Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Royal Hospital

Inspection report

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Ratings

Overall rating for this location	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Gloucestershire Royal Hospital

Requires Improvement 

Gloucestershire Hospitals NHS Foundation Trust received authorisation on 1 July 2004. It was formed from Gloucestershire Hospitals NHS Trust, which was established following a reconfiguration of health services in Gloucestershire in 2002. The Trust provides acute hospital services from two large district general hospitals, Cheltenham General Hospital (CGH) and Gloucestershire Royal Hospital (GRH). Maternity Services are also provided at Stroud Maternity Hospital. Outpatient clinics and some surgical services are provided by Trust staff from community hospitals throughout Gloucestershire. The Trust also provided services at the satellite oncology centre in Hereford County Hospital.

We carried out this short announced focused inspection because at our last inspection in April 2022, we rated the trust overall as requires improvement and two warning notices were issued for Surgery and Maternity. We only visited the maternity unit at Gloucestershire Royal Hospital at this inspection.

At our last inspection, carried out on the 6 and 7 April for maternity and the 12 and 13 April for Surgery, 2022 (on site) and the subsequent provision of evidence, the Commission found that:

Surgery

1. Areas within Gloucester Royal Hospital were being used outside of their intended purpose with a lack of mitigation, timely risk escalation and insufficient governance processes.

2. There was a lack of assessment of risks to the health and safety of service users receiving the care and treatment.

3. There was not an effective governance systems or processes and that Standard Operating Procedures for theatre care and treatment were out of date or overdue a review

See the surgery section for what we found during this inspection.

Maternity

1. There was a lack of assessment of risks to the health and safety of service users receiving care and treatment.

2. There was not enough staff to support the provision of safe care. There was a lack of assessment of staff competence and skills to ensure the delivery of safe care. There were insufficient numbers of suitably qualified staff to deliver and manage the maternity triage service or the induction of labour process.

3. The governance systems and processes did not work effectively to ensure the oversight of the service and to learn from incidents and improve practice to keep service users safe.

Our findings

Following the inspection, the trust was served a warning notice under Section 29A of the Health and Social Care Act 2008, requiring them to make significant improvements. This was to ensure safeguarding training level 3 was provided for all staff and incidents to be investigated in a timely way so learning can be shared quickly to reduce the risk of it happening again. This is a repeat of part of the warning notice issued following the inspection in April 2022.

See the maternity section for what we found during this inspection.

We did not rate this surgery at this inspection. The previous trust rating of requires improvement remains.

Surgery

Inspected but not rated

- Staff told us that they felt there had been an improvement in staffing since last inspection and we note that vacancies across the directorate had been reduced.
- Staff informed us that they had a positive relationship with their directorate managers who were visible on the units at Gloucester and Cheltenham sites.
- We saw that there had been a significant improvement in the numbers of patients nursed in areas that were outside of their intended purpose.
- We saw that the Surgical Assessment Unit had been extended and that the numbers of patients who required ward-based care being nursed in recovery had been reduced.
- Staff told us that the auditing of NEWS2 and patients notes had improved.
- We found that mixed sex accommodation breeches were being recorded.
- We found that there had been a reduction of never events across both sites with no reported never events from December 2021.
- We saw patient notes across both sites showed evidence of risk assessments being undertaken.
- Staff informed us that they were involved in the governance process.
- Staff told us that there were fortnightly escalation reports circulated for a direct targeted response to incidents. And that staff received support from twice weekly drop-in sessions from the risk lead to discuss incidents and lessons learnt.
- An Acute Care Response Team Manager (ACRT) had been recruited to review workforce needs, attends the deteriorating patients committee and to work on the draft governance framework.
- A new dashboard had been completed for the monitoring of overnight stays in areas other than the wards and delayed discharges.
- The Patient Flow and Escalation policy identified the Mayhill Day Surgery Unit as an escalation area.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

They service did not keep all areas and premises visibly clean, however this was limited to non-clinical areas only.

Surgery

Not all areas were clean due to ongoing building work. We saw there was a significant amount of building work being undertaken across the hospital, including in areas of the surgical directorate. We saw that ceilings in the non-clinical areas were dirty with a significant amount of dust. Staff told us the infection prevention and control team had assessed these areas and concluded they were in fact non-clinical.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff were trained to use equipment and managed clinical waste well.

