Care Quality Commission

Gloucestershire Hospitals NHS Foundation Trust

Cheltenham General Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Cheltenham General Hospital is one of two district general hospitals run by Gloucestershire Hospitals NHS Foundation Trust. It is an acute hospital with 379 beds. It provides urgent and emergency services, medical care, surgical care, critical care, maternity and gynaecology, end of life care and outpatient and diagnostic and imaging services. It provides specialist cancer care to patients from Gloucestershire, Worcestershire and Herefordshire as the hub for the three counties' cancer network

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

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

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

Our key findings were as follows:

Safe

- Safety was judged as good in critical care, surgery and maternity, but in all other areas it required improvement.
- The emergency department was frequently overcrowded; this was associated with a lack of patient flow, which in turn led to the risk that patients might not be promptly assessed, diagnosed and treated. Patients were not always cared for in the appropriate part of the department, with particular concerns about the safety of patients being cared for in the corridor when the department was so busy that it could not accommodate patients in clinical areas.
- Staff were aware of how to report incidents and felt encouraged to do so. However, overall the trust was reporting fewer incidents than the national average (6.8 per 100 admissions compared with 9.3 per 100 admissions for the NHS England average in the period from November 2013 to October 2014).
- The majority to staff stated they received feedback after reporting incidents; however, some staff, for example, nurses in the emergency department and outpatient staff, reported that they did not receive feedback. In all areas there were examples of learning from incidents.
- The trust had reported one Never Event in 2014 for interventional radiology, which was related to wrong-site surgery. (Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented.) This incident had been thoroughly investigated and an action plan was in place. This incident took place in one of the specialist theatres, and changes to practice had been made with the introduction of the World Health Organization (WHO) checklist in this area; however, no audit of the use of the checklist had been undertaken.
- A further two Never Events had taken place in January 2015, which were still under investigation at the time of our inspection.
- Overall, the hospital was visibly clean; however, there were some areas such as in the emergency department, where a toilet was not clean, and the waiting room was untidy at the end of the day. In the imaging department, where building work was taking place, dust and dirt were escaping into the corridor, and the room for patients with mental health needs and areas in the medical wards were found to be dusty, dirty and/or to contain litter.

Summary of findings

- The number of cases of Clostridium difficile had been significantly lower than previous years, and at 34 cases up to February 2015 was well below the trust's target maximum of 55 for the year. There had been just one case of methicillin-resistant Staphylococcus aureus (MRSA) in the year to date.
- Throughout the hospital we found medication stored in resuscitation trolleys was not secured to demonstrate it had not been tampered with between checks.
- In some areas, records were not stored securely.
- The majority of staff had attended safeguarding training in order to keep people safe from abuse. The exception to this was staff in urgent and emergency services, where for level 2 child protection training, particularly for junior doctors, completion rates were low at 68% compared with the trust's target of 90%.
- Staff had access to a range of mandatory training, and attendance was monitored; this showed that the majority of staff had attended the required mandatory training, and the trust's target of 90% was exceeded. However, in the unscheduled care division, medical staff were performing less well at accessing such training.
- Systems were in place to assess and respond to patient risk; these included risk assessments relevant to patients' needs and early warning scoring systems to determine whether patients were at risk of deteriorating.
- The trust's target for completion of venous thromboembolism (VTE) risk assessment had not being met since the first quarter of 2013/14.
- Nurse staffing levels had been reviewed and assessed, with oversees recruitment having taken place in order to meet the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidance. Some areas, such as the flexible capacity wards, relied heavily on the use of bank and agency staff.
- Medical staffing was at safe levels in many services. However, there were some exceptions; these included consultants in acute medicine, general and old age medicine and radiology, and junior doctors in medicine and emergency care.
- The trust had a major incident and business continuity plan in place. The majority of staff were aware of their roles and responsibilities should the plan be activated.

Effective

- Services were found to be effective in surgery, maternity and gynaecology, end of life care and critical care. The latter we judged as outstanding. Improvements were required in urgent and emergency services and medicine.
- In most services, people's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance.
- Mortality rates were in line with those of other trusts as measured by the Hospital Standardised Mortality Ratio.
- Information about patient outcomes was routinely collected and monitored, with the trust participating in a number of national audits so it could benchmark its practice and performance against that of other trusts. In a number of these audits, the trust was performing less well than other trusts, for example the College of Emergency Medicine (CEM) audits, the National Sentinel Stroke Audits, The National Heart Failure Audit, and the Royal College of Physicians National Care of the Dying Audit 2104. Overall in surgery and critical care, the trust was performing better than the England average in most of the national audits it took part in.
- Patient pain was assessed and well managed; the exception to this was in the emergency department, where not all patients had a pain score recorded and not all patients consistently received prompt pain relief.
- In the ward areas, we found that patients had access to adequate food and fluids, observing that drinks were left within their reach.
- Staff had access to training to develop their skills, knowledge and experience to deliver effective care and treatment. The trust's target for the percentage of staff who had an annual appraisal was 90%, with the actual figure standing at 85%.
- Multidisciplinary working was evident in all areas we inspected.

Summary of findings

- The hospital was working towards providing services seven days a week. The pharmacy service was open for limited hours on a Saturday and Sunday. Some on-call cover was provided at weekends by allied health care professionals. The palliative care team was available from 9am to 5pm, Monday to Friday, with the specialist palliative care nurses providing an out-of-hours telephone advice service for clinicians.
- Weekend ward rounds did not take place in some areas such as stroke, gastroenterology or the diabetes and endocrinology wards. In cardiology, a ward round took place on both days of the weekend.
- Weekend discharges were problematic, with significantly fewer patients being discharged at this time.

Caring

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

Responsive

- Urgent and emergency care and medicine required improvement; all other services were rated as good.
- Bed occupancy at the hospital was constantly over 91%, which was above both the England average of 88% and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital. The hospital had been operating at near 100% occupancy in the months leading up to the inspection.
- There were issues with the flow of patient into, through and out of the hospital. The emergency department frequently became overcrowded when demand for services exceeded capacity. This was a hospital and community-wide issue. In December 2014 and January 2015, the trust had declared an internal major incident when the situation became unmanageable.
- The standard that requires 95% of patients to be discharged, admitted or transferred with four hours of arrival in A&E was consistently not being met. Trust-wide performance was 82.86%, with Cheltenham General Hospital achieving 80.59%.
- There were numerous examples of initiatives to reduce inappropriate emergency department attendances, to ensure patients were directed to the appropriate services, to prevent admission and to shorten length of stay. Some of these were in their infancy and not yet fully developed to enable an effective and comprehensive service to be provided seven days a week.
- The average length of stay for patients admitted as elective cases fell to its lowest level in February 2015; however, this masked a performance that was better than the national average in surgery and worse than the national average in medicine. For non-elective patients, the average length of stay had risen to 6.7 days, which was above the trust's target of 5.8 days for the third month in a row.
- The number of emergency admissions within 30 days of discharge for both elective and emergency patients was above the trust's target and had been for the last year.
- The 18-week referral to treatment targets were being met in almost all surgical specialities. Urology and ophthalmology were just behind the 90% target at 85% and 87% respectively. The trust was below (that is worse than) the NHS England average 62-day cancer waiting time target. The trust was treating 74.7% of cancer patients within the 62-day target against the NHS England average of 81.2%.

Summary of findings

- The number of elective patients cancelled on the day of admission for a non-medical reason had not met the target in over a year, reaching its peak over the three months from December 2014 to February 2015, which matched the time during which the trust had been facing significant increased demand. This was also reflected in the number of patients who were cancelled and not rebooked within 28 days, which saw a significant rise in January 2015.
- There was an agreement with partners in the local health economy that the daily number of patients who were medically fit discharge would not be more than 35 a day; this had reached 74 in February 2015.
- The two-week wait target for urgent GP referrals for cancer and the 62-day wait from GP referral to treatment were not consistently being met. However, other targets such as the 31 days for surgery and radiotherapy were constantly met, as was the 31-day period from diagnosis to treatment.
- Systems were in place to identify patients who were living with dementia or who had a learning disability and might need additional support.
- Patients knew how to make a complaint if they wanted to, and information was available around the hospital outlining how to make a complaint and how it would be dealt with. There were examples of learning from complaints to improve care.

Well-led

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

We saw several areas of outstanding practice including:

- Patient record keeping in critical care was outstanding. All the patients' records we saw were completed with high levels of detail. The records contained all the essential details to keep patients safe and ensure all staff working with them had the right information to provide safe care and treatment at all times.
- There was an outstanding holistic and multidisciplinary approach to assessing and planning care in the department of critical care. All the staff involved with the patients worked with one another to ensure the care given to the patient followed an agreed treatment plan and team approach. Each aspect of the care and treatment had the patient at its centre.

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- In critical care, there was an outstanding commitment to education and training by both nurses and trainee doctors. Nurses and trainee doctors followed comprehensive induction programmes that were designed by experienced clinical staff over many years. All the staff we met who discussed their training and development spoke very highly of the programmes on offer and there being no barriers to continuous learning.
- There was outstanding care for bereavement in critical care. All staff spoke highly of how they were enabled to care for and support patients and relatives at this time. Bereavement care had been created with input from patients, carers, relatives and friends, and staff were particularly proud of the positive impact it had on bereaved people and patients nearing or reaching the end of their life.
- The outstanding arrangements for governance and performance management in critical care drove continuous improvement and reflected best practice. There was a serious commitment to leadership, governance and driving improvements through audits, reviews, and staff honesty and openness. All staff had a role to play in this area and understood and respected the importance of their work.
- The trust had a mobile chemotherapy unit, which enabled patients to receive chemotherapy treatment closer to their home to prevent frequent travel to hospital.
- On the surgical division, we found the following outstanding practice: the trust had developed and printed its own style of controlled drugs register for patients' own controlled drugs. Patents with 'patients own controlled drugs' were listed on a whiteboard on the controlled drugs cupboard door to help ensure patients took all their medicines home with them.
- Medicines dispensed for an individual patient but not labelled for discharge had an additional yellow label attached stating, "NON-STOCK DO NOT SEND HOME WITH PATIENT".

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Improve its performance in relation to the time patients spend in the emergency department to ensure that patients are assessed and treated within appropriate timescales.
- Continue to take steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced consultants and middle grade doctors to provide senior medical presence in the emergency department 24 hours a day, seven days a week, and to reduce reliance on locum medical staff.
- Continue to reduce ambulance handover delays and take steps to ensure that patients arriving at the emergency department by ambulance do not have to queue in the corridor because there is no capacity to accommodate them in clinical areas.
- Develop clear protocols with regard to the care of patients queuing in the corridor. This should include risk assessment and the identification of safe levels of staffing and competence of staff deployed to undertake this care.
- Work with healthcare partners to ensure that patients with mental health needs who attend the emergency department out of hours receive prompt and effective support from appropriately trained mental health practitioners.
- Ensure that systems to safeguard children from abuse are strengthened and children's safeguarding assessments are consistently carried out. There must be a process to ensure all appropriate child safeguarding referrals are made.
- Ensure that senior medical staff in the emergency department are trained in level 3 safeguarding.
- Ensure that patients in the emergency department have an assessment of their pain and prompt pain relief administered when necessary.

