was a reducing vacancy rate for medical staff. Turnover was low as was sickness and absence. However, staff sometimes found it challenging at night when the emergency department became a minor injuries unit. As part of this transition medical staff from the service were expected to support with any remaining admissions from the day and any new admissions through the night. This was in addition to their responsibilities for the wider medical care service in the hospital, including any medical patients being cared for in temporary beds.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was always a consultant on call for junior doctors to contact during evenings and weekends. Where there were gaps in rosters the service requested locum medical staff and they were provided when needed.

Is the service effective?

Inspected but not rated

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Each ward had a daily multidisciplinary discussion about the patients in their area, called a board round. This included patients'

diagnosis, treatment plans, concerns and any discharge planning. In areas where patients with complex needs were cared for (such as stroke rehabilitation) there were more formal multidisciplinary meetings on a weekly basis to ensure patients were receiving the best care and their discharge pathway remained correct. A consultant told us the hospital had good multidisciplinary teamwork and the different professions in the hospital had respect for one another. This had been noticed by a patient to who told us they had seen good teamwork across the hospital.

Staff worked with external clinical professionals and agencies when required to care for patients. We saw evidence of multidisciplinary working throughout our inspection and this was supported by documentation in patients' notes. For example, notes contained entries from doctors, specialist nurses, therapists and dietitians. However, staff told us they felt access to social services had become more difficult during the COVID-19 pandemic as staff had been required to move offsite for safety.

Staff referred patients for mental health assessments when they showed signs of mental ill health. The service had a contract with a local NHS mental health service to provide access to specialist teams to support patients.

Patients had their care pathway reviewed by a consultant to ensure their care and treatment was effective. In the records that we reviewed we found patients had a prompt consultant review on admission and throughout their stay on daily ward rounds.

Seven-day services

Key services were mostly available seven days a week to support timely patient care.

Consultants led daily ward rounds on acute wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We reviewed the notes of five patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission.

Staff could call for support from doctors and other clinical professionals, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Most medical staff we spoke to told us there was good access to diagnostic services and a patient we spoke to was impressed at how short a time they had to wait for an urgent test they needed.

Staff told us there was access to therapies (such as physiotherapy and occupational therapy) seven days a week. However, this was not the case in all areas and there was a reduced service at the weekend that focused on patients (usually in respiratory distress) who needed help the most.

Access to pharmacy operated on reduced hours at the weekend. However, it was available seven days a week and there was an on-call service outside of usual working hours.

Managers told us that access to social services (including discharge teams) was available Monday to Friday. The service could not access social services to discharge patients at the weekend as this was limited to admission avoidance for the emergency department.

Medical care (including older people's care)

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. However, due to pressures on bed capacity, there were times when patients were cared for in areas not designed for that purpose.

Facilities and premises were mostly appropriate for the services being delivered. However, during and surrounding the time of our inspection, the hospital was almost full at times with patients, and sometimes over full capacity with temporary beds opened. To meet this demand there were times when care was delivered in areas not set up for that purpose.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We did not see any mixed sex breaches at Cheltenham General Hospital during our inspection.

The service had systems to help staff care for patients in need of additional support or specialist intervention. The service had a variety of specialists including specialist nurses who were available to offer advice and support to staff and patients. For example, the service had access to a tissue viability team to help with patients developing or at risk from developing a pressure ulcer.

The medical care service relieved pressure on other departments when they could treat patients in a day. We visited the ambulatory emergency care unit, a unit which sees ambulatory patients, some of who were transferred from the emergency department. Patients referred to this unit had been assessed as needing short-term care which should be possible to provide in the same day. Staff in the unit would see patients the same day and told us they were able to ask them to return for follow-up appointments if needed. Patients could also be referred to the trust's rapid access 'hot clinics' for consultant review and not have to stay overnight. Rapid access respiratory and cardiology clinics occurred two or three times each week.

The service mostly had suitable facilities to meet the needs of patients' families. In most areas we visited there were rooms available for patients' families. During the COVID-19 pandemic the trust had implemented different levels of visiting restrictions which meant visitors were not always allowed. However, owing to high demand these areas were sometimes used to accommodate patients to provide care.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, due to pressure on bed capacity, the use of temporary beds meant the privacy and dignity of patients at times was not meeting their needs.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff we spoke to were understanding of the needs of patients with dementia. During our inspection we met trainers visiting wards to specifically raise awareness on patient deconditioning, as part of the national 'end PJ (pyjama) paralysis' campaign (this encourages patients to get up, get dressed and get moving as they might at home). Staff were receiving refresher training on the key principles of how to stop deconditioning.

Medical care (including older people's care)

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Carers were able to download the 'This is me' document from the trust website to fill in and bring in for staff to learn about more important information about caring for the patient.