Noticeboards were in place to inform staff of policy updates, training, reviews of incidents, lessons learnt and general governance information.

The service consistently reported mixed sex breaches. Staff reported that any breaches of mixed sex accommodation were reported through the Datix reporting system.

The Surgical Assessment Unit:

On our last inspection we found that the Surgical Assessment unit did not have sufficient capacity to accommodate the volume of patients.

This unit had been extended since the last inspection with the addition of a trolley bay. There were no patients seen in the foyer area which had been noted on the previous inspection.

Alongside the trolley area, we also saw there was a mixture of chairs and recliners on the unit.

The Mayhill day surgery unit:

On our last inspection we found that the day surgery unit was used for overnight care and had inadequate facilities.

On this inspection we found that the service did not have suitable facilities to meet the needs of patients and their families. This area was being used for patients requiring overnight stay.

This unit had patients from several specialisms (medical, surgery, orthopaedics, vascular) and we were told that patients could spend up to 3 weeks on the unit. The day unit did not allow visitors, and did not have enough facilities (showers, toilets) for the numbers and gender mix of the patients cared for on the unit.

We were told by staff that a toilet was used for patients to change in preparation for theatre. We saw that this toilet was small and did not give sufficient space to change.

We saw the patient toilets and showers were accessed through 2 bays which meant male patients had to cross the female bay to access the toilets and showers.

We saw that the unit had 4 trolley and bed spaces which could be swapped to allow for an all-male or all female space. We were informed that this could mean a patient being moved several times during their stay, depending on demand. A patient informed us that they had been admitted to the hospital on the 10 April 2023 and had been relocated 5 times until they were admitted onto the day unit.

Surgery

The discharge lounge:

The discharge lounge is not managed by the surgical division but is used by patients who have been treated by the surgical team. The lounge accepted patients waiting to go home and closed at 7.30pm. Any patients still on the unit at that time were returned to the wards. We were informed that there was no record kept of when this happened, but we were informed it could be twice during a 7-day period. The discharge lounge consisted of 6 bed spaces and 2 side rooms and a lounge area for a further 10 patients. The discharge lounge was external to the main hospital building, accessed via a covered walkway, requiring patients to go outside in all weather conditions. We saw 2 nurses pushing a bed down a ramp into the unit. This would constitute a manual handling risk in wet and Icy conditions. We were informed by the Trust that the risk has been identified and work is ongoing to address these risks.

Main theatres:

At the time of our re-inspection there was refurbishment and building work being undertaken across site which included theatres. We saw that the area had limited storage which led to large pieces of equipment, consumables and other materials being stored in corridors. We saw that in some areas the floors had been repaired. We were informed that 2 theatres were currently being refurbished.

We found that the access corridor to recovery had been closed due to the building works being undertaken which meant patients had to take an alternative, longer route, to recovery from theatre. We were informed that work was due to be completed in June 2024.

Is the service responsive?

Inspected but not rated

Access and flow

People could not always access the service when they needed it and receive the right care promptly.

The Mayhill day surgery unit:

On our last inspection we were shown a draft standard operating procedure for the admission of patients to theatre recovery areas who require ward-based care. This did not include consideration or mitigation, for mixed sex accommodation of patients staying overnight.

On this inspection we found that the trust had a Standard Operating Procedure (SOP) for admission criteria to the Mayhill Day Surgery Unit. This procedure was due for review in November 2023. It provided current criteria and working practice as well as listing those patients that were not suitable for admission to Mayhill. Included in this SOP were exclusions of children and patients requiring admission prior to the day of surgery. The document noted that these areas were not designed as inpatient areas, however it was used to accommodate patients for short term overnight stays during times of escalation, in line with the Flow and Escalation policy.

Surgery

The trust provided a patient flow and escalation policy with review date of December 2024. It provided levels of escalation, the responsibility of staff and a description of escalation triggers. It also stated the arrangements and checklists for the opening of escalation beds. Escalation areas identified included the Mayhill unit.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards.

Managers worked to minimise the number of surgical patients on non-surgical wards.

Managers monitored that patient moves between wards/services were kept to a minimum.