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- Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.
- Ensure the administration of eye drops complies with the relevant legislation.
- Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.
- Ensure that patients' records across the hospital are stored securely to prevent unauthorised access.
- Ensure an effective system is in place in the medical wards to detect and control the spread of healthcare-associated infection.
- Ensure patients' mental capacity is clearly documented in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) and 'unwell/potentially deteriorating patient plan' (UP) forms. Improvements in record keeping must include documented explanations of the reasoning behind decisions to withhold resuscitation, and documented discussions with patients and their next of kin or reasons why decisions to withhold resuscitation were not discussed.
- Review communication methods within maternity services to ensure sensitive and confidential information is appropriately stored and handled, whilst being available to all appropriate staff providing care for the patient concerned.
- Ensure that in the surgical division, when medicines are issued from wards or departments, the issued medicines comply with the relevant legislation and best practice.
- Ensure that appropriate written consent is obtained prior to procedures being carried out in the outpatient department.
- Ensure that all patients (men and women) are able to access the full range of tests in the urology outpatient department.
- Ensure that systems are in place to ensure that medication available in departments is in date and therefore safe to use.

In addition the trust should:

- Review how staff perceive the feedback they get from incident reporting and the level of detail received.
- Ensure that patients, including children, are adequately monitored in the emergency department waiting room to ensure that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Take steps to improve the experience for patients and visitors in the emergency department waiting room. This should include the provision of drinking water, a TV, and appropriate reading material and information about waiting times.
- Review the emergency department nursing staff mix and training to ensure adequate numbers of staff are trained to identify, care for and treat seriously ill children.
- Continue to improve hospital-wide ownership of the emergency department four-hour target, to ensure that delays in admission are minimised.
- Identify suitable accommodation for the ambulatory emergency care unit and ensure that it is adequately staffed to provide a more comprehensive and effective service.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.

Summary of findings

- Consider displaying feedback from patients and relatives for each individual medical ward.
- Consider a system to identify when patient equipment has been cleaned.
- Ensure all areas are clean and free from litter.
- Record all controlled drugs in critical care in line with the trust's policy.
- capture and report safety thermometer data in the department of critical care alongside the other data on patient harm data that the department collects.
- Ensure all items are within their expiry date.
- Maintain continuity of care for patients on the day surgical unit to ensure they have their needs met when it is open 24 hours a day, seven days a week.
- Review the medical and surgical cover at weekends for the day surgery unit to make sure patients are reviewed and discharges not held up.
- Ensure patients who are admitted to the surgical day surgery unit can have their needs met by the staff team.
- Reduce the number of times patients are moved between wards for continuity of care.
- Review the security and safe storage of medicines, including medical gases.
- Review the security of and records of equipment and medicines, including medical gases required for resuscitation and the treatment of anaphylaxis.
- Review the security and safe storage of medicines, including medical gases in the mobile theatre.
- Review the staffing levels of physiotherapists against the requirements of the Faculty of Intensive Care Medicine Core Standards.
- Ensure the specialist palliative care team can be sustained and are able to remain responsive to the evidenced increased demands of complex referrals, provide a face-to-face seven-day service, provide ongoing staff training in line with national policy, and make improvements to inconsistent governance, risk management and quality measures.
- Ensure a strategy for end of life care is developed.
- Ensure all patients who are referred by their GP with suspected cancer are seen with two weeks of referral and treatment is started within 62 days of referral.
- Ensure that in maternity services, both service risk registers detail actions underway to mitigate risks.
- Ensure that cleaning schedules in maternity services are reviewed and systems devised to ensure staff know when equipment has been cleaned and is ready for use.
- Review the processes in maternity services to ensure early screening (pre 10 weeks' gestation) can occur where the need for such screening is indicated.
- Within maternity services, review the timeliness of access to patient information in alternative languages.
- Ensure all patients' referral-to-treatment times do not exceed national targets, and that services are delivered in a way that focuses on patients' holistic needs and does not mean patients experience long delays in receiving their first outpatient appointment.
- Ensure all outpatient departments provide sufficient facilities for disabled people, such as accessible toilet facilities.

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- Ensure staff promote the confidentiality of patients by ensuring conversations about patients cannot be overheard by other patients.
- Ensure that the temperature of fridges used for the storage of medication and equipment can be checked daily.
- Ensure that patients' privacy and dignity are fully respected when patients are waiting for tests in public areas such as waiting rooms.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

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

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unsafe when the department was overcrowded and overwhelmed. There was a lack of a clear protocol around the management of the department when it was at full capacity.
We had some concerns around the care and treatment of children. There was not a dedicated children's nursing workforce, although most staff had been trained in paediatric life support. Arrangements to ensure children were safeguarded from abuse were not robust.
Patients' needs were not always appropriately or promptly met. Ambulance handover delays, although reducing, still occurred too often. Patients queuing in the corridor were uncomfortable and lacked privacy and dignity. Other patients were moved around the department in order to free up cubicles, which impacted on their patient experience.
The department had not performed well in national audits to ensure best practice and good clinical outcomes. Pain relief, in particular, was an area of concern, and we could see no clear plan of action to address this poor performance. Indeed, our findings were similar to those of previous audits in this area. There was some evidence of local audit but no evidence of adequate dissemination of findings throughout the department.
There was a strong, cohesive and supportive management team and a committed workforce. Staff felt well supported and had good access to ongoing education. Multidisciplinary team working was good and there were excellent working relationships with external partners, including the local clinical commissioning group (CCG), community trust and ambulance service.

Medical care **Requires improvement**

Patients were treated with compassion and respect. All patients we spoke with told us they were happy with the care provided.
We found that medical care services required improvement in some areas of patient safety, effectiveness and responsiveness, and in being well-led. Systems to record and report safety concerns were not reliable to keep patients safe. The trust's overall score for the Sentinel Stroke National Audit Programme (SSNAP) had steadily declined; data for April to June 2014 showed a score

of E on a scale of A to E, with A being the best. Cheltenham General Hospital performed worse in the heart failure audit 2012/13 compared with other trusts.
The trust consistently had a high bed occupancy rate. Systems to track patients, particularly out of hours, were not robust or embedded.
Records were not consistently stored to maintain patient confidentiality.
Challenges in recruiting and retaining clinical staff led to a lack of sufficient permanent staff.
Access to seven-day services was variable throughout the hospital. Most services were working towards providing a seven-day service, and this had been identified on the medical division's risk register. Staff reported a lack of staffing resources to achieve seven-day services.
The directors of the medical vision were passionate about providing a high quality service. The service was clinically led; however they felt they lacked sufficient autonomy to enable them to drive improvements and instigate change.

Surgery

Good

We have judged surgery services in Cheltenham as good in relation to safety, effectiveness, caring and leadership. Improvements are required to make surgery services responsive to patient needs.
Staff were encouraged to report any incidents on the trust's computer system. Learning from incidents that had been investigated at ward level was shared at ward meetings and included in the minutes so staff could refer to it at a later date.
Learning following Never Events was seen with the introduction of the surgical safety checklist for interventional radiology.
The trust was working on its compliance with the World Health Organization (WHO) surgical safety checklist following the results of its audits. Use of the checklist was also being monitored for compliance to improve patient safety. A safety briefing and recording document had been introduced in theatres.
Due to the increased demands on their services and beds, the day surgery unit was at times open out of hours and at weekends. This was staffed by bank and agency at these times, which meant continuity of care might have been affected and patients'

needs might not always have been met. Patients from other specialties were placed on the Kemerton Suite, and staff felt they didn't always have the skills and knowledge to meet their needs.
The trust had devised its own method of recording patients' controlled medication. Not all packs of medicines for patients to take home complied with the labelling requirements for a medicine supplied against a prescription, or the trust's own documentation.
Storage of patients' notes was not consistently secure and meant visitors to the hospital could have had access to these confidential records.
The trust participated in national and local audits, including the national bowel cancer audit, in which the trust was above (better than) the England average. The trust had identified where it required an external review of one of its services for fractured neck of femur. The average length of stay was slightly longer at Cheltenham General Hospital compared with the England average.
There was good multidisciplinary working within the units and wards to make sure there was coordination of patient care. Patients we spoke with felt the care they received was very good and staff respected their privacy and dignity.
Information was provided for patients about their operations, and patients were able to ask questions and were kept up to date on their progress. Relatives were able to be part of this process with the consent of the patient, and other arrangements were in place for patients who were not able to consent.
The trust had not met it target for the year for the number of patients cancelled on the day of their operation for non-medical reasons and had only met the national targets for rebooking patients within the 28-day timescale in one month.
The 18-week referral to treatment targets were being met in almost all surgical specialities. Urology and ophthalmology were just behind the 90% target at 85% and 87% respectively. The trust was below (that is worse than) the NHS England average 62-day cancer waiting time target. The trust was treating 74.7% of cancer patients within the 62-day target against the NHS England average of 81.2%.

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Staff told us they were aware of the trust's visions and values. Staff on the wards and units told us they felt supported and listened to by their management team, divisional management and executive board.
Governance systems were in place for monitoring the services. These fed into the divisional management team, and any serious risks were shared with the executive board.

Critical care

Outstanding ☆

The effectiveness, caring and leadership of the service were outstanding, and safety and responsiveness were good. Treatment, care and rehabilitation by all staff were delivered in accordance with best practice and recognised national guidelines. There was a holistic and multidisciplinary approach to assessing and planning care and treatment for patients. Patients were at the centre of the service and the overarching priority for staff. Innovation, high performance and the highest quality care were encouraged and acknowledged. All staff were engaged in monitoring and improving outcomes for patients. They achieved consistently good results for patients who were critically ill and with complex problems and multiple needs.
Patients were truly respected and valued as individuals. Feedback from people who had used the service, including patients and their families, had been exceptionally positive. Staff went above and beyond their usual duties to ensure patients experienced compassionate care and care promoted dignity. People's cultural, religious, social and personal needs were respected. Innovative caring for patients, such as the development of patient diaries, was encouraged and valued.
The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. All the senior staff were committed to their patients, their staff and their unit with an inspiring shared purpose. There was strong evidence and data to base decisions upon and drive the service forwards from a clear, approved and accountable programme of audits. There was a high level of staff satisfaction, with staff saying they were proud of the unit as a place in which to work. They spoke highly of the culture and

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consistently high levels of constructive engagement. Innovation and improvement was celebrated and encouraged, with a proactive approach to achieving best practice and sustainable models of care.

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

Some improvement was needed to ensure that one stock of a specific controlled drug was clear and that consumables were within their expiry date. The patient harm data was low, but the internal and external recording and display of some information could be improved.

The critical care service responded well to patients' needs. There were bed pressures in the rest of Cheltenham General Hospital that sometimes meant patients were delayed on discharge from the unit, but incidences were below (that is better than) the NHS national average for similar units. Some patients were discharged onto wards at night, when this was recognised as less than optimal for patient wellbeing, but this rate was also below (better than) the NHS national average rate. There was a very low rate of elective surgical operations being cancelled because a critical care bed was not available.

The facilities in critical care were excellent for patients, visitors and staff, and met all the modern critical care building standards.

Patients were treated as individuals and there were strong link nurse roles for all aspects of patient need, including learning disabilities, dementia and

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

Maternity and gynaecology

Good

There was a good culture of incident reporting, openness and learning, with good governance processes to support this. Women were provided with one-to-one care in labour, and patient risks were well managed. Care was delivered in line with national guidance in a caring and compassionate manner with high levels of patient satisfaction. The provision of gynaecological oncology services in Cheltenham General Hospital ensured timely access to ongoing oncology support and treatment. The maternity service meant women were able to have normal midwife-led care closer to their homes. The services were well-led by a long-established cohesive team.