Wards we visited were set up to meet the specific needs of patients. The service had a specific ward dedicated to stroke rehabilitation, Woodmancote ward. This ward was staffed by a multidisciplinary team to support a variety of patient needs and had equipment designed for the use of patients recovering from a stroke. There were also specific wards designated for the care of older people.

During times of increased demand when boarding of patients was taking place, privacy and dignity had the potential to be compromised. However, staff were aware of this and told us how they would use screens to maintain patient privacy and dignity although accepting this was not ideal. On Woodmancote ward we saw screens were available if patients were being cared for in temporary beds.

Staff understood and applied the trust's policy on meeting the information and communication needs of patients with a disability or sensory loss. The service was able to provide access to British Sign Language interpreters if needed. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to arrange access to foreign language interpreters to support patients and relatives during their stay.

Staff told us patients were given a choice of food and drink to meet their cultural and religious preferences. If patients had any special dietary requirements staff were able to contact the catering team to have these needs met.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Patients were being moved, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.

The hospital had ongoing capacity problems with available beds due to the high number of patients who were medically fit to go home, but there was no care package immediately available for discharge to be carried out safely. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively.

However, a number of the delays we reviewed were categorised in records as being for 'unknown' reasons. For example, on 9 December 2021 the trust had 241 delayed patient discharges. Of these, 47 were waiting for local authority funding, 52 were awaiting assessment arrangements when they went home, and 41 were in the 'unknown' reason for delay category. We discussed this with managers, and they recognised this was unhelpful but were taking actions to improve their understanding of the delays.

Wards we visited had high numbers of patients who had delayed discharges and no longer needed to be in an acute hospital bed. On Woodmancote ward, a stroke rehabilitation ward, 16 out of 32 patients were medically fit for discharge. Consequently, the stroke team were finding it increasingly difficult to admit patients onto the ward from the emergency department and acute stroke wards. On Woodmancote ward staff told us most of their patients were delayed in being discharged as there were issues with capacity for community stroke rehabilitation beds.

Medical care (including older people's care)

Other patients awaiting discharge were waiting for a package of care, a discharge to assess bed in the community or continuing healthcare assessments to progress their discharge. There were many patients waiting for community hospital beds for rehabilitation after an acute illness and these patients had complex needs with most wanting to return to their own home.

Due to complexities in assessing patients who needed onward care, and the lack of packages available to be purchased or arranged by social services, there were long delays in getting patients home. The staffing shortages in adult social care providers had a detrimental effect on the whole system of access and flow for medical care.

Managers recognised the impact that delayed discharges were having on flow in the service and were aware of the poor flow through the wider Gloucestershire care system. They had discussed improvement plans with social care colleagues and felt there was a high level of system working towards resolving these issues.

Staff supported patients when they were referred or transferred between services. Staff made prompt referrals to other services where these were needed. Where care was required beyond the hospital, staff arranged referral and the service had access to an onward care team who acted as discharge coordinators.

To manage access and flow to acute medical services, community partners including primary care and the ambulance service used an electronic system to contact the acute medical team. This 24 hour a day, seven day a week service was staffed by a consultant during the day and a junior doctor at night. Decisions were made on whether patients would be admitted, and if so, where they should attend. Medical staff were able to give clinical advice to manage patients at home if this was indicated in their assessment. Medical staff then used the system to record referral information and form initial plans meaning that when the patient arrived at hospital nursing staff and junior doctors could commence care promptly.

Managers worked to minimise the number of medical patients being cared for on non-medical wards (known as outliers). They were discussed at all site meetings. While managers attempted to reduce the number of outlying patients this was made more challenging by the bed capacity pressures on the service. Managers had arrangements for medical staff to review any medical patients on non-medical wards and there was a medical team responsible for the care of outlying patients.

Managers monitored waiting times and aimed to make sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this.

The medical care leaders were aware of the current status of the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. During these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two.

The hospital policy was to keep patient moves between wards to a minimum. The use of an electronic system allowed managers efficient oversight of this. However, owing to ongoing issues with bed capacity in the service, patients were sometimes moved between wards. For example, a patient had attended the ambulatory emergency care unit and was admitted to a temporary bed in the emergency department overnight. During the night they were then moved to a ward.

Medical care (including older people's care)

As it was recognised as adding at least stress and anxiety for patients, staff tried not to move patients between wards at night. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night.

There was some inefficiency in transport arrangements when patients were moved to the other hospital in Gloucester. As part of a hospital trust with two acute hospitals, sometimes patients needed to be moved between hospital sites. Beds would be reserved for patients for this purpose. However, we were told transport would often be delayed. This meant beds could be unoccupied for some time while waiting for transfers or the move would be cancelled, and the bed given to another patient.