Recovery:

On our last inspection we found that the holding of patients requiring ward-based care in recovery was a frequent occurrence. On this inspection we found that a new dashboard had been completed for the monitoring of overnight stays and onward delayed discharges. We were shown a copy of the Post Anaesthesia Care Unit (PACU) congestion dashboard up to March 2023. This showed the overall number of patients in recovery deemed medically fit, overnight stays in recovery, overall number of patients in recovery unit, and percentage of patients with total length of stay in recovery in hours.

Overnight stays in recovery had dropped from an overall number of 36 in February 2022 to 3 in March 2023 with 1 overnight in February 2023.

The percentage of patients staying in recovery for over 4 hours had dropped from 15.5% in January 2022 to 10% in March 2023 while the number of patients staying 2 to 3 hours had dropped from 31.5 in February 2022 to 30 in March 2023.

On our last inspection the number of mixed sex breeches were under reported by the trust. On this inspection staff told us that all mixed sex breeches were now been recorded across both sites. We saw a mixed sex audit conducted over February to April 2023 which showed patient numbers had reduced from 223 episodes in September 2022 to 22 episodes in March 2023. This had also been broken down to surgical areas impacted by mixed sexed breaches to give further oversight of where problems persisted.

Is the service well-led?

Inspected but not rated

Leadership

Leaders were visible and approachable in the service for both patients and staff.

Staff told us the Divisional Leads and Senior Management were visible on the units and there were regular team and mentor meetings. Staff we spoke to stated that the executive team was not as visible but social media and virtual teams' meetings were in use and staff commented that they found these useful.

Surgery

The executive team provided details of ward visits and scheduling of future visits. The Chief Executive Officer (CEO) had gone to considerable lengths to address perception of visible leadership. Members of the executive board had spent time working and visiting the surgical services.

We were shown an example of a 'we said, you did' initiative for the Post-Anaesthesia Care Unit (PACU). This gave details of the format for proposals to provide extra training for staff working with more complex cases.

Governance

Leaders operated effective governance processes throughout the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

On our last inspection we found that the trust did not operate effective governance systems or processes.

On this inspection we found that the trust governance processes provided a review of the trust action plan sent to CQC. A standard operating procedure for governance processes had been implemented which included a tracking system to ensure policies were kept under timely review. The number of overnight stays in recovery had been significantly reduced and the NEWS2 audit program had now been established.

There were no never events recorded in theatres.

The Electronic Patient Record (EPR, 24-hour patient documentation) was reported as having risen from 78% compliance by staff, in April 2022 to 84% in January and 86% compliance in March 2023. Work was ongoing to create a seamless EPR system across the patient pathway.

All SOP and policies were in place for theatres. Currently there were 21 SOPs with 3 awaiting review and a further 3 were in draft.

Management of risk, issues and performance

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

On our last inspection we found that there was a lack of assessment of risks to the health and safety of service users receiving the care and treatment.

On this inspection we found that the trust had adopted a cross county clinical governance meeting for anaesthetics, theatres, critical care and pain services. The meeting was chaired by the consultant anaesthetist and clinical governance lead, staff attended from all areas and included consultant anaesthetists, matrons and senior nursing staff. The meeting reviewed the risk register and provided details of incidents and progress reports.

This meeting reviewed operating practices, presented learning from complaints, incidents and risk escalation and safety alerts. A copy of the CQC action plan was also included and reviewed.

Surgery

A review of risks was undertaken with the risk team, which was also reviewed at both the quality board and the divisional board. A fortnightly escalation report was circulated, and wards areas were supported by a twice weekly drop-in session with risk lead managers. The trust had a deteriorating patients committee and there was currently a review of the workforce and needs taking place for the Acute Care Response Team.

Each area had a surgical directorate clinical governance board. This board was in a prominent place for all staff and had headings that included incidents, shared learning, identified risks for the trust and the surgical division. We were shown updates of clinical audits, patient experience, training compliance, training and education improvement opportunities and vacancies. The directorate also produced a SOP newsletter which was distributed to staff, which provided updates on any changes to standard operating procedures. There was also a shared drive where staff had access to agreed policies, incident reviews and information note.