However, there was no process to identify whether equipment had been cleaned and was ready for use, and medicines were not securely stored or held within tamper-evident containers.

End of life care

Requires improvement

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

Improvements were needed to identify patients who were potentially in their last year of life in order to better plan care. Discharge procedures needed to be evaluated to identify whether patients

achieved their preferred place of care. There was no end of life strategy, and governance processes were inconsistent. The priorities for the service were not fully understood or articulated at trust board level. However, the specialist palliative care team was highly valued and respected by colleagues, and team members worked collaboratively and effectively with other palliative services in the community and with the local clinical commissioning group (CCG).

Outpatients and diagnostic imaging

Requires improvement

There was an increased risk that patients would experience avoidable harm during the provision of care and treatment. Systems were not consistently followed to protect patients from the risk of medication that had potentially been stored at an incorrect temperature. Emergency equipment was not readily available in every department. Patients and staff were not protected from the risks associated with ongoing building work in areas accessible by the public.

Systems were in place to record and report safety concerns and incidents, and staff demonstrated a good understanding of the systems. Staff were compliant with the trust's infection control policies and procedures.

People were at risk of not receiving effective care or treatment. Consent was not always obtained or recorded in line with relevant guidance and legislation. Equipment was not available to provide a full range of services to women within the urology clinic. Medication was not consistently administered in line with current legislation in the ophthalmology outpatient department.

The service was delivered by trained and competent staff who had been provided with induction, mandatory and additional training specific to their roles.

Patients received a caring service, as staff treated them with compassion, kindness and respect. Positive feedback had been received by the trust from patients using the outpatients and diagnostic and imaging departments. We observed two incidents where the privacy and dignity of patients was compromised.

Outpatient services were not organised in a manner that responded promptly to ensure patients' needs

Summary of findings

were met. Some patients experienced long delays in receiving their first outpatient appointment. The booking team was taking action to address waiting times and monitored patients who did not attend for appointments.
Staff were responsive to patients' specific care needs and supported patients to be seen promptly on arrival at clinic if their medical conditions required this.
The leadership, governance and culture prompted the delivery of person-centred care. Staff were supported by their local and divisional managers. Risks were identified and addressed at local level or escalated to divisional or board level if necessary. The trust promoted a good working culture, although some staff did not feel supported by their managers.

Cheltenham General Hospital

Detailed findings

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

Detailed findings

Contents

Background to Cheltenham General Hospital

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

The trust has three main locations that are registered with the Care Quality Commission (CQC), which are Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital. There are 1,072 beds across these three hospitals. The trust has six further locations registered at which the trust runs outpatient clinics and provides imaging services. There are 379 beds at Cheltenham General Hospital.

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

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

According to the last census, in all the districts in Gloucestershire the proportion of black, Asian and minority ethnic residents was less than the England average, ranging from 11.0% in Gloucester to 1.6% in the Forest of Dean. The percentage of residents aged 65 years and over was higher than the England average of 17.3% in the Forest of Dean (22.3%), Stroud (20.9%), Tewkesbury (21.4%) and Cotswold (23.9%).

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

The inspection team inspected the following seven core services at Cheltenham General Hospital:

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

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers,

Specialist clinical advisor

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

The team included CQC inspectors and a variety of specialists:

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

How we carried out this inspection

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

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

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

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

Facts and data about Cheltenham General Hospital

Overall, Gloucestershire Hospitals NHS Foundation Trust has 1,072 beds, about 7,400 staff and provides acute healthcare services to a population of around 612,000 people in Gloucestershire and the surrounding areas. There are 379 beds at Cheltenham General Hospital.

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

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

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

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

CQC inspection history

Detailed findings

Gloucestershire Hospitals NHS Foundation Trust has had a total of nine inspections since registration. Five of these have been at Cheltenham General Hospital.

In March 2011 an unannounced inspection was undertaken in response to concerns. Concerns were found relating to: care and welfare of people using services, working with other providers, safeguarding, cleanliness and the environment. Following further concerns, an announced inspection was undertaken in July 2012. Seven standards were inspected; six were found to be met and one not met with minor concerns relating to records. This standard was reviewed in February 2103 and found to be met. In April 2013 following an unannounced inspection in which three standards were inspected, one relating to the management of medicines was not met. The most recent inspection was a planned but unannounced inspection in May 2103, at which all five standards inspected were met.

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

Urgent and emergency care and treatment is provided at Cheltenham General Hospital by the unscheduled care service, which forms part of the medical division. An emergency department, otherwise known as the accident and emergency department, operates 24 hours a day, seven days a week. The emergency department sees approximately 45,000 patients a year, of which approximately 7,000 are children.

Emergency and urgent services in Gloucestershire were reconfigured in July 2013 when night-time services at Cheltenham General Hospital's emergency department were reduced. Self-presenting (walk-in) patients continue to be seen in the emergency department throughout the 24-hour period, but between 8pm and 8am the department operates as a nurse-led emergency care centre. Critically injured or ill patients are taken by ambulance to Gloucestershire Royal Hospital, where emergency-medicine doctors are available 24 hours a day. Critically ill children or children who need to be admitted are taken to Gloucestershire Royal Hospital, where paediatric services are provided.

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

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

We visited the emergency department for one weekday and conducted a further unannounced visit during the evening. We also spent a short time on the ambulatory emergency care unit. We spoke with approximately 18 patients and relatives in the emergency department and one patient in the ambulatory emergency care unit. We spoke with staff, including nurses, doctors, managers, therapists, support staff and ambulance staff, and attended a meeting of the emergency care board. We observed care and treatment and looked at care records. We received information from our listening events and from people who contacted us to tell us about their experiences. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

Emergency and urgent services provided by Gloucestershire Hospitals NHS Foundation Trust are located on two hospital sites, the other being Gloucestershire Royal Hospital. Services at Gloucestershire Royal Hospital are reported on in a separate report. However, services on both hospital sites are run by one management team and within the trust

are largely regarded as one service, with some staff rotating between the two sites. For this reason, it is inevitable that there is some duplication in the two reports.

Summary of findings

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

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

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

Patient safety was seen as a priority. Risks were understood and systems were in place to ensure that learning resulted from mistakes. However a significant number of staff felt the service was unsafe when the department was overcrowded and overwhelmed. There was a lack of a clear protocol around the management of the department when it was at full capacity.

Urgent and emergency services

We had some concerns around the care and treatment of children. There was not a dedicated children's nursing workforce, although most staff had been trained in paediatric life support. Arrangements to ensure children were safeguarded from abuse were not robust.

Patients' needs were not always appropriately or promptly met. Ambulance handover delays, although reducing, still occurred too often. Patients queuing in the corridor were uncomfortable and lacked privacy and dignity. Other patients were moved around the department in order to free up cubicles, which impacted on their patient experience.

The department had not performed well in national audits to ensure best practice and good clinical outcomes. Pain relief, in particular, was an area of concern, and we could see no clear plan of action to address this poor performance. Indeed, our findings were similar to those of previous audits in this area. There was some evidence of local audit but no evidence of adequate dissemination of findings throughout the department.

There was a strong, cohesive and supportive management team and a committed workforce. Staff felt well supported and had good access to ongoing education. Multidisciplinary team working was good and there were excellent working relationships with external partners, including the local clinical commissioning group (CCG), community trust and ambulance service.

Are urgent and emergency services safe?

Requires improvement

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

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

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

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

Incidents

- Staff were encouraged to report incidents, and most staff told us that they did so. Some staff told us they did not complete incident forms but passed their concerns to the nurse in charge. Some staff said that when they did complete incident forms, they did not always receive individual feedback. Medical staff expressed a contrary view and said that feedback was good. We saw that

there were regular reminders to staff to report patient safety concerns. General themes were reported at departmental meetings so that learning was disseminated.

- There was a communication log book held at the nurses' station where any events or issues that affected the smooth running of the shift were recorded. This also served as a handover tool and recorded any issues related to, for example, equipment, stock or staffing that needed to be actioned by the next incoming shift. At night, an electronic log was maintained and emailed to managers the next morning.
- There was evidence that lessons were learned and improvements made when things went wrong:
- Bimonthly meetings were held to review incidents and discuss outcomes and learning. Safety bulletins were circulated to share learning following incidents. Incidents included needle-stick injuries, incidents during blood transfusion, and those relating to pump settings, missed antibiotics and record keeping.
- There were regular emergency department safety meetings. Two case studies of suboptimal care were discussed in February 2015 to ensure learning within the team.
- Mortality and morbidity meetings were held every two months to review the care of patients who had complications or an unexpected outcome. Learning points were shared with staff, and real incidents were used in simulation training. Mortality and morbidity trends were reported in monthly emergency pathway performance reports.
- There was a safeguarding and domestic homicide educational programme which incorporated issues raised during incident reviews. Two university accredited courses, 'Caring for the unwell patient' and 'Caring for the unwell child', were included in this programme and were run in April and September each year.
- There had been a high level of incidents and negligence claims in relation to failure to detect abnormal radiology results. A review by the trust identified the system in the emergency department required improvements. As a result an improvement plan had been produced by a consultant in emergency medicine, and a bid for resources to make the necessary improvements had been submitted and accepted. In the meantime, there was a protocol whereby each day a middle grade doctor took responsibility for X-ray reporting and acting on any missed radiology findings.
- Staff told us their main safety concern was overcrowding, and that they regularly reported concerns. Two registered nurses staff told us they believed the department was "unsafe the majority of the time" due to capacity issues.
- The service had a good track record on safety. Four serious incidents were reported in the emergency department (trust wide) in 2014. Three related to delayed or missed diagnosis and one related to equipment failure.
- The department had a system in place to ensure that patients were informed when something went wrong, given an apology and informed of any actions taken as a result. This is known as the duty of candour. The governance lead shared with us an example of a patient who had suffered a poor outcome and the service had been proactive in explaining what had gone wrong and had apologised.

Cleanliness, infection control and hygiene

- In CQC's 2014 A&E survey 8.7 out of 10 patients (trust wide) described the A&E departments as clean.
- The emergency department was mostly tidy and visibly clean during our announced visit, and we saw cleaning in progress throughout our visit. However, the waiting room became untidy towards the end of the day. At our unannounced visit, the patients' toilet was unclean and the main waiting room was untidy.
- There were two assessment/treatment rooms in majors where infected patients could be isolated and barrier-nursed to prevent the spread of infection.
- Emergency department staff frequently washed their hands and they observed the 'bare below the elbows' policy. Monthly hand hygiene audits were undertaken. At the last audit, in February 2015, the department had scored 100%.
- Protective clothing and equipment, such as gloves and aprons, was available and used by staff.

- There were appropriate arrangements for the segregation, storage and disposal of waste, and we saw that emergency department staff mostly complied with guidance in this respect; however, during our unannounced visit, we saw used disposable gloves discarded on a patient's trolley.
- It was reported at a staff meeting in February 2015 that in a recent cleaning audit the department had scored 100%.
- The department used evidence-based care bundles (a series of actions/care elements) to prevent healthcare-associated infections when undertaking invasive procedures such as cannula and catheter insertion. Compliance with these safe systems was monitored on a monthly basis and was consistently between 80% and 100%.