Due to bed capacity problems, staff told us sometimes the length of stay in short stay wards and assessment areas was beyond what was clinically expected for some patients. This was as a result of capacity issues elsewhere in the hospital and patients being found a bed in areas which were not those planned for their care and treatment. In the acute care unit staff told us they aimed to keep stays on the ward to less than 48 hours. We saw one patient who had been on the unit for two weeks. However, the average length of stay in the acute care unit in the four weeks prior to our inspection was 29 hours.

Managers and staff started discharge planning for patients as early as possible. Most staff said discharge planning started from when the patient arrived. Staff planned discharge carefully, particularly for those with complex mental health and social care needs. The hospital had specific teams to support with discharge planning and finding onward care.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff discussed patient discharge plans daily and there was active challenge on whether their chosen pathway remained correct.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, they were sometimes not always visible and approachable in the service for patients and staff. Staff morale in the service was low due to the immense and unrelenting pressures which had been ongoing for a number of years.

The medical care service had a clear senior management leadership structure. This was divided into planned and unscheduled care with further departmental divisions beyond this. The service had a joint leadership team between the trust's two sites, Cheltenham General Hospital and Gloucestershire Royal Hospital.

Leaders had the skills and abilities to run the service and we saw evidence that they were actively engaged and committed to safe patient care and supporting their staff. However, this was challenging given the pressure the service was facing. Leaders were aware of issues with delayed discharges impacting flow and were working hard to maintain patient safety.

Medical care (including older people's care)

Some staff told us that they had the perception some leaders were not always visible and approachable. Leaders told us this was an area for improvement and felt this had been made worse by the COVID-19 pandemic and the additional pressures this had created. However, a member of staff said they found the chief executive of the trust accessible and when they had emailed them, they had received a quick response. Staff told us they received regular email communication from leaders, and they found this was helpful.

The service had a coherent leadership strategy that was shared by service leaders. They had processes to review and improve the leadership strategy. Leaders wanted to support staff to have the best working environment they could and were keen to support development. Staff told us staff wellbeing support was good. However, with all the immense and unrelenting pressure on the whole service, nursing staff told us morale was low.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid compromising the quality of care.

The service had systems for recording, reviewing and managing risks. The risk register for the service was comprehensive and had been reviewed regularly. Many of the risks on the register recognised the impact that poor flow had on increased risk to patient care and there was evidence of trying to manage those risks.

Leaders in the service attended quality and performance meetings and contributed to them to improve the service. We saw evidence leaders were actively challenged from board members on how they were working to manage risks and improve services. Leaders responses gave us further assurance they understood the risks of the service.

Staff told us they were well informed by leaders on the risks the service and wider trust was facing including daily updates and key areas of focus. Medical staff told us they felt involved in the process of managing risks.

Managers from the service took part in daily site meetings which had a focus on improving flow through the hospital where possible. These meetings were attended by colleagues from across both hospital sites meaning risk could be considered as an overall trust and shared.

Outstanding practice

We found the following outstanding practice:

- The use of an electronic system to record referrals received from community partners including GP services. This 24 hour a day, seven day a week service was staffed by a consultant during the day and a junior doctor at night. Decisions were made on whether patients would be admitted and where they should attend. There were initial plans made, meaning when the patient arrived at the hospital nursing staff and junior doctors could commence care promptly.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Medical care (including older people's care)

Action the trust MUST take to improve:

Cheltenham General Hospital Medical Care

- The trust must ensure that the medical day unit premises are safe to use for their intended purpose and used in a safe way. (Regulation 12(d)).

Action the trust SHOULD take to improve:

Cheltenham General Hospital Medical Care

- Continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Gloucestershire.
- Continue to regularly review the nursing staffing levels in order to increase these to meet establishment levels.
- Look at the patients who are in the discharge category with unknown reasons for the delay in order to help staff expedite the process.
- Review the timeliness and effectiveness of discharge documentation including prompt completion to support safe discharge of patients. Offer the health and care community a way to contact key staff when paperwork or discharge arrangements are lacking or missing.
- Review the transport arrangement for patients transfers where this was leading to inefficiency in bed management.

Urgent and emergency services

Inspected but not rated

Cheltenham General Hospital provides emergency department services for adults and children. Extremely unwell children are directed to attend the Gloucestershire Royal Hospital emergency department where there is a specialist service for children. The department was reconfigured as a minor injuries and illness unit during the COVID-19 pandemic and has now reverted to an emergency department in daytime hours since June 2021. The emergency department at Cheltenham General Hospital is open between the hours of 8am and 8pm. After 8pm the emergency department provides care as a minor injuries and illness unit in line with pre-pandemic services.