The Trust had a guideline for paediatrics – urgent and emergency treatment, which required any child requiring a general surgical option, to be admitted to GRH children's inpatient unit. The trust also had guidance around anaesthesia and intensive care for paediatrics with a review date of June 2024 This provided guidance for paediatric anaesthesia for children from birth to the age of 16.

Outstanding practice

We found the following outstanding practice:

The trust has sustained zero never events for its surgical division for 256 days. This has been achieved through a multi-disciplinary, multi stranded improvement project and the adoption of a culture of continuous quality improvement within the surgical division.

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 MUST take to improve:

Surgery

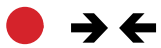
- The trust must ensure that the Mayhill Day Surgery unit at Gloucester Royal Hospital has sufficient amenities and provision for the patients. (Regulation 15(1)(c)

Action the trust SHOULD take to improve:

- The trust should ensure that oxygen cylinders are stored correctly with the correct signage. Regulation 12.

- The trust should consider a cleaning schedule to address the dust and debris from the works being undertaking. And regular infection control assessments of these areas are undertaken.

Maternity

Inadequate 

We carried out this short announced focused inspection of maternity services on Wednesday 26 April 2023 to follow up on a warning notice issued at the last inspection in April 2022. The warning notice was issued because we had concerns about the safety, and quality of some of the service provision.

As this was a focused inspection, we only inspected parts of safe, effective and well led.

Following the inspection, the trust was served a warning notice under Section 29A of the Health and Social Care Act 2008, requiring them to make significant improvements. This was to ensure safeguarding training level 3 was provided for all staff and incidents to be investigated in a timely way so learning can be shared quickly to reduce the risk of it happening again. This is a repeat of part of the warning notice issued following the inspection in April 2022.

We rated maternity services as inadequate. We found.

- Not all staff were trained to level 3 in safeguarding children.
- A tool designed to identify and monitor women at risk of deterioration was not always used for this purpose.
- Safety nets for the safe use of the birthing pools were not always visible in the room and this wasn't followed on up on safety checklists.
- Not all medicines practices were safe and potentially placed women at risk of harm.
- Incidents were not always investigated in a timely way which delayed the outcome and learning being shared.

However:

- Staff had worked hard to make sure the majority of women experienced 1 to 1 care in labour, and they were working on meeting the 100% target.
- The service mostly had enough staff to care for women and keep them safe.
- Staff had training in key skills for maternity and understood how to protect women from abuse.
- Safety checks on emergency equipment was completed daily to make sure it was ready to use.
- Staff made sure the birthing pools were clean and ready to use.
- Staff assessed risks to women and acted on them.
- Improvements had been made to the length of time women had to wait for induction of labour, but this still required more work to meet the trust target.
- Waiting time for women in triage to meet the 15 minute standard had improved to reduce any delays in care and treatment. However more work was needed to ensure all women were triaged within the 15-minute standard.
- Managers made sure staff were competent.
- The service engaged with women and the community and staff to plan and manage services. Systems had been developed to monitor service provision.

Maternity

Is the service safe?

Inadequate  

Our rating of safe remained the same. We rated it as inadequate.

Safeguarding

Staff were not up to date with their training and junior medical staff were not trained in line with guidance to make sure children were protected.

Nursing and midwifery staff received training specific for their role on how to recognise and report abuse, however this was not in line with the trust target. At the last inspection we issued a warning notice due to poor levels of compliance with safeguarding training level 3 for children. Following this inspection, we were sent information regarding their training compliance. The figures from April 2023 showed that 73% of midwives had completed level 3 safeguarding children and 57% had completed level 3 safeguarding adults training. Whilst the figure for safeguarding children had improved since our last inspection, they were not in line with the trust target of 85%.