Environment and equipment

- The emergency department was generally laid out and equipped to protect people from avoidable harm. However, at busy times overcrowding was an issue. It was reported in a departmental meeting in January 2015 that "there have been difficulties with space". It was highlighted that there were problems when the department was very busy, and that triage nurses didn't know where to put patients because insufficient cubicles were available.
- A receptionist told us the waiting room was too small and that sometimes patients queued outside the door.
- There were poor lines of sight to the main waiting area, which meant that not all waiting patients could be seen. Children could not be observed at all. This meant that a deteriorating patient or inappropriate behaviour might go unnoticed. Triage nurses expressed their concern about this lack of observation.
- We checked a range of equipment, including resuscitation equipment, in the emergency department. Resuscitation trolleys were all in order and appropriately stocked at the time of the inspection. A staff member told us that checks took place "at some point" after the equipment had been used. Trolleys were not sealed following these checks to ensure that they were tamper evident. Although trolleys were checked daily there were items missing and not replaced for a number of days.
- Records showed that defibrillators were checked daily.

Medicines (includes medical gases and contrast media)

- Medicines were appropriately stored in locked cupboards or fridges. In the emergency department and on the ambulatory emergency care unit, fridge temperatures were regularly checked and were correct the time of our visit.
- Controlled stationery relating to medicines (prescription pads) was securely stored and appropriate records were kept.
- In the CQC's 2014 A&E survey, 8.8 out of 10 patients (trust wide) said that the purpose of new medicines was explained before they left A&E. However, only 4.3 out of 10 patients said they were told about possible side effects of those prescribed new medicines while in A&E.
- A range of medicines could be prescribed by nurse prescribers or by authorised nurses under patient group directions. This was essential as the department was nurse-led out of hours. The range of medicines available under patient group directions was appropriate and had been reduced to minimise errors whilst maintaining consistency with prescribing guidelines. One patient group direction (out of 75 available) did not reflect good practice. Paracetamol given intravenously was not weight-adjusted in accordance with the manufacturer's guidance (British Medical Society letter 30 March 2012).
- We checked 50 patients' records dated 11 March 2015. Sixteen of these records had no allergy status recorded. This increased the risk that patients might be given inappropriate medicines that might have a harmful effect.

Records

- Patients' records were in paper and electronic format. Paper records were scanned onto the electronic system when patients were discharged or transferred.
- We looked at a sample of 50 records and found that on the whole they were not well completed. The time when care or treatment or assessment took place was often not recorded, and staff did not always sign or initial their entries.

- There was no system-held data on patient allergies, so this had to be recorded at each attendance. In the sample of records we looked at, allergy status was not consistently completed.
- Reception staff told us that they struggled to access patients' records from Gloucestershire Royal Hospital. During the day, requested notes were transported by bus (in a locked cabinet), but there were frequent delays in obtaining them.

Safeguarding

- Processes were in place to identify and manage adults and children at risk of abuse (including domestic violence). Staff understood their responsibilities and were aware of safeguarding policies and procedures. We looked at a sample of 50 patients' records, of which six were children's. Only three out of these six children's records contained a completed safeguarding checklist. Only one of the 44 adult records reviewed included a safeguarding assessment.
- The department was meeting most of the safeguarding children standards produced by the College of Emergency Medicine's (CEM's) clinical effectiveness committee:
- Training records showed that as at 31January 2015, 83% of all staff in unscheduled care (trust-wide) had received a minimum of level 2 child protection training. All middle grade doctors had received training, but only 68% of junior doctors had.
- The trust told us that all senior emergency medicine doctors (ST4 or equivalent and above) had received level 3 child protection training, although five out of 23 doctors required updating.
- The department had access to a senior paediatric and senior emergency medicine opinion 24 hours a day for child welfare issues.
- The patient record system identified previous child attendances in the last 12 months so that staff would be alerted to possible safeguarding issues.
- Frequent attenders (more than three attendances in last year with different conditions) were notified to the local safeguarding children services.
- Child attendances were notified to GPs, health visitors and school nurses.
- We were told that all skull or long bone fractures in children under one year were discussed with a senior paediatric or emergency department doctor during the child's emergency department attendance.
- We were concerned there was a lack of any system to ensure all appropriate child safeguarding referrals were made. A health visitor liaison team attended the emergency department every few days to check referrals, but did not check all child attendances to see whether any had been missed. Three children's records out of our sample of six records contained no safeguarding assessment.

Mandatory training

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

Assessing and responding to patient risk

- The trust used a recognised triage system (Manchester) in the emergency department for the initial assessment of all patients. Guidance issued by the College of Emergency Medicine (CEM) (triage position statement dated April 2011) states that a rapid assessment should be made to identify or rule out life/limb threatening conditions to ensure patient safety. This should be a face-to-face encounter within 15 minutes of arrival or registration, and assessment should be carried out by a trained clinician. This ensures that patients are streamed or directed to the appropriate part of the

department and the appropriate clinician. It also ensures that serious or life threatening conditions are identified or ruled out so that the appropriate care pathway is selected.

- During our visits we saw triage mostly took place promptly. The trust told us that all patients who arrived by ambulance were assessed on arrival, therefore performance against this standard was assumed to be zero. The time from arrival to initial assessment for self-presenting patients was separately measured. Median performance against the 15-minutes standard ranged from seven to 11 minutes between March 2014 and February 2015.
- Receptionists in the minors' area told us they used their judgement and experience to recognise a seriously unwell/injured patient who needed immediate clinical attention. There was no written guidance about 'red flag' conditions, although receptionists were able to name some of these, such as chest pain and profuse bleeding. They told us they summoned help either in person or by phone.
- There was insufficient observation and monitoring of patients in the waiting room, and some of the room was not within the receptionist's line of sight. We observed that the triage nurse did not enter the waiting room when calling patients in for assessment. Children were not supervised as recommended in Health Building Note 15-01, which states "the waiting area should be provided to maintain observation by staff."
- Staff in the emergency department used recognised early warning tools for adults and children. Observations were recorded, as indicated by the early warning score. We saw evidence that observations were regularly recorded.
- Risk assessments were carried out to ensure that risks were identified and appropriately managed. Patients with mental health problems were risk assessed and prioritised using a mental health assessment pro forma. Patients were assessed for the risk of developing pressure damage, and we saw some evidence of this. Staff told us patients identified as at risk would be provided with pressure mattresses.
- We were told that staff were trained to recognise serious illness in children. There were clear protocols for the transfer of paediatric patients and critically ill adults who attended Cheltenham General Hospital emergency department at night.
- Overcrowding in the emergency department was a serious and ongoing risk. There was a trust-wide escalation policy which set out a range of triggers that would enable the trust to mitigate risks associated with capacity and overcrowding. Within this policy, the emergency department had a separate internal escalation plan and a series of triggers which were linked to its ability to achieve the following key performance measures:
- Assessment within 15 minutes
- Senior review within one hour
- Management plan within three hours
- Admission/discharge within four hours.
- Other trigger factors included the number of patients in the department, the space available in majors and resuscitation and the number of ambulances queuing. The nurse coordinator in the emergency department was responsible for reviewing the status of the department every hour.
- There were a series of action cards for medical and nursing staff to follow in the event of escalation. Actions included reallocating staff, requesting additional staff and diverting patients to other emergency departments. The common practice of caring for patients in the corridor appeared to be pragmatic and not guided by protocol or risk assessment.

Nursing staffing

- The department currently had 1.4 whole time equivalent vacancies for band 5 nurses; recruitment was underway. The department was one registered nurse short on both the early and the late shifts on the day of our visit. This was due to short-notice sickness.
- Two nursing staff told us that staffing levels were appropriate unless staff were moved to a ward, which they said was a regular occurrence.
- Temporary (bank or agency) staff were employed where possible to cover shortfalls in staffing, although cover

could not always be provided. Between December 2014 and March 2015, 25% of shifts were unfilled. Bank/ agency usage ranged between 6.2% and 9.6% from September to November 2014.

- We were concerned about the effect that queuing patients had on staffing levels in the department. There was no protocol that defined a safe nurse-to-patient ratio. The clinical nurse manager for the department told us patients would be triaged by a trained nurse, but thereafter might be cared for in the corridor by a healthcare assistant.
- There was no dedicated children's nursing workforce, and the department could not ensure that a registered children's nurse was always on duty. Although the ambulance service would take seriously ill children to Gloucester Royal Hospital, sick and injured children were still brought into CGH's ED by their parents. The Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012) identifies that there should always be registered children's nurses in the emergency department, or trusts should be working towards this. Staff should, as a minimum, be trained in paediatric life support. We were assured, however, that all nurses were trained in paediatric life support. Training records confirmed that all but two of 45 staff were appropriately trained. All nursing staff were trained during their induction to recognise and respond to unwell children. Further extended training was available after one year in post, but we were not provided with information that showed what proportion of staff had completed this training.
- The trust told us that a registered children's nurse was always available in the hospital and could be summoned by bleep if required.

Medical staffing

- There was medical presence in the emergency department until 10pm, although ambulance patients were not brought in after 8pm. Out of hours the department was nurse-led. Nurses told us there was good support from the medical and surgical inpatient teams. There was also an out-of-hours primary care service provided close to the department which provided "really good support". Concerns were expressed by many staff, however, that this service was to change from 1 April 2015.
- The monthly emergency pathway performance report presented to the February 2015 board meeting records that, "Despite recruiting additional consultants, gaps in the emergency department doctors' rotas, especially at middle and junior grades, continue to remain the biggest risk to delivering emergency department performance."
- A 15th consultant was appointed in October 2014, bringing the total to 14.8 whole-time equivalents. Overseas recruitment had recently taken place and a further two middle grade doctors had been recruited.
- Locum usage in unscheduled care (trust wide) ranged between 10.7% and 12.4% from September to November 2014.

Other staffing

- Two staff members told us that sometimes there was only one porter in the department, which meant that nursing staff frequently had to leave the department to escort patients to wards.

Major incident awareness and training

- A staff member told us that the major incident plan was currently under review. They said that a practice had not been held in the department for the last two years. Another staff member commented that there was a high turnover of staff and frequent use of temporary staff, so they were not confident that all staff were familiar with the major incident plan or their responsibilities. A senior nurse told us they thought a practice was held annually. There were action cards for each staff role, and the senior nurse was confident that most staff would be aware of how to respond in a major incident and that they would be directed by senior management.
- The trust told us that staff received training during their induction. They told us there had not been a full practice for many years, although a walk-through simulation of a patient with Ebola had been undertaken recently.
- A receptionist told us that recent scheduled training in how to deal with casualties contaminated with

chemical, biological or radiological materials had been cancelled. They said they thought that in the event that a contaminated patient presented at reception, they would send them outside.

- Staff told us they thought security arrangements were adequate, although in a staff meeting held in January 2015 it was recorded that, "night time does feel particularly vulnerable". A security service was on site which could be summoned via the hospital switchboard when needed. There were plans to issue staff with new security cards (already in place in Gloucestershire Royal Hospital's emergency department) that could be used to summon assistance directly.
- The risk register identified high levels of violence and aggression incidents. There were 86 reported incidents of violence and aggression in unscheduled care from April 2014 to January 2015. There was a bid to the trust management team for a security service.
- Staff were provided with conflict resolution training. The medicine division was sending letters to patients who had behaved inappropriately in the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

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

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

Evidence-based care and treatment

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

Pain relief

- Patients did not consistently receive prompt pain relief. We spoke with five patients about pain relief on the day of our visit and they all confirmed they had received prompt analgesia. However, we looked at 50 patients' records dated 11 March 2015. These related to 44 adults and six children. Pain scores had been recorded for 43 patients. None had repeat pain scores recorded, which meant we could not be assured that the effectiveness of their pain relief had been assessed or their pain adequately controlled. Twelve patients had moderate pain recorded; however, five of these patients were not given pain relief (one had been in the department for four hours).
- The emergency department performed poorly in the College of Emergency Medicine (CEM) renal colic audit 2012 and did not meet the required standard in respect of the provision of prompt pain relief. Only 10% of patients in severe pain received analgesia within 20 minutes (the standard is 50%), and only 25% received analgesia within 30 minutes (the standard is 75%).
- The emergency department performed poorly in the CEM fractured neck of femur audit 2012/13. Hip fractures are painful and the administration of pain relief should be a priority in the emergency department. The department was in the lower quartile in England for all indicators relating to pain.
- In the CQC 2014 A&E survey, 7.8 out of 10 patients (trust wide) said staff did everything they could to control their pain.