Total A&E attendances at Cheltenham General Hospital between June and November 2021 were 23,551. Of these 4,037 (17%) were children. This was below the England average for the same time period.

There is a paediatric area where children and their families can wait and is separate to the adult waiting area.

There is a designated area for patients who are tested as positive for COVID-19.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff understood the different forms of abuse and what action to take to promote patient safety. They explained how they would report safeguarding concerns and they could access the hospital's safeguarding team with questions or to seek additional advice when necessary. Staff said the trust-wide safeguarding practitioners were supportive and approachable with any concerns staff raised.

Staff were confident in the action they would take to ensure patients' safety.

There were systems which flagged up if there were any safeguarding concerns about children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas we visited were visibly clean and had suitable furnishings which were well-maintained. Furnishings, such as chairs and flooring, were wipeable and easy to clean. We did not find any dust in hard to reach places.

Managers audited staff compliance with infection control practices as part of a wider COVID-19 assurance framework. Staff compliance was reported to infection prevention and control specialists within the trust and actions needed were fed back to staff in the department. Managers monitored and reviewed all areas of the department each month and documented areas that needed more cleaning or repairs. This information was fed back to cleaning or maintenance staff for action. Hand hygiene audit results for September, October and November 2021 showed good staff compliance.

Urgent and emergency services

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff being bare below elbows for more effective hand-washing and wearing surgical masks at all times. Staff wore disposable gloves and disposable aprons when they were required as they were assisting patients with personal care.

Most staff were up to date with training in infection prevention and control with records showing 84% compliance in the department across both sites.

Staff screened patients for signs and symptoms of COVID-19 when the attended the emergency department. Patients brought in by ambulance were screened in the ambulance on route using a lateral flow device. If patients tested positive, the ambulance crew took patients straight to Gloucestershire Royal Hospital. Once patients were admitted into the majors area of the emergency department, patients were screened again using a fast PCR test giving a result in 30 minutes. This meant patients could be managed within different COVID-19 safety procedures as soon as possible. If patients tested positive, they were placed in isolation cubicles.

Staff told us they were testing themselves for COVID-19 but the hospital did not keep staff testing records for assurance that testing was carried out. All staff had been offered COVID-19 vaccinations and boosters in line with national guidance.

Staff cleaned equipment after patient contact and we saw equipment which was less often used labelled to show when it was last cleaned.

Environment and equipment

In times of normal demand and capacity in the emergency department, the design and maintenance of facilities, premises and equipment kept people safe. However, the use of premises during times of excessive capacity pressure did not always keep patients safe.

Patients could reach call bells most of the time and staff responded quickly when called. However, some patients were cared for in areas where there were no call bells. For example, when capacity pressure was high some patients were asked to sit in an area referred to as a 'sub waiting area'. These patients were assessed as being fit to sit in a chair while they awaited results or for ongoing observation. The area was close to the main hub/nurses' station and could be overseen by staff walking around in the department but patients did not have access to call bells in the event they felt unwell. However, staff were aware of this and these patients were observed by staff who were close by.

The use of the designed premises and environment did not always follow national guidance. The department was accommodated in an older part of the hospital but the service had enlarged and moved into adjacent areas that were not designed to be ED facilities. The 'majors 2' area was small and it was difficult for patients to observe social distancing although areas were separated by curtains.

The provision of waiting and treatment areas for children was not ideal in terms of safety. There was a designated children's waiting area which was separate to adults waiting areas. However, it was not in the line of sight of staff and made clinical oversight of children difficult. Staff recognised this and mitigated where possible by observing the area at intervals during the shift. However, this was not always possible in busy periods. In addition, children usually attended with a responsible adult who could summon support using an alarm button if they were concerned. Managers were arranging a review of the area to increase safety.

Urgent and emergency services

In the emergency department, staff had enough suitable equipment to help them safely care for patients. Staff carried out daily safety checks of specialist equipment most of the time. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was in the emergency department.

The service had suitable facilities to meet the needs of patients' families. Managers had reduced the risk of potential transmission of COVID-19 by reducing the numbers of people wating with patients in the department. Family and friends could wait in the relatives' room. Staff assessed whether patients needed their relative with them based on individual needs.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal and specific sharps disposal bucket for sharp instruments such as needles used for injections.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. This included tools to record vital observations and to assess for possible sepsis (severe reaction to an infection) for adults and children of different ages in accordance with national guidance. Early warning scores were used to monitor patients' vital observations. This information was logged and shared through the electronic dashboard to allow the emergency physician in charge (consultant) and nurse in charge oversight of the clinical risk of patients in the department.