Not all medical staff received training specific for their role on how to recognise and report abuse. At the last inspection we identified that training grade medical staff were not trained to safeguarding children level three. This was not in line with the intercollegiate document which states “it is expected that doctors in training (including foundation level doctors) who have posts in these level 3-affiliated specialties/with significant children/young person contact, will also require level 3 training.” At this inspection the position remains the same. For training grade medical staff compliance rates with safeguarding adults' level 3 was 19.2%. Consultants safeguarding adults' level 3 was 63.6% and for safeguarding children level 3 it was 70.6%. These figures were below the trust target. The trust was also not compliant with NHS England / Improvement Southwest Safeguarding Training Framework 2022 – 2025 they state, “Every NHS organisation and each individual healthcare professional working in the NHS has a responsibility to ensure that the principles and duties of safeguarding children and adults are consistently applied, with the well-being of those children and adults at the heart of what we do”. This Framework aims to provide information on mandatory safeguarding training requirements, including Prevent for all staff (and Mental Capacity Act training where required) within NHSEI Southwest. This guidance states all clinical staff working with children, and or adults with care and support needs must have level 3 safeguarding training in children and adults.

We identified this issue at the inspection in April 2022 and issued a warning notice requiring the trust to provide this training to all medical staff. This had not been addressed at this inspection and we issued the warning notice again.

Cleanliness, infection control and hygiene

Staff kept equipment clean and ready for use.

Staff followed infection control principles when cleaning the birth pools. At our last inspection we found there was no assurance that the birth pools were cleaned in line with the protocol and were safe for women to use. During this inspection staff told us they knew how to clean the birth pools, and this was done in between each woman using the birthing pool. On the birth unit we saw daily checks were completed to make sure the birth pools were clean and ready to be used.

Staff were aware of women who were isolated due to infection. At our last inspection we found information about women who had tested positive for COVID-19 was displayed in the office but no information on the door to their room was visible. At this inspection senior staff told us their infection prevention and control team had removed the need for signage due to changes in national guidance on the management of COVID-19. There was no longer the need for testing of women prior to admission for COVID-19. Staff routinely asked women if they had any symptoms of COVID-19 and information about this was shared with other staff. If a women presented with another infection that required them to be isolated staff told us signage would be placed on the door to the side room informing staff and visitors of any precautions required. This information was also recorded in the daily checklist for safe to respond and shared at the safety briefings.

Assessing and responding to patient risk

Staff mostly identified and quickly acted upon women at risk of deterioration, but tools used to assist them were not always used as part of this process. Safety equipment was standardised and checked to make sure it was safe and ready to use in an emergency.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. However, these were not always completed to demonstrate when a trigger was found, and the required actions were not recorded on the tool.

We reviewed 10 sets of women's records. One woman had not given birth at this location. Of the remaining 9 all had a MEOWS charts in their notes. None of the 9 charts had frequency of observations recorded. We saw other areas on the form where there were inconsistencies when completing the MEOWS. For example, for oxygen saturations and respiratory rate some were ticked whereas others had a number. Staff were recording physical observations differently on the form some used numbers or others used lines. This meant it was difficult to see if there was a change in the observations. We also saw on 2 MEOWS women required escalation in the way of a repeat measurement of physical observations in one hour. But this was not documented on the form as proof of being completed. MEOWS charts being present in women's records was an improvement from our last inspection in April 2022.

The trust had re-started audits of MEOWS from August 2022, and they sent us 7 copies of these post inspection, dated from September 2022 to March 2023. These recorded the compliance rates with the MEOWS charts. The compliance rate for MEOWS charts being present had improved with percentages in the 90’s and 100%. However, this had dipped in February and March 2023 to the high 80% range. In the audits we received from Sep 2022 until March 2023 we saw that amber triggers where a set of repeat observations should have been taken an hour later were not always recorded so therefore, no evidence they had been completed. The trust had identified this as an area for improvement. This was found during our review of 10 sets of women's records during the inspection. The auditing of MEOWS was an improvement since the last inspection.

Safety checks were completed to make sure safety equipment was ready to be used in case of an emergency. At our last inspection we found equipment safety checks were not in line with national guidance or trust policy. At this inspection we found a new system had been introduced where each unit/ward in maternity had to declare they were ‘safe to respond’. Staff had to complete this checklist, and these were kept as evidence. We checked the records on the maternity ward for checks on the safety equipment. We checked the last 3 months of records and found there were 3 gaps in this time. However, a senior member of staff was able to cross check this with the safe to respond forms to evidence the checks had been completed but not recorded. This was an improvement from the last inspection.