- The emergency department had undertaken an audit of pain management in children that focused on children aged five to 15 years old who presented at Cheltenham General Hospital emergency department with fractures in moderate or severe pain between September 2013 and April 2014. The audit found that none of the CEM clinical standards had been met and concluded that significant improvement was required. A poster had been developed publicising the standards and the audit results. A 'pain passport' had also been developed to encourage the involvement of children and parents in pain assessment. A programme of education was planned and a re-audit to measure progress.

Nutrition and hydration

- We saw that nursing staff recorded in patients' records when they were offered food and drink. The department had recently purchased small whiteboards where staff recorded food and drink offered, and this provided a more visual reminder to ensure people's needs were met.
- In the CQC 2014 A&E survey, 7.3 out of 10 patients (trust wide) said they were able to get suitable food or drinks when they were in the A&E department.

Patient outcomes

- The trust participated in national CEM audits so it could benchmark its practice and performance against best practice in other emergency departments. Overall the trust's performance was mixed.
- In the CEM 2013/14 audit of severe sepsis and septic shock, performance at Cheltenham General Hospital was mixed. The administration of fluids was below the national mean, although some indicators scored above the national mean. The results were published in September 2014. We spoke with the outgoing audit lead. They were not able to provide us with an action plan to show how performance was to be improved. Compliance with the sepsis 6 bundle (a set of interventions to be undertaken within the first hour of sepsis presentation) was monitored on a monthly basis. Between January 2014 and January 2015, performance had been variable (between 67% and 100%). In January, compliance was 84%. The sepsis protocol had been introduced in 2013, but the outgoing audit lead told us, "It is difficult to keep it at the top of the agenda."
- The department was meeting the standard which requires the number of patients re-attending (unplanned) the emergency department within seven days to be less than 5%. Performance between March 2014 and February 2015 ranged from 1.7% to 2.7%.
- The emergency department performed poorly and performance showed a downward trend in the 2013 audit of consultant sign-off. This measured the percentage of patients presenting at the emergency department in certain high risk patient groups (adults with non-traumatic chest pain, febrile children less than one year old, and patients making an unscheduled return visit with the same condition within 72 hours of discharge) who are reviewed by an emergency department consultant (or, in exceptional circumstances, by an ST4–7 or a career grade doctor with sufficient experience to be designated to undertake this role by the emergency department consultant) before discharge.
- The trust performed below CEM standards in respect of the measurement and recording of vital signs. In the 2010/11 audit, the emergency department scored in the lower England quartile for the measurement and recording of pulse, blood pressure and oxygen saturation. The trust provided no evidence to show that effective action had been taken to improve this performance.

Competent staff

- A junior doctor told us that they were well supported, supervised and received regular ongoing education; however, they "struggled with the rota".
- There was a programme of emergency department competency-based training and professional development training for each grade of nursing staff. Each staff member maintained their own training record which was overseen by their manager.
- Appraisal rates for the unscheduled care division trust wide were as follows:
  - Additional clinical services staff: 85%
  - Administrative and clerical staff: 92%
  - Medical staff: 79%
  - Nursing staff: 87%
- The General Medical Council (GMC) reported in October 2014 that feedback from trainee doctors in the

emergency department had significantly improved since the development of an emergency department education group to oversee training in the department. They reported that junior doctors were always supervised by an emergency department consultant or middle grade doctor. There was positive feedback about departmental teaching and one-to-one teaching sessions with consultants. They reported that the emergency department consistently released trainees for teaching. Work intensity and rotas had received negative feedback from higher level trainees but not at a more junior level.

Multidisciplinary working

- Staff, teams and services mostly worked well together to deliver effective care and treatment. There was an effective and cooperative relationship with the acute physicians who managed ambulatory emergency care and the ambulatory care unit, and these staff had jointly developed care pathways.
- Emergency department staff reported that they were well supported by some specialties; however, there was a lack of ownership of the four-hour emergency department target in the rest of the hospital. There were frequent difficulties in transferring patients from the emergency department to appropriate beds once the decision to admit had been made. A senior clinician told us that only 23% of agreed admissions were transferred within an acceptable time frame to ensure that breaches did not occur. A performance measure had recently been implemented whereby specialties were required to accept admissions from the emergency department within 30 minutes of the decision to admit. This was monitored by daily analysis of breaches. It was hoped that this would enable more cooperative working and ownership of the target by the medical division. However, in the December minutes of the joint emergency department/acute care operational meeting it was recorded that, "General physicians are paid for on-calls but attend infrequently. Weekend specialties few and far between. There doesn't appear to be any focus on discharging patients."
- It was reported at an emergency department staff meeting in January 2015 that some difficulties had been experienced when transferring patients to ward. It was recorded, "Beds often aren't ready and there is no help in getting the patient settled."

Seven-day services

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

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are urgent and emergency services caring?

Urgent and emergency services

Good

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

Although the Friends and Family Test in the emergency department yielded a low response rate (which is not uncommon in emergency departments), the majority of respondents provided positive feedback.

The service received few complaints and more compliments than complaints.

Compassionate care

- Patients were treated with care, compassion and respect, and their privacy and dignity were respected. We observed staff interacting with patients in a caring, friendly and respectful manner. Staff wore name badges and we heard them introducing themselves. One healthcare assistant told us they always asked patients how they wanted to be addressed.
- In the CQC's 2014 A&E survey, trust wide:
  - 7 out of 10 patients said they had enough privacy when discussing their health problem with the receptionist.
  - 9.2 out of 10 patients said they were given enough privacy during examinations and treatment.
  - 8.9 out of 10 patients said they were acknowledged by staff and staff did not talk in front of them as if they weren't there.
  - 7.3 out of 10 patients felt reassured by staff if they were distressed while in A&E.
- Patients we spoke with during our visit all spoke highly of the staff and were very happy with their care. Reception staff were engaged, helpful and polite.
- Feedback on the NHS Choices website described emergency department staff as "helpful" (October 2014), "pleasant, hardworking" (November 2014) and "efficient, caring and accommodating" (December 2014).
- A relative contacted us to tell us, "The service in Cheltenham emergency department on Saturday 7 March was wonderful; despite being clearly busy, the staff were caring and engaging, and the treatment my (child) received was really good."
- At the emergency department staff meeting held on 17 February 2015, the team received a presentation about the 'Hello my name is...' project, which had been launched at the trust in December 2014. This was a national campaign that encouraged staff to introduce themselves to patients before delivering care.
- The department used the Friends and Family Test to capture patients' feedback. In common with many emergency departments, response rates were low although improving (16.8% in January 2015). The majority of respondents said they would recommend the service to friends and family.
- We spoke with a patient in the ambulatory emergency care unit who told us they had been well cared for by caring and friendly staff, made comfortable and offered food and drink.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved as partners in their care. In the CQC's 2014 A&E survey:
  - 7.8 out of 10 patients (trust wide) said they were as involved as much as they wanted to be in decisions about their care and treatment.
  - 8.1 out of 10 patients felt the doctor or nurse explained their condition and treatment in a way they could understand.
  - 8.8 out of ten patients felt the doctor or nurse listened to what they said.
  - 7.7 out of 10 patients said they had enough opportunity to talk to a doctor if they wanted to.
- Self-presenting patients did not know how long they would have to wait to be seen and were not informed of current waiting times. Reception staff told us that sometimes people became frustrated and if waiting times were long, they asked the nurse in charge to come to the waiting room to make an announcement and provide an explanation.

Emotional support

Urgent and emergency services

- Patients and those close to them received the support they needed to cope emotionally with their care, treatment or condition. In the CQC's 2014 A&E survey, 7.3 out of 10 patients (trust wide) said the doctor or nurse discussed any anxieties or fears they had about their condition or treatment.
- The service had recently employed a bereavement counsellor, whose role was to support bereaved relatives and to support staff who had experienced traumatic events at work. The counsellor told us that they usually contacted bereaved relatives approximately four to six weeks after their loss to offer support.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

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

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

Some of these schemes were in their infancy and their full effects were not apparent. The anticipated impact of the ambulatory emergency care service and the potential of the older people's assessment and liaison service had not yet been realised because of funding and staffing issues. The ambulatory emergency care unit, in particular, had suffered because permanent suitable accommodation had not been identified and the service had moved numerous times. Uncertainty about the future of the service had impacted on staff morale and the ability of the service to attract and retain staff. The service was currently significantly under-staffed and having to reduce the number of patient pathways that could be offered. Nevertheless, these admission avoidance initiatives were commendable, and there was a clear plan to develop them further to achieve a more significant impact on patient flow.

Service planning and delivery to meet the needs of local people

- Services had been adapted to meet the needs of the local population. In July 2013, the trust made changes to emergency care provision across the county. The changes meant that at Cheltenham General Hospital the emergency department was run by emergency nurse practitioners between 8pm and 8am. Patients with a critical illness or injury who required treatment from emergency medicine doctors were taken by ambulance to Gloucestershire Royal Hospital at night. In the event that a critically ill patient self-presented, they would be assessed and receive initial treatment and a decision would be made to either admit them under the care of the acute physician or transfer them by ambulance to Gloucestershire Royal Hospital. These changes were made primarily because the trust was unable to provide sufficient medical cover to provide a full service on both the Gloucestershire Royal Hospital and Cheltenham General Hospital sites.
- Staff told us that the Gloucestershire Royal Hospital emergency department regularly (three or four times a week) diverted emergencies to Cheltenham General Hospital. Records showed that this occurred on 18 occasions in February 2015. This was universally unpopular, and some staff felt that it was unsafe as staffing was not increased to accommodate the increased demand. They told us it was also inconvenient and sometimes distressing for patients whose relatives had to travel a significant distance to be with them.

- Premises and facilities were mostly adequate for the services provided, but with some limitations.

Available parking close to the department was limited, although there was a drop-off zone. Several patients and relatives complained to us about the lack of parking on the hospital site, which caused frustration and anxiety.