Staff completed risk assessments for each patient on arrival using a recognised tool, and reviewed this regularly, including after any incident. Staff used an electronic version of the emergency department safety checklist in accordance with national guidance. This checklist prompted staff to complete and record observations and risk assessments hour by hour. These risk assessments included vital and neurological observations, signs of sepsis (severe infection) and pain as well as immediate investigations to ensure these were timely. For example, patients presenting with signs of a stroke should receive a CT scan within one hour. We reviewed the records of one patient where this had been completed within the recommended national guidance and arrangements for transfer to Gloucester Royal Hospital was arranged promptly.

The checklist was continued for patients who had been in the department for longer periods due to delays in beds being available or waiting for decisions. Records we reviewed confirmed patients had received care, prescribed medicines, food and drinks. Patients were offered a hospital-style bed rather than a trolley if they were in the department for more than four hours to reduce risk of pressure damage. Staff supported patient nutrition by providing food and fluids.

The audit of patient records showed safety metrics linked to assessing and responding to risk were not being recorded in a timely way. Staff used an electronic version of the emergency department safety checklist in accordance with national guidance. This checklist prompted staff to complete and record, for example, vital observations, early warning scores, antibiotic compliance and pain management every hour. The electronic record system was introduced in July 2021 with the paper-based version phased out by the end of November 2021.

Audit results were of concern as they reported for November 2021 an overall completion of patient safety measures as just 49%. Audit results were of concern as they reported for November 2021 an overall completion of patient safety measures as just 40%. However, this was due to failure of the new system to accurately process data.

Urgent and emergency services

Audit reports showed a high level of compliance with safety metrics prior to the introduction of the new electronic system. There was no evidence to show patients were not receiving safe care and individual records we looked at showed patients were given care as required. Within the new system, apart from the pain score in the first hour, none of the key metrics met the level for compliance with safety. However, the audit records showed that prior to the introduction of the electronic system, all metrics met the safety threshold. The audit information for the emergency department across both sites, was being improved using electronic systems. Instead of paper based audits of a small number of records, every patient record was audited which provided more accurate results.

Staff received training in how to recognise signs and symptoms of sepsis. During the COVID-19 pandemic to alleviate pressures on NHS services and allow staff to prioritise clinical need, NHS trusts had received guidance that, as a temporary measure, audit data collections would not be mandatory. Managers reviewed which audits were essential to provide assurance on treatment provided, which included continuation of the audit around sepsis care and treatment.

The sepsis audit gave cause for concern. Audit information showed seven records had been audited for Cheltenham Hospital emergency department, in November 2021. Of these, the time the antibiotics was given was not recorded in four records. Antibiotics were given within one hour for one patient and within two hours in two records. This evidence showed either the records were inaccurate or the care was not in accordance with evidence-based practice.

Staff knew about and dealt with most specific risk issues. Care and treatment were provided in accordance with national clinical guidelines. However, the way actions were recorded did not always give an accurate overview of whether patient safety actions had been taken. For example, we reviewed care and treatment provided to patients presenting with specific symptoms such as chest pain. Patients had received the care they needed, but it had been recorded on paper records and not on the electronic system, which would have given managers effective oversight. The process for staff to use electronic records was still being embedded as it had recently changed from paper records.

Staff had access to guidance, policies and procedures about treatment pathways for patients presenting with different health conditions.

The service had 24-hour access to mental health liaison and specialist mental health support. Mental health support was available 24 hours a day for patients aged over 16 years and between 9am to 5pm for children aged 11 to 16 years although advice from these teams was available at all times.

The emergency departments at both Gloucestershire Royal Hospital and Cheltenham General Hospital had seen an increase in people attending with mental health needs during the COVID-19 pandemic. This team was based in Gloucestershire Royal Hospital and travelled to Cheltenham General Hospital to see any patients referred to them. It generally took longer for referred patients at Cheltenham General emergency department, to be seen by the mental health support team.

Shift changes and handovers included all necessary key information to keep patients safe. Nursing and medical staff attended handovers when they first commenced their shift. We observed a consultant handover which was clear and included relevant information and discussion about patient treatment. There were also planned safety briefings for all staff. However, we did not observe one as the safety briefing planned for the afternoon on Wednesday 8 December 2021, did not take place.

Urgent and emergency services

Nurse staffing

It was recognised by senior management that shortages of staff trained in emergency care meant the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift.

Nursing staff were employed to work across both sites. Employed nursing staff numbers in the emergency departments at both sites had increased since our previous inspection of the emergency department at Gloucestershire Royal Hospital in March 2021 with new staff being employed. Managers had increased the number of nursing staff it required on shifts (establishment) since our last inspection. The increase in establishment had created nursing vacancies, some of which had been recruited to and others still within the recruitment process. The highest number of vacancies across Cheltenham General and Gloucestershire Royal Hospitals, were in the band 5 nursing roles (24%). Before the nursing establishment review, the band 5 nursing vacancy rate had been 51%. However, the service was not able to always have enough nursing and support staff to meet the newly assessed staffing numbers needed.