Maternity

Safety equipment for emergencies was standardised across the maternity unit to make sure all staff were trained and familiar with the equipment. Staff had not identified the safety net for one of the birthing pools was not easily visible in the room. The evacuation net was for the use in the birth pool if an emergency was to arise. Staff told us it had gone for cleaning. The birth pool was in use the day after the inspection as we attended the multi-disciplinary safety briefing and staff on the unit confirmed it was being used. The checklist on the door to this room did not reference the safety net being present and ready to use. Following the inspection, senior staff from the trust told us the safety net was available in the room and staff were able to locate it after we had left the unit. They had also added the availability of the safety net to the checklist.

Midwifery staffing

The service mostly had enough maternity staff to provide women with timely care and treatment.

The triage service mostly had enough midwifery staff to keep women and babies safe.The trust was monitoring the timescale of 15 minutes for triage daily. We were sent the data of how often they met this target from September 2022 to March 2023. These ranged from 76% in September 2022 to 94% in March 2023. The trust was also monitoring the average time for medical review in triage, we were sent figures from November 2022 to February 2023. The times for medical review ranged from 1 hour 13 minutes in November 2022 to 1 hour 30 minutes in February 2023. This was an improvement from the last inspection.

Some women did not receive timely access to care and treatment. At our last inspection in April 2022, we found there were delays for some women in the starting and continuation of induction of labour. This meant some women were not being induced at the optimum time for the health of their baby and the women putting them at risk of complications. At this inspection senior staff told us that from February 2023 they had started, twice daily huddles and a third could be arranged if needed to discuss women on the induction of labour pathway. The purpose was to prioritise those women who had greater clinical need for induction of labour and for all staff to be aware of any changes in the clinical condition of women. This would also enable staff to be allocated to meet the demand and to put measures in place to mitigate any risks due to delays. We observed part of one of these huddles, there was no consultant present only midwives. A form had been devised for staff to complete. We reviewed 2 forms. The 1 for the huddle we observed was due to be completed but the form from the day before had not been completed. Staff told us this was because it was a low risk day and staff had managed the risk. Following the inspection senior staff told us the form was completed but was stored in one of the consultant's offices. Data sent from the trust about induction of labour showed, in February 2023 there had been 14 delays in starting induction of labour and 81 delays in continuing induction. For March 2023, there was 10 delays in starting induction of labour and 71 in continuing induction. For April 2023 (1-24) there was 6 delays in starting induction and 47 in continuing induction. The figures showed an improvement in reducing the delays for women.

All staff working in clinical areas including the maternity ward were included in a local safety huddle to ensure awareness of risks, pressures and safety concerns were shared. This was an improvement from the last inspection.

Staff on the maternity ward told us staffing level had improved since the last inspection, however when other areas were short staffed midwives were taken from them to cover other areas within the maternity unit. Staff felt this was due to them not having an acuity tool to work out the numbers of staff required to safely care for the women and their babies. Following the inspection senior staff told us they had an acuity tool, but it was not in use as the company they purchased it from were in the process of improving the acuity tool. The trust had introduced band 5 nurses on the maternity ward. Staff felt they were a great asset to the team as they were able to take some roles from midwives which left them to be able to care for the women and babies.

Maternity

Medicines

Some systems for the management of medicines were not safe and potentially placed women at risk.

Not all staff followed safe systems for the management of medicines. On the birth unit staff had decanted two different types of medicines from its original packaging and had stored them in another container in the fridge. This was unsafe practice as the medicines could have been mixed up and the wrong one administered placing women at risk. This was reported to senior staff from the trust for them to action. Following the inspection senior staff from the trust told us this practice has now ceased and was being monitored.

We also found some anti-emetics (anti-sickness medicines) were being stored in the controlled drugs cupboard without this being required. Senior staff from the trust told us this was not in line with their guidance, and they would review this.

Incidents

Learning from incidents was shared with staff across the maternity division, however there was no checking staff had read any updated policies or procedures following incidents.

Learning from incidents was shared with staff across the maternity division. Following this inspection, we were sent copies of newsletters which were emailed to staff and displayed on noticeboards. Staff were encouraged to attend meetings for example, post-partum haemorrhage (PPH) risk group and Maternity Clinical Governance meetings. Minutes of these were also circulated to all staff. A copy of presentations given to junior doctors was also shared. At the change of each shift as part of the team talk staff would be updated on any learning and any immediate safety changes to practice that would be required. Each ward/unit had a communication book where this information could be written for staff who were not on duty.