- The main waiting area was fairly small, and staff told us that when the department was busy, patients sometimes queued out of the door. The area was an unwelcoming space. There was no television, and a limited selection of out-of-date reading material was provided.
- The trust was working with health and social care partners to ensure there was a system-wide approach to managing demand and the impact that fluctuating and increasing demand had on the emergency department. There was a local health resilience partnership which was examining all aspects of the urgent care system and agreeing plans to address identified areas of pressure.
- There was a county-wide, centrally held information system that all partners contributed to. The data was collated and analysed to help health and social care teams understand performance trends and the causes and effects of key measures.
- Following detailed analysis of data, the local health resilience partnership identified four main priorities:
- Ensuring sufficient capacity to support discharges; this included ensuring that sufficient re-ablement and domiciliary care were available for patients
- Increasing weekend discharges
- Increasing patient flow by ensuring patient discharges took place earlier in the day and understanding how sufficient beds could be made available at times of surge in demand or of infection outbreak
- Management of emergency department demand: ensuring that staff capacity matched anticipated peaks in demand. This included the appropriate diversion of patients to other services, including a new primary care service in the emergency department (Currently working "most weekdays"), ambulatory emergency care and community-based services such as minor injury units ad rapid response services.
- All health and social care partners, including Gloucestershire Hospitals NHS Foundation Trust, Gloucester Care Services NHS Trust, South Western Ambulance Service NHS Foundation Trust, the council and the clinical commissioning group (CCG), participated in a daily teleconference call to monitor patient flow and pressures and agree necessary action and escalation plans for the day ahead. At times of pressure, meetings took place several times a day. Prior to the call, a dashboard of information was prepared. Gloucestershire Hospitals NHS Foundation Trust submitted performance information for the previous day, including the number of emergency department attendances, performance against the four-hour standard, the number of emergency admissions and discharges, bed availability and the number of medically stable patients who were ready for discharge.

Meeting people's individual needs

- The service took account of the individual needs of different patient groups.
- The emergency department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available in the department, although one staff member told us that the department sometimes ran out of wheelchairs. Staff could access wheelchairs and trolleys that could accommodate bariatric patients.
- The waiting room was small; staff told us that most of the time it was adequate to accommodate patients and relatives but there was limited space for queuing patients, and sometimes they queued out of the door. It was difficult to maintain confidentiality at the reception desk because of the confined space. Patients had access to food and drink.
- Patients did not know how long they would have to wait to be seen; reception staff told us they did not inform patients of current waiting times, although if asked they might advise people how many patients were in front of them in the queue. They told us that waiting time was the most common cause for complaint. Reception staff could call a senior nurse to provide an explanation to patients if they thought this was necessary. They also offered complaints leaflets to patients if they wanted to complain, and patients were directed to the Patient

Advice and Liaison Service (PALS). There was a PALS office based at Gloucestershire Royal Hospital, with only limited presence on the Cheltenham General Hospital site.

- There were male and female toilets. There was no designated area for breastfeeding mothers, but staff told us they would always try to find a suitable private space.
- There was a separate waiting area for children, which was not overlooked by the adults' waiting area. The children's area was in the process of being updated to make it more child friendly.
- A mental health liaison team supported the emergency department and ambulatory care unit from 8am to 10pm seven days a week. The team was employed by the local mental health trust, 2gether NHS Foundation Trust, although commissioned by Gloucestershire Hospitals NHS Foundation Trust. The team aimed to respond verbally to all crisis referrals and urgent referrals for mental health advice or assessment and provide assessment according to the urgency of the referral. Between April and September 2014, all urgently referred patients were seen within two hours. Most non-urgent referrals were seen within 24 hours. Outside these hours, staff could contact the crisis home treatment service (2gether NHS Foundation Trust) or the on-call psychiatrist. Staff told us that this service was not responsive, as only two mental health practitioners covered the whole county. Staff told us that at night patients were likely to be admitted and assessed the next morning. However, funding had been secured to extend the mental health liaison team to provide night-time cover, and recruitment was underway.
- Staff told us that patients waiting for a Mental Health Act assessment who had been assessed as high risk would be cared for in one of the assessment (review) rooms in majors. Low and medium risk patients might be accommodated in the sub-waiting room. Where possible, staff would be allocated to sit with them. There was no designated space for mental health practitioners to conduct Mental Health Act assessments.
- We case-tracked the care and treatment of a patient who attended in the early hours of the morning with an acute mental health problem. They had been advised by the crisis team to attend the emergency department because the crisis team did not have the capacity to see them. The patient was assessed by emergency department staff as requiring a Mental Health Act assessment, and pending this staff initiated one-to-one nursing to keep the patient safe. They were unable to admit the patient, because the medical ward refused to accept them as they had no medical illness. The patient spent the remainder of the night in the emergency department and was seen by the mental health liaison team approximately six hours after they presented.
- Guidance was available for emergency department staff to assist them to identify and manage patients with a learning disability. A team of learning disability liaison nurses could be called upon to support staff.
- A dementia champion in the department acted as a staff resource for learning and support around dementia care. All staff completed mandatory training in dementia care. The department had a purple butterfly stamp that was used on the front of patients' records to alert staff that a patient had specific needs associated with dementia.
- Staff recognised the importance of supporting bereaved relatives. Deceased patients were moved to a side room where family members could spend time with them.

Access and flow

- People did not always receive care and treatment in a timely way. The trust was consistently failing to meet key national performance standards for emergency departments:
- The trust was consistently failing to meet the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. In January 2015 the emergency department did not achieve the 95% target, for the fourth consecutive month. Trust-wide performance was 82.86%, with Cheltenham General Hospital achieving 86.95%.
- While waiting no more than four hours from arrival to departure is a key measure of A&E performance, there are other important indicators, such as how long patients wait for their treatment to begin. A short wait will reduce patient risk and discomfort. The national

target is a median wait of below 60 minutes. The department consistently achieved this target, with an average wait of 50.25 minutes between March 2014 and February 2015.

- Another important indicator for patients who require admission to a hospital ward is the time it takes for their transfer to take place from the time of decision to admit. In January 2015, 18% of emergency admissions via the emergency department waited four to 12 hours. Fifty-nine per cent of breaches of the four-hour target trust wide were due to patients awaiting a bed. It was reported in November 2014 by the director of service delivery that patients often spent the night in the emergency department waiting for a bed. Staff confirmed this was a regular occurrence. They told us that hospital beds were obtained so that patients did not have to sleep on trolleys.
- The trust consistently achieved the national target which requires that the number of patients who leave the department before being seen by a clinical decision-maker (which is recognised by the Department of Health as an indicator that patients are dissatisfied with the length of time they have to wait) should be less than 5%. In January 2015, the proportion of patients leaving before being seen (trust wide) was 1.2%.
- Some patients brought into the emergency department by ambulance waited too long to be handed into the care of emergency department staff. Joint work with the ambulance service aimed to reduce these delays; however, there were 113 delays of over 30 minutes in February 2015. 'Black breaches' (patients waiting over an hour to be offloaded from an ambulance) occurred nine times in January 2015.
- The department aimed to have no ambulance handover delays. When the department was busy and there were no available cubicles, patients queued in the corridor, but, where possible, they would be transferred to a hospital trolley and cared for by the designated 'corridor nurse'.
- We did not witness any queues on the occasions we visited; however, staff told us that delays were a regular occurrence (three or four days a week). One staff member told us that up to eight patients could be queueing at one time. They told us that they had been asked to care for up to six patients on the corridor, and they were uncomfortable with the fact that they had to take blood from patients in this open area where there was no privacy. Staff told us they did all they could to ensure patients in the corridor were comfortable, but acknowledged that sometimes it was cold and there was little privacy, although mobile screens could be used. Staff told us that patients were moved around the department in order that more seriously ill patients could be seen in a cubicle. One staff member told us they had moved a patient into the resuscitation area so that they could use a bedpan in private.
- The trust recognised that overcrowding in the emergency department presented a risk to patient safety, patient experience and performance against key waiting time targets. A trust escalation policy (reviewed June 2013) set out steps to mitigate these risks by ensuring that patient flow throughout Gloucestershire Royal Hospital and Cheltenham General Hospital was managed.
- The escalation policy described and 'RAG rated' the escalation level of each hospital, ranging from green (low risk) to black (very high risk). The escalation level was triggered by bed capacity or emergency department capacity or both and was reviewed regularly. In the emergency department, escalation status was reviewed hourly by the nurse coordinator who monitored the department's performance against key indicators: time to initial assessment, senior review, management plan and discharge or admission.
- A series of action plans were in place for each escalation status. Actions included opening additional beds, providing additional staff, cancelling training and diverting patients to other hospital sites. When escalation status was declared black, an internal major incident would be declared.
- During the winter months, the trust declared an internal major incident on two separate occasions (December 2014 and January 2015). This was due to more patients requiring admission attending the two emergency departments than Gloucestershire Royal Hospital and Cheltenham General Hospital had beds for, resulting in overcrowding in the emergency department. The trust also experienced sudden peaks in demand following the

festive season. In declaring this heightened level of alert, the trust was able to mobilise extra resources (specialist discharge team, additional staff, equipment and facilities).

- The emergency care board had discussed and agreed a resilience plan for the forthcoming Easter holiday.
- The trust had developed a number of initiatives to prevent unnecessary emergency department attendance and/or admission to hospital and thereby improve patient flow.
- Since September 2014, all GP calls for an ambulance were handled by the Gloucestershire single point of clinical access run by Gloucestershire Care Services NHS Trust, which would consider alternatives to emergency department attendance.
- The trust was working with partner healthcare organisations to encourage members of the public to choose the most appropriate service when they needed urgent healthcare advice or treatment. The trust's website directed people to a range of local services, including primary care (including out of hours), NHS 111, pharmacies and local minor injury units. Live information was also posted on the website showing how busy each minor injury unit and emergency department in the county was and what services were offered by each of the locations.
- Media campaigns encouraged the public to think carefully before coming to the emergency department and to consider other sources of care and support.
- The emergency pathway report to the board in February 2015 reported that January 2015 saw the lowest number of total emergency department attendances and the lowest average daily attendance since before April 2011. It was believed that the reason for this decrease was primarily because of the regional and national media coverage the NHS received in January 2015, resulting in low acuity patients choosing not to go to the emergency department.
- Staff completed 'inappropriate attendance' forms to provide data that could be used to inform health and social care partners and commissioners of services and help to provide an understanding of patient behaviour and referral patterns.
- The trust had commissioned the integrated discharge team provided by Gloucestershire Care Services NHS Trust to work in the emergency department and on the acute care unit. The team, made up of health and social care professionals, assessed appropriate patients and, where possible, directed them to other services in the community. It also supported patients (inpatients and emergency department patients) who needed ongoing health or social care services after they were discharged, and helped to facilitate their early discharge. The service operated from 8am to 8pm, Monday to Friday, and from 9am to 5pm at weekends and over bank holidays.
- The integrated discharge team was highly regarded and valued by the emergency department team because of its proactive approach to admission avoidance. The emergency intensive support team had praised this service following its visit in September 2014. There were plans to formally audit the effectiveness of the service but early indications were positive. The integrated discharge team saw 1,410 patients in the emergency department or ambulatory care unit between September and November 2014, of which approximately half were not admitted to a ward.
- The integrated discharge team often liaised with the older people's assessment and liaison service, which had been developed with the aim of reducing the need for admission or reducing the length of stay. The service was established approximately 12 months previously and was run by two consultants in elderly care, who were being back-filled by locums because the service had not been able to appoint consultants in elderly care.
- The older people's assessment and liaison service was valued by the emergency department. A list of patients over 80 years of age was passed to the service each weekday morning, and appropriate patients were selected and assessed. Gloucestershire clinical commissioning group (CCG) reported in January 2015 that 58% of patients reviewed were able to go home the same day. A GP had also been recruited to work with the service. The medical/unscheduled care division's risk register (December 2014) recorded that this service was not fully staffed and there had been recruitment difficulties. One of the two consultants told us that they had successfully recruited a third consultant, who was due to commence in September 2015. The trust was a

member of the national Acute Frailty Network, which was looking at how the pathway for frail older patients could be improved. The service was in its infancy so its effectiveness had not been fully measured. However, one of the team's consultants told us that currently 73% of emergency department patients over 80 years of age arriving by ambulance were admitted to hospital. This 'conversion rate' had improved since the establishment of the current integrated discharge team and older people's assessment and liaison teams, but there was potential to improve this further. The service was aiming to improve on this and achieve a 60–70% admission rate.