The trust reviewed and monitored nursing staffing and moved staff to ensure safe staffing levels across both sites as far as possible. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift to meet demand and to keep patients safe.

During our inspection there were not as many nurses on duty as planned. Data supplied by the trust for November 2021 showed across both emergency departments there were 19% of shifts not filled according to the calculated requirement. Much of this was related to the increase in establishment numbers for nursing staff. There was a high reliance on bank and agency nursing staff to fill gaps in rotas. Managers requested staff who were familiar with the service where they could and provided staff with an induction if they were new to the service. Staff worked together and extended their role in order to maintain safety. For example, the nurse in charge/coordinator carried out patient triage if there were not enough registered nurses on duty.

On Wednesday 8 December 2021, there was meant to be seven registered nurses but there were only five of which two were agency nurses. There was meant to be four healthcare assistants (HCAs) but there were only three healthcare assistants on duty. Staff worked well together to ensure care and treatment was provided. However, there were not enough registered nurses to be assigned to a three-bedded area known as the annex. Instead this area was staffed by an assistant practitioner and/or a healthcare assistant and overseen by a registered nurse. Patients with high acuity (poorly patients) were not assigned to this area.

Staff raised concerns about safe staffing of the minor injuries and illness unit (MIIU) overnight from 10pm to 8am. The minor injuries and illness unit was a nurse-led service with an emergency nurse practitioner (ENP) as the clinical decision maker, two registered nurses, a healthcare assistant and an additional registered nurse who worked a twilight shift. Rotas showed there were two emergency nurse practitioners covering most of the night shifts. We saw rotas which demonstrated staffing levels were increased when patients needed to be cared for overnight in the department due to there being no available inpatient beds. There were no reception staff in the department overnight to answer calls or provide administration support for patients attending the department. This meant clinical staff needed to spend time on these tasks which took them away from providing patient care.

One registered children's nurse was employed in the emergency department to cover both hospital sites and managers had raised the lack of dedicated paediatric support, as a risk for Cheltenham General Hospital emergency department and the trust were actively trying to recruit children's trained nurses. The emergency department did not provide a specialist children's service and indicated this at the entrance to the department although children could attend by

walking into the department. Nursing staff had received additional skills training in caring for children who attend the emergency department or the minor injuries and illness unit. Very poorly children were directed to Gloucestershire Royal Hospital emergency. Information was available for the public regarding services offered at Cheltenham General Hospital for children.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Medical staff were employed to work across both emergency departments. The service had reducing vacancy rates for medical staff. Gaps in medical rotas had been a concern at our last inspection in March 2021. Since this time, newly recruited staff had included three consultants and five junior doctors to work across both departments. There was a plan to recruit four physician associates (who, while not a doctor, work to the medical model and perform a similar role as junior doctors) and two further advanced care practitioners. Emergency department managers had developed a five-year plan to meet staffing levels as recommended by the Royal College of Emergency Medicine.

Managers observed working time directives for junior doctors although this at times made it difficult to fill weekend rotas. However, senior staff were confident there had not been any incidents where patients had come to harm because there had not been enough doctors on duty. Incidents records reviewed confirmed this. Medical rotas showed that any gaps were filled using locums. Many of the locums used were familiar with the department. Managers made sure locums had a full induction to the service before they started work.

Clinical oversight was provided until 10pm. This was two hours after the emergency department closed at 8pm and was designed to support the transition to operating as a minor injuries and illness unit. However, this time was not always adequate to see all waiting patients and medical staff said they stayed beyond their shift if required. After 10pm the emergency nurse practitioner would have to call medical staff from elsewhere in the hospital or the emergency department in Gloucestershire Royal Hospital for advice if required.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Children who needed urgent care were directed to Gloucestershire Royal Hospital where there was a 24 hour paediatric urgent and emergency care service.

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. This was challenging at times when there were increased pressures on the service.

Urgent and emergency services

We saw staff interactions were respectful and kind between each other and with patients and families. Staff did their best to provide privacy for patients by using curtains and lowering their voices so as not to be overheard. A separate room was available for families who received distressing news or needed a greater level of privacy.

Several patients told us how they wouldn't want to be cared for anywhere else. Patients said staff treated them with kindness and recognised staff were working under challenging circumstances. We saw staff interact with patients in a friendly and caring way. Patients told us how they valued the care provided and how welcoming staff were.

Staff understood and respected the individual needs of each patient. They showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs and referred to the mental health liaison team when needed. We observed staff treating patients with kindness and compassion when discussing treatment options. Treatment choices were discussed calmly and with consideration to the patient's emotional needs.