Each ward/unit had a governance board which had a section about which policy/procedure had been updated following an incident. Staff told us there was no checking they had read the changes to policies/procedures. Senior staff also confirmed there was no system for making sure staff had read and were familiar with the changes to policies/procedures.

Is the service effective?

Inspected but not rated

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. Specialist training was provided for staff and midwives had access to support and guidance.

Improvements had been made for midwives to access to support and advice from the professional midwifery advocate (PMA) service. Since our last inspection in April 2022 this service had been paused. Following this inspection, the trust sent information about how this service was re-started and the monthly papers shared with the board. The lead for this

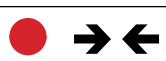
service was appointed in August 2022, and 3 other midwives have been trained in PMA. One of the team has been employed as a PMA to support band 5's during their preceptorship period The trust's aim was to have one PMA midwife to every 20 midwives. Restorative Clinical Supervision (RCS) which has been rephrased by the trust to Restorative Conversations with staff was provided by the PMA team and the monthly papers prepared for the board had evidence of themes that had been identified.

Staff in the maternity unit had access to competency assessments to make sure they had the skills and knowledge to meet the needs of women and babies in their care. Following this inspection, we asked for copies of the competency programme for midwives, maternity support workers (MSW) and maternity care assistants (MCA). The trust told us that 17 of their MSW and MCA were completing the apprenticeship programme, however they did not say out of how many of these staff they had in the maternity unit. As part of this programme, they had to complete a competency framework. This was monitored and checked during their annual appraisal. For MSW their appraisal rate and competency assessment were 100% and for MCA it was 78%. A competency passport was in the process of being developed for MCA. This was an improvement from our inspection in April 2022.

For midwives we were sent details of their revised competency assessment. The trust told us the number of areas for assessment had been reduced as midwives need to be compliant in some areas to become registered with the Nursing and Midwifery Council. The team leader for each midwife had to assess and sign off their competency assessments and these were checked at appraisal. The current appraisal and competency rate was 78%. Below trust target. An action plans had been devised to improve this. As part of continued training the trust told us training workshops/trolley training sessions were frequently run by the practice development team to ensure staff regularly had the opportunity to be trained, rather than this being a competency assessment. This was an improvement from our last inspection.

Staff were provided with specialist training to maintain their skills and knowledge. We were sent details about compliance with maternity cardiotocography (CTG) refresher training. for midwives it was at 82% and obstetricians it was 88% as of April 2023. This was an improvement from the last inspection.

Is the service well-led?

Inadequate 

Our rating of well led remained the same. We rated it as inadequate.

Governance

Governance systems and processes were working to ensure there was oversight of the service. Learning from incidents and improved practice kept women and babies safe within Gloucestershire maternity services. However, not all incidents were being investigated in a timely way which delayed any learning or actions disseminated within trust target.

There were processes and systems for the oversight of the quality of the service. Auditing of the tool used to identify and monitor women at risk of deterioration had been re-introduced. Areas for improvement had been identified along with good practice. Resuscitation equipment and equipment required for the management of postpartum haemorrhage (PPH) was available and checked daily to make sure it was safe and ready to use following the implementation of 'safe

to respond' daily checklist completed by maternity ward and units. This was also being audited for compliance. Staff training and competencies were being monitored by the trust but not all staff were meeting the trust target for compliance with training and competency assessment as part of their appraisal. This was an improvement from the last inspection.

A system to monitor maternity specific mandatory training had been implemented since the last inspection. For the practical obstetric multi-professional training (PROMPT) theory and skills combined for midwives, maternity care assistants and maternity support workers this was at 82%, just below target of 85%. The same training for obstetricians for part 1 was 61% and part 2 was 67%. The compliance rates for 2022 for PROMPT for all maternity staff was above 90%. Training figures sent from the trust showed midwifery specific mandatory training was at 90% above target. E-learning for mandatory training was at 80% just below trust target but the senior staff felt this was impacted by junior doctor rotation.