- The older people's assessment and liaison service was described by the emergency intensive support team as "an example of very good practice", although its limitations in terms of staffing and resources were noted. The emergency intensive support team recommended that the older people's assessment and liaison service should have access to a short term assessment unit or clinical decision unit, ideally based at the 'front door'. It also suggested closer working with the ambulatory emergency care unit. There were plans to pilot an older person's assessment and short stay unit, starting in the spring of 2015.
- An ambulatory emergency care unit was open between 10am and 6.30pm, Monday to Friday. Patients could be referred by the emergency department or by their GPs or the ambulance service via the single point of clinical access helpline. It was reported to the December 2014 board meeting that activity was increasing steadily, and the service exceeded the anticipated attendance rate during December 2014 and January 2015.
- The ambulatory emergency care unit currently occupied temporary accommodation, shared with the medical day unit. Staff told us the unit had moved nine times in nine months. One staff member told us this made them feel undervalued. Accommodation issues and uncertainty about the future of the service (recurrent funding had only just been secured) had affected staff morale. Although staff showed real pride in their service and were passionately committed to developing the service, morale had suffered and this in turn had made it difficult to recruit and retain staff. The service was currently short-staffed by 1.6 whole-time-equivalent advanced nurse practitioners and 1.4 WTE band 5 registered nurses. A staff member told us the unit only managed to remain open because it was supported by staff from the medical day unit. This meant, however, that a reduced service was offered and medical pathways were restricted. We were told the service aimed to see eight to 12 patients per day. On the day of our visit there were three patients in the unit, with a fourth expected.

Learning from complaints and concerns

- Between June and August 2014, 27 complaints were received in unscheduled care (which includes A&E and the acute assessment unit). This represented 11% of the trust's complaints. The most common cause for complaint was waiting times to be seen in A&E.
- The emergency care division responded to 98% of complaints within 35 days from June to August 2014. The trust's internal standard was 95%.
- Staff were familiar with the complaints procedure and felt confident to deal with complaints.
- Compliments and complaints were shared with staff at departmental meetings. The unscheduled care service produced a monthly analysis of compliments, concerns and complaints. This analysis also reported on the response time to complaints and highlighted any significant complaints or themes and actions taken. In February 2015, it was noted that changes were being made to a GP referral pathway for patients with giant cell arteritis, following a complaint of delayed diagnosis. There were also plans to present the learning from this case.

Are urgent and emergency services well-led?

Good

The service had a clear trust-wide vision to provide a comprehensive and integrated unscheduled care service where people received appropriate, seamless and timely care and treatment. The vision, however, was not well understood by the majority of staff, who were more concerned with the 'here and now'. A staff member told us that staff morale at Cheltenham General Hospital "hit rock bottom" when the emergency department services

across the county were reconfigured and night-time services were reduced, but felt that morale had improved. There remained however, uncertainty about the future of the emergency department service at Cheltenham General Hospital. There was also a perception expressed by several staff that the service at Cheltenham General Hospital was seen as secondary to the service at Gloucestershire Royal Hospital. One staff member told us, "Gloucester gets everything they ask for and Cheltenham gets what is left over."

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

Vision and strategy for this service

- There was a clear vision and a credible strategy to deliver safe, high quality unscheduled care. The long term vision for the service was to develop a major-emergency care centre. This would require further reconfiguration of urgent and emergency care services in the county and concentration of the majority of emergency care pathways at Gloucestershire Royal Hospital.
- A series of external reviews had taken place of systems and to examine the issues affecting operational effectiveness and patient flow. These included the clinical commissioning group (CCG) and the emergency care intensive support team. The emergency care intensive support team last visited in September 2014. Recommendations focused on the management and prompt discharge of inpatients, increasing the number of short stay beds, further developing the older people's assessment and liaison service and ambulatory emergency care, and better aligning emergency department staffing to demand. Recommendations had been incorporated into the trust's emergency care board (ECB) plan, and progress against milestones was closely monitored both by the ECB and the trust's board.

Governance, risk management and quality measurement

- Robust governance arrangements were in place. The service regularly examined data that provided a holistic understanding of patient safety and patient experience.
- An emergency care board (ECB) reported performance monthly to the board against key performance indicators, identified risks and the ECB milestone plan.
- The corporate risk register and divisional risk register detailed the risks associated with poor patient flow, increased activity and emergency department delays. Three main areas of concern were identified: demand, staffing (medical and nursing) and beds and capacity. These risks mirrored what staff and managers told us were on their 'worry list'. An emergency care plan was in place to manage and mitigate these risks, overseen by the emergency care board, which reported monthly to the board. Poor performance in national clinical audits was not identified as a risk.
- Relationships were excellent with external healthcare partners, including the clinical commissioning group (CCG), the local community trust and the ambulance service.
- A manager from the ambulance service told us they had never worked with a trust that was so engaged with the problem associated with delayed ambulance handovers, and that the trust had worked relentlessly to find a solution to this.
- The corporate risk register detailed the risks associated with poor patient flow, increased activity and emergency department delays. Three main areas of concerns were identified: demand, staffing (medical and nursing), and beds and capacity. An emergency care plan was in place to manage and mitigate these risks, overseen by the emergency care board which reported monthly to the board.

Urgent and emergency services

Leadership of service

- There was a service-wide management triumvirate comprising senior medical, nursing and general managers. They were a well-informed, cohesive team who were highly respected by staff. They demonstrated passion and drive to meet the significant challenges in unscheduled care and to develop and improve their service.
- The local management team and departmental senor nurses were described as visible, approachable and supportive. Most staff were not familiar with more senior managers or executives and were not aware of whether they visited the department, although the director of nursing was better known.

Culture within the service

- Some staff expressed the view that although they worked for a trust-wide service they believed they were not treated the same as their sister service in Gloucester Royal Hospital. One staff member said, "Gloucester gets everything they need and Cheltenham gets what is left over." One staff member told us, "Morale hit rock bottom when we were downgraded but it has begun to improve."
- Staff told us they felt valued and respected.
- Many staff complained about parking on the hospital site. Staff paid for their parking but were not guaranteed a space. Particularly on a late shift, they frequently struggled to find a parking space. This meant that some staff came to work early just so that they could park. One staff member told us that some staff came in as much as one and a half hours before their shift began; others arrived late for their shift. It was felt that parking problems had led staff to leave. Staff were confident that their managers were aware of the problem and had raised it but no solution had been found. Staff also complained about a lack of office and meeting space.

Public and staff engagement

- The emergency department used the Friends and Family Test to capture patient feedback and was taking steps to improve response rates. Staff were regularly reminded at staff meetings to give out feedback cards. A volunteer had been employed in the waiting room three days a week to help with this.
- The service had developed close links with Healthwatch Gloucestershire, and members of this group had visited the department. (Healthwatch is a national consumer champion for health and social care which aims to ensure that the voice of the consumer is heard by those who commission and provide services.)
- There were weekly staff meetings for nursing staff. These were used to disseminate information, share learning from complaints and incidents, and celebrate successes. Meetings were recorded and minutes were circulated to all staff. Staff could suggest topics for discussion by putting them in a box in the sister's office.
- Nursing staff had not been actively engaged so that their views were reflected in the planning and delivery of services and in shaping the culture. None of the emergency department staff we spoke with could articulate the department's vision or strategy; however, they told us they were encouraged to raise concerns and felt they were listened to. At the staff meeting in February 2015, it was announced that a staff engagement group was to be launched in March, with aim of "breaking down barriers between staff and management".

Innovation, improvement and sustainability

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

Medical care (including older people's care)

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

Information about the service

Gloucestershire Hospitals NHS Foundation Trust provides inpatient medical services at Cheltenham General Hospital.

There are nine medical wards and one acute care unit. There are approximately 208 medical beds.

We visited the following inpatient wards: Avening (respiratory), cardiac and coronary care unit, Woodmancote (general medicine), Knightsbridge (respiratory), Rendcomb (oncology and haematology), Hazleton (gastroenterology), the acute care unit and the discharge lounge.

We spoke with 39 members of staff, including nurses, doctors, therapists, administrators and housekeepers. We spoke with 36 patients and six relatives. We observed interactions between patients and staff, considered the environment and looked at care records. We also reviewed the trust's medical performance data.

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

Summary of findings

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

In effectiveness, the trust's overall score for the Sentinel Stroke National Audit Programme (SSNAP) had steadily declined. Data for April to June 2014 showed a score of E on a scale of A to E, with A being the best. Cheltenham General Hospital performed worse in the heart failure audit 2012/13 compared with other trusts.

The trust consistently had a high bed occupancy rate. Systems to track patients, particularly out of hours were not robust or embedded. Access to seven-day services was variable throughout the hospital. Most services were working towards providing a seven-day service, and this had been identified on the medical division's risk register. Staff reported a lack of staffing resources to achieve this.

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

The service responded to incidents reported and demonstrated change where it was needed. Data was collected to analyse and address patient harm. The hospital was visibly clean, and staff adhered to infection control policies and procedures. There had been a

Medical care (including older people's care)

marked decrease in cases of hospital-acquired Clostridium difficile, although cases had recently begun to increase in number. Patient risks were assessed and care plans developed to keep patients safe. These included assessments for mobility, falls, pressure ulcers, nutrition and hydration. Patient records were completed well, although there were some that were not supervised or locked away at all times.

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

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

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

Patients were treated with compassion and respect. All patients we spoke with told us they were happy with the care provided.

Are medical care services safe?

Good

Safety in medical care services was judged overall as good, although some aspects required improvement.

The service responded to incidents reported and demonstrated change where it was needed. Data was collected to analyse and address patient harm. The hospital was visibly clean, and staff adhered to infection control policies and procedures. There had been a marked decrease in cases of hospital-acquired Clostridium difficile, although cases had recently begun to increase in number. Patient risks were assessed and care plans developed to keep patients safe. These included assessments for mobility, falls, pressure ulcers, nutrition and hydration. Patient records were completed well, although there were some that were not supervised or locked away at all times.

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

Incidents

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

Medical care (including older people's care)

- Safety incidents were reported using an electronic system, and staff throughout the hospital understood their responsibilities to raise concerns and to record safety incidents and near misses.
- Prior to our visit, we received information about nine incidents on Avening Ward from August to November 2014 that were not reported using this system because junior doctors felt their concerns had been ignored previously. We spoke about these concerns with senior staff, who told us the concerns had been discussed and plans initiated to address improvements to handovers and clarity about levels of responsibility, particularly out of hours.
- During our visit, medical staff told us they were encouraged to complete incident reports and were confident in using the reporting system.
- We saw learning from incidents had occurred, for example root cause analysis investigation reports had been completed for pressure ulcers of grade 3 or above. The trust had implemented further training and information for staff as a response to the incident reports around pressure areas.
- All disciplines told us they received feedback from the reports. Incidents that affected the whole staff team were discussed at multidisciplinary meetings on all of the medical wards. This was to ensure that lessons were learned from the incident investigations.
- Only permanent members of staff had access to the computer-based incident reporting system. Other staff without access to the computer system could use the telephone incident helpline.
- Some junior doctors told us the medical specialties did not regularly hold mortality and morbidity meetings. The director of safety told us regular morbidity and mortality meetings were organised at specialty level and the meetings were monitored as part of the quality framework. Each division had to confirm in its divisional quality report that mortality and morbidity meetings had taken place. We saw in the quality board minutes that the medical specialties had notified the quality board that a meeting had taken place. This was recorded in the form of a green-coloured square, which meant meetings had been held on a quarterly basis. The trust told us this was a "self-assessment of process not content". We were unable to view the minutes of the mortality and morbidity meetings and were told, "In general the note-keeping in some of the divisions is not ideal," by the director of safety at the trust. We could not be assured that meetings had taken place to enable any trends to be identified or learning to take place.
- Prior to our visit, we received information about safety concerns about Avening Ward that had been raised by junior doctors to the board and departmental consultants, and also at clinical governance and morbidity and mortality meetings. We were told these concerns had not been addressed and no plans had been made for further investigation or change in practice. However, we saw minutes of a raising concerns meeting held on 28 November 2014 where concerns were discussed and plans initiated to address improvements to handovers and improve clarity about levels of responsibility out of hours in the evening and at weekends.
- Medical staff of various grades were not familiar with the term 'Duty of Candour', but from their responses demonstrated their awareness of the need to be open when incidents occurred.