Reception staff provided compassionate support to patients' relatives while staff provided immediate clinical treatment at the time it was needed. Staff expressed and demonstrated how they kept patients at the centre of care they provided.

Staff considered patient comfort and offered hot and cold food, fluids and pain relief when they needed it. Staff showed understanding of how patients might be feeling and explained treatment in different ways to help with clarity for patients. Every patient we spoke with knew the next stage of their treatment plan and were happy with the level of care they had received.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw staff providing care in a way which met patients religious needs such as providing specific foods and ensuring privacy.

Is the service responsive?

Inspected but not rated

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on capacity caused by shortages of available beds for transferring patients. Staff risk assessed patients who attended the emergency department and treated those with urgent needs promptly. However, reviews for patients in the emergency department from doctors in other specialities were not happening in accordance with agreed timescales.

Managers monitored waiting times and adapted services to support patients' access to emergency services. They monitored treatment within agreed timeframes and national targets but due to capacity pressures were not always able to achieve them. The emergency department collected data and monitored how many people were in the department, how long they had been in the department and how many ambulances were queueing to handover patients. This data was reviewed continuously by the emergency physician in charge and the nurse in charge/coordinator.

Urgent and emergency services

There were regular meetings held each day, with representation from across the trust. Escalation triggers regarding bed availability and demands on services, were discussed and assessed in accordance with the risk. This information was shared with senior managers and we saw representation from Cheltenham General Hospital emergency department. The information was provided to staff following these meetings and prompted further action to free up bed capacity across inpatient areas.

The trust had struggled now for many years to achieve the NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours. Patients who attended the smaller emergency department at Cheltenham General Hospital, were usually seen more quickly than those who attended Gloucestershire Royal Hospital emergency department.

Patients received initial reviews within national timeframe standards. Systems had been adapted to increase the number of patients who were assessed within 15 minutes of arriving by ambulance. At the time of our visit we saw most patients had received assessment within this time which was an improvement when compared with performance measures in previous months.

Children brought in by ambulance as an emergency case or sent by NHS 111 should have been taken or directed to Gloucestershire Royal Hospital according to a directory of services managed by the clinical commissioning group. However, we were advised this was in need of updating and due to be amended in January 2022. This would then provide accurate information about service provision for all urgent and emergency care services including ambulances and NHS 111. Children who attended the minor injuries and illness unit were treated and discharged or directed to other services.

Service managers and trust executives monitored capacity and demand pressures. They managed existing bed capacity and acted to create areas where patients could receive care and treatment. For example, discussions between managers and the trust's executive team identified how many additional beds were needed for patients for the day or night. When demand was in excess of bed spaces, patients remained in the emergency department overnight and were moved to inpatient beds in the morning.

Managers and staff worked to make sure patients did not stay longer than they needed to. However, it was not always possible to discharge patients from the department in a timely manner due to exceptional demand on beds. Managers monitored how many and how often patients were cared for overnight in the department. During the four weeks prior to our inspection this had occurred on nine occasions. Numbers of patients varied but had reached 12 on one occasion. The department was not commissioned for overnight care. This was at a time when there were a high number of patients elsewhere in the hospital who did not need further medical care but there was no community provision arranged or available to support their discharge.

Some of the reasons for patients spending longer than they needed to be due to waiting for clinical review from specialty doctors. Staff spoke of difficulties in onward referral to other speciality doctors and in particular patients who needed a surgical review. Patients who needed a surgical review were transferred to Gloucestershire Royal Hospital emergency department. The hospital had an arrangement with an independent ambulance service for these transfers. Patients who were referred to mental health liaison teams waited for staff to travel from Gloucestershire Royal Hospital in response to requests.

Urgent and emergency services

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, they were not always visible and approachable in the department for patients and staff.

The leadership of the emergency department comprised of two clinical leads (managers), a general manager and a matron who covered both sites. Each of the leaders had a defined role within the department. There was a plan to recruit to a nurse consultant role in line with the Royal College of Emergency Medicine (RCEM) and modern advanced practice workforce requirements.

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us they had the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment. They clearly articulated the challenges within the department, as well as celebrating the successes they had achieved.

Staff told us they rarely saw clinical and executive leaders in the department. The matron who had recently joined the trust was onsite one day a week but staff said they rarely saw any other leaders. This was acknowledged by the emergency department leaders and managers. They told us they did not have the capacity to oversee two sites, especially when the department at Gloucestershire Royal Hospital remained so challenged.