Improvements had been made to the monitoring of one-to-one labour for women. The one-to-one care data for March 2023, was 98% and the year to date was 97%. Just below the trust target of 100%. This was an improvement from the last inspection.

Feedback was used to improve the service. Following this inspection, the trust sent to us information on how feedback was being used. Feedback from the Maternity Voices Partnership (MVP) was being to use to make improvements. For example, how to improve information for women about the induction of labour process. Videos were due to be produced to inform women about the procedure. Friends and Family Test on average was 86% over the last year. Areas identified with the lowest scores were subject to an improvement plan. This related to the maternity ward. The trust also sent us feedback from 'what you said' and 'what we did'. For example, one of the points was about over the bed cots and the trust responded to say they have purchased more of these to improve the environment for women and babies.

Staff were able to give feedback to the trust. For example, staff could give feedback to the Maternity and Neonatal Safety Champions. Topics included the closure of Stroud and Cheltenham stand-alone birthing units and the delay in introducing a new digital system.

Feedback from 7 women and 1 relative was positive. Comments included "I've read their maternity report and I was worried, but actually they've been brilliant." "The anaesthetist was brilliant, the set up and music made it a wonderful experience." "They are coming in and checking on me regularly and changing my dressing, I couldn't speak highly enough of them here" and "The hospital liaised with my community midwife so there is continuity of care." Two women felt their partners could have been treated better as they felt they could not always visit when the women needed them.

Incidents were not being investigated in a timely way. At the end of March 2023 there were 215 incidents overdue. This was an improvement from the last inspection, but further improvement was required to ensure poor practice was identified, improvements were made and there was timely learning following incidents occurring. The trust action plan following our last inspection in April 2022 stated that overdue incidents were being discussed at weekly meetings of matrons and band 7's for all areas. They reviewed outstanding incidents and actions arising from those. Themes and learning were collated, discussed and shared. However, review of incidents should be timely to ensure poor practice and learning was identified, and improvements made to ensure safety of mothers and their babies. Monitoring of the number of incidents was completed using the maternity scorecard. At this inspection we were told that band 7s would be investigating incidents, but they had not been provided with training on how to do this, only for the use of the reporting system.

Maternity

Whilst the trust had made some progress in reducing the number of incidents waiting to be fully investigated within their time frame the number outstanding is still too high. Incidents must be investigated within the trust timescale to ensure learning was identified quickly and shared with staff to prevent the incident from happening again. This was identified at the inspection in April 2022 and a warning notice was issued. As this had not been fully addressed a warning notice has been re-issued following this inspection.

There were governance boards on the ward and in the units. Staff told us they did not know what the governance boards were for. The ward governance board for March 2023 displayed, 49 open incidents, 45 overdue incidents and 18 risks on the risk register. For the birthing unit for March 2023, they had 22 open incidents and 17 overdue incidents and 18 risks on the register. A member of staff told they were not sure what the figures related to as they felt they had less incidents.

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 MUST take to improve:

The trust must ensure that care and treatment is provided in a safe way. Medicines must be stored in safe way. Regulation 12(2)(g)

Action the trust SHOULD take to improve:

- The trust should continue to audit MEOWS to look how this tool can be used as part of the care and treatment of women.
- The trust should review the storage of some anti-emetic medicines in the CD cupboard on the birth unit.
- The trust should consider informing staff about the purpose of the governance boards.
- The trust should ensure that a system is devised for monitoring compliance with new and amended policies and procedures. Regulation 17

Our inspection team

How we carried out the inspection

The inspection team consisted of 3 inspectors and 2 specialist advisors, 1 with expertise in midwifery and 1 with expertise in surgery.

The inspection was overseen by Catherine Campbell Deputy Director of Operations.

You can find 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.

We reviewed documents and records kept by the service. For surgery we spoke with 25 staff and 2 patients at Gloucester Royal Hospital. In addition, we reviewed 10 sets of patient notes.

During the maternity inspection we spoke with 15 staff including the director of midwifery, consultant obstetric lead, divisional management team, consultants, clinical matrons, specialist midwives, midwives and maternity care assistants. We spoke with 7 women and 1 relative. We reviewed 10 sets of 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.

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
Surgical procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Enforcement actions

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
Maternity and midwifery services	S29A Warning Notice