Safety thermometer

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

incidence of hospital-acquired infection they would be visited by the infection control team. The results of all the audits undertaken were discussed in monthly team meetings.

Cleanliness, infection control and hygiene

- We checked equipment for the delivery of treatment and care, including commodes, and found all items to be clean.
- There had been a marked decrease in cases of hospital-acquired Clostridium difficile, although cases had recently begun to increase in number. The rate had fallen over the period of April 2013 to November 2014, and particularly since June 2014. However, at the time of the inspection the overall trend across the trust had increased. As a result, the trust reported rates higher than the NHS England average for the months December 2014 to March 2015. These were not solely attributable, however, to the medical division. In the period January to December 2014 there were three cases reported on the medical wards which was below both the NHS England average and the target set for the hospital trust.
- We saw staff adhering to the trust's infection control policy. Information was clearly displayed above sinks in ward areas to remind staff about correct hand-washing procedures. We observed staff were 'bare below the elbows', were seen washing their hands and using hand gel appropriately, and used personal protective equipment. We saw an audit of hand-washing compliance conducted across the medical division. The trust's target was 95% compliance. We saw that staff regularly exceeded this target, with the exception of October 2014 when 94% of staff adhered to correct hand-washing techniques.
- The majority of nursing staff had completed their updated training in infection prevention and control. The trust target of 90% had been met and exceeded with 95% of the nursing staff having undertaken their training.
- The medical staff were not meeting the trust target for infection prevention and control updated training, with 77% of these staff from a target of 90% having undertaken the refresher course.
- The trust monitored clean, safe care through the Saving Lives audit tool. This tool measured the incidence of infections relating to invasive equipment such as cannulas and urinary catheters. The audit showed the majority of patients received safe care, but 20% of patients fell below the target of delivery of 100% of harm-free care.

Environment and equipment

- The wards were well lit, clean and tidy.
- Weekly equipment-cleaning checklists were completed.
- Equipment was clean and functional. Items were labelled with the last service date, and equipment stores were locked.
- All the areas we visited had portable resuscitation trolleys for use in an emergency. We inspected eight of these in the medical wards. For safety reasons they were all centrally located within the wards. The defibrillators on the top of the trolleys had been serviced and tested each day and this was documented. The trolleys contained such medication and equipment to be used in the event of a cardiac or respiratory arrest. The medication within the trolleys was stored in tamper-evident containers. However, none of the drawers within the trolleys were themselves tamper-evident so medicines could be removed between checks without this being apparent.
- Records showed that one trolley had not been checked at night because of a lack of time, and one was not covered with the appropriate cover, which was hanging at the back of the trolley. The trolleys contained medication that was to be used in the event of a cardiac arrest; however, none of the trolleys were able to be locked, and they were stored in public areas. This meant medication could have been accessed by unauthorised people. Other trolleys were seen to have been checked.
- Staff told us there were delays in repairing or replacing some ancillary equipment. A new dishwasher was ordered and arrived 10 days later on the cardiac ward. During this time, washing up had to be taken to another ward. Housekeeping staff spent lengthy periods away from the ward while they transported items, and this had a detrimental effect on their other duties.

- Housekeeping staff told us the plastic mop handles often split and were difficult to use because they hurt their hands. They were concerned that this affected the thoroughness of their cleaning. There were delays in replacing the handles.
- We saw 95 expired blood bottles on Ryeworth Ward, including 29 red-top, 4 pink-top, 25 black-top and 37 grey-top bottles. Blood samples could have been inaccurate if expired bottles had been used. We alerted the nurse in charge, who agreed to dispose of the bottles.
- Prior to the inspection, we had information from staff detailing their concerns regarding the use of old and out-of-date equipment for providing patients with continuous positive airway pressure. During the inspection, we found that equipment had been replaced and was available for patient use.

Medicines

- Controlled drug cupboards were closed and locked. However, the door to a cupboard containing intravenous fluids was unlocked on Avening Ward and could be accessed by unauthorised personnel.
- Most medicines refrigerators were secure. Temperatures were checked twice daily to ensure medication was stored at the correct temperature. Records showed that the temperature was at the recommended level. However, temperature recordings had not been made for three weeks during February and two dates in March on Ryeworth Ward, and on three dates on Avening Ward. This meant that ward staff could not have been assured that medication was stored at the correct temperature during these periods.
- Medication trolleys were securely attached to the wall when not in use.
- We found two out-of-date intravenous fluid bags containing glucose, sodium chloride and potassium chloride on Knightsbridge Ward. We alerted the senior member of staff, who disposed of them immediately.
- Nursing staff told us that there could be a delay in ordering medicines for patients being discharge from hospital. Doctors would confirm a discharge but might not be in a position to submit an order until the end of the ward round. This resulted in patients waiting for several hours until their medication was despatched.
- Pharmacy staff, including pharmacy assistants, medicines management technicians and pharmacists, visited the wards on a planned basis from Monday to Friday. We saw the necessary medicines reconciliation to ensure that patients were taking the correct medication.

Records

- We looked at 15 care plans and most were up to date. All records showed that risks to patients had been identified and care plans put in place. For example, we saw that a patient who was at risk of falls had had an assessment and had a mattress on the floor.
- Most patients' records were stored securely on the wards. However, records on Ryeworth Ward were not securely stored. There were two records trolleys, one stored adjacent to the nurses' station and the other stored in front of the nurses' station in the main corridor of the ward. Neither trolley was locked. We observed periods when no staff were present in the main corridor. There was a risk that notes could be accessed by unauthorised staff.
- Ward clerks told us there were delays in receiving medical notes from other departments in the hospital and from Gloucestershire Royal Hospital. There could be a delay of up to three days from an initial request. Nursing staff confirmed that this led to delays in obtaining a full medical history.

Safeguarding

- All staff we spoke with were able to describe what constituted a safeguarding concern and were aware of their role and responsibilities to safeguard vulnerable adults from abuse. From training records sent to us by the trust for January 2015, we saw the trust ran two safeguarding courses and that the target for attendance was 90%. For the medical division trust wide, we saw that 93% of all staff in the medical division had attended the safeguarding adults' awareness course. Of staff in the medical division, 88% had attended the safeguarding awareness level 2 course.

Mandatory training

- Staff we spoke with told us they were able to attend regular mandatory training in subjects such as manual handling, fire and infection control. The trust's target for attendance at study days was 90% of all staff. Between

August and November 2014, we saw that between 91% and 93% of staff had attended training. This meant staff ensured they remained up to date with their skills and knowledge to enable them to care for patients appropriately.

Assessing and responding to patient risk

- Each specialty had a risk register that documented risks in its areas. Risk assessments were in place relevant to patients' needs. These included assessments for mobility, falls, pressure ulcers and nutrition.
- All ward areas used an early warning score to determine whether patients were at risk of deteriorating. We saw in the patients' records we reviewed that the early warning scoring system had been used appropriately.
- Before our visit, we received information about an incident on Avening Ward where a patient receiving positive airway pressure had been transferred from acute assessment unit C without a handover to ward doctors. Senior staff told us registered nurses had attended further training delivered by the consultant and a senior nurse to enable staff to care for patients who required such treatment.

Nursing staffing.

- Monthly nursing metrics audits were conducted. The audit was an assessment tool used by the trust to monitor the safety and quality of care delivered. This included areas such as staff vacancies, completion of early warning scores and monitoring of hospital-acquired infections. The results of the audit were analysed by the clinical audit department, and any areas for concern were fed back to senior ward staff and discussed in the divisional quality report. Action plans were produced to address any concerns. Most ward staff were not routinely aware of how their ward performed on the nursing metrics assessments, because the results of the audits were not displayed. Ward staff told us they relied on their managers to pass on relevant information.
- We saw bank staff working on most wards. Staff told us there were recruitment and retention issues, with eight trained nurses having left acute assessment unit C in the last three months. Promotion and horizontal moves had created gaps in the establishment.
- We saw nursing handover sheets that contained information about current diagnosis, past medical history and plans for discharge. We observed ward nurses using the sheets throughout bedside handovers. Information was discussed about care needs, and patients were included in these discussions to ensure information was correct.
- Staff confirmed that additional staff were employed when patients required one-to-one care, for example mobile patients with cognitive impairment who required constant monitoring.
- Staff told us that the shortage of parking for staff had impacted on the start of some nursing shifts, particularly late shifts. Staff allowed at least an hour to find a space and sometimes missed the start of handover.
- Staff from all ward areas felt there were times when there were not enough staff to enable them to care for patients appropriately. Periods of absence were not always covered by bank or agency staff. Patients told us they had to wait a long time for their buzzers to be answered. During our inspection, most wards were staffed as planned and any gaps in staffing had been filled by bank or agency staff to ensure that enough staff were available to care for patients.
- During our unannounced inspection, which took place out of hours, we saw that wards were fully staffed.
- From data sent to us prior to the inspection, a 3.67% nursing vacancy rate across the medical division was recorded.
- We saw that use of agency and bank nurses was lower than in some areas at Gloucestershire Royal Hospital. For example, between September and November 2014, the percentage was between 8.9% and 11.2% on Avening Ward, between 8.7% and 11% on Knightsbridge Ward, and between 1.9% and 5.2% on Rencomb Ward. Ward staff told us they tried to ensure the same agency and bank staff were employed on the ward to give continuity of care to patients. The trust had identified that recruitment of nurses was an issue, and had recently visited other countries to recruit nurses.

Medical staffing

- During our focus group meetings and throughout our inspection, junior and middle grade doctors raised their concerns about staffing levels, particularly out of hours.

Medical care (including older people's care)

- During our out-of-hours inspection, we had difficulty finding a doctor. We asked to speak to the doctor at 9.30pm; however, the doctor was busy treating patients. We spoke with the doctor at 11pm and they told us they were required to cover six wards while on duty.
- Junior doctors told us they regularly worked over their contracted hours, by up to two hours each day, because of the volume of patients they were treating and extensive paperwork.
- Prior to our visit, concerns were raised about the handover of patients from acute assessment unit C to the wards. During our visit, doctors and nurses told us that patients often arrived on the ward with no medical or nursing handover. Some consultants we spoke with told us they were conducting a project to address the concerns about handover of care on acute assessment unit C.
- From information sent to us before the inspection, we saw that between September and November 2014, agency locum rates were between 2.0% and 3.5% for the medical division.

Major incident awareness and training

- The trust had a major incident plan and a business continuity