Prior to this inspection a letter had been written to the executive team by staff within the emergency departments in Gloucester and Cheltenham. This raised concerns regarding “unsustainable” working conditions, and risks to patient safety. The leaders within the department recognised there were challenges to meet the expectations of all staff especially those based at Cheltenham, were they lacked the capacity to be available enough for staff. They told us there was a reliance on using emails to update staff and provide feedback, and staff did not always have the time to read emails. They had introduced a weekly meeting which could be attended remotely but recognised this did not compensate for being on site. They told us they were looking at ways to communicate more effectively with staff.

We observed effective leadership in the department on the day we inspected. The emergency physician in charge and the nurse in charge provided good leadership and retained oversight of demand and capacity in the department.

Culture

Staff felt respected, but not all felt supported and valued all of the time. They were focused on the needs of patients receiving care. Staff felt concerns they raised were not always listened and responded to. Patients and their families could raise concerns without fear.

Staff within the department demonstrated strong and respectful working relationships between each other. However, some staff felt unsupported by their senior managers. Some staff felt discouraged from reporting concerns to managers and leaders of the department. Staff felt not all managers understood the unpredictable nature of the emergency department, particularly at the time of transition to a minor injuries and illness unit when there were also patients being cared for overnight.

Some staff felt senior and executives listened but did not 'hear' what staff said meaning little notice was taken of what they said. Executive leaders did not visit the department very often and acknowledged the priorities tended to lie in the Gloucestershire Royal Hospital due to the capacity pressure on services. Staff felt managers used 'one way communication' such as blogging and vlogging to relay messages. Senior leaders described how updates such as 'all staff webinars' were well attended by staff in the medical division and prompted staff to raise concerns with them. However, attendance by Cheltenham staff was limited due to work pressures.

Staff were encouraged to report incidents. All staff we spoke with told us they would report high risk incidents. However, some staff told us that due to pressures in the department they may not report all low risk incidents, or they might report them from home after their shift had finished. The majority of reported incidents related to admissions and patient transfers. When we asked staff whether they received feedback on these incidents, we received a mixed response. Some staff told us they did not receive feedback, but this may be because they did not always have time to read emails. However, we did see feedback from serious incidents was included in safety briefs.

Staff were encouraged by managers to take breaks but were often not able to do so due to pressures of work.

Staff had not all received up to date appraisals from their managers. The appraisal system had been temporarily suspended to allow staff to focus on clinical need during the COVID-19 pandemic.

There was a protocol for staff to call on porters overnight for support if they felt at risk of violence or aggression from patients or families attending the department. However, staff expressed this support was not always readily available due to smaller numbers of porters and demands on their time across other hospital departments. Senior managers recognised this concern and were part of a violence and aggression committee to monitor incidents and identify improvement actions.

Patients and their families could raise concerns and these were monitored by department managers and discussed at oversight meetings.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

There was a departmental risk register and risks were reviewed and reported through an assurance report to the emergency care board. The risk of delayed assessment and treatment for patients in an emergency department at both sites, which was full to capacity as a result of poor patient flow and delays to patient discharge was identified on the risk register. For Cheltenham emergency department the risk of delays at transition to a minor injuries and illness unit was also included and mitigating actions were being reviewed monthly.

Managers told us they felt urgent and emergency care (including the ambulance service) were holding a significant amount of risk for the health and social care system across the county. This was felt by frontline staff too. Managers told us they did not get feedback from the urgent and emergency board and were not represented at these meetings.

Senior staff were aware of risks in the department and listed paediatric staffing, violence and aggression from patients and ambulance waiting times as being the biggest risks.

Managers had initiated a system to reduce patient risk when the emergency department transitioned to a minor injuries and illness unit. However, staff felt this did not manage the whole of the risk at this time.

Urgent and emergency services

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust SHOULD take to improve:

Cheltenham General Hospital Emergency Department

- Continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Gloucestershire.
- Look at ways for staff to have oversight of children waiting to be seen in the department.
- Resolve the issues with the system producing audit results which show patient records are not being updated as they should or some elements of patient care, such as sepsis management, are not being provided in a timely way.
- Required staff should attend safety briefings.
- Continue with plans to improve staffing levels for nurses and medical staff to full establishment.
- Provide administrative support for clinical staff out of hours when admitting patients using administration systems to allow staff to continue with their clinical tasks.
- Consider the capacity of the leaders and managers to provide support for Cheltenham General Hospital emergency department team.
- Consider how to better support emergency department staff overnight so they feel safe and not at risk from violence and aggression.
- Address the perception in the emergency department of limited senior and executive visibility, recognition, understanding and support.
- Department managers should discuss how to communicate more effectively with staff and look for options to support wellbeing.
- Review the representation of the emergency department leadership at the urgent and emergency board to allow their views to be included.

Our inspection team

The team that inspected the service comprised of five CQC inspectors, and a specialist advisor. The team was overseen by Catherine Campbell, Head of Hospital inspections.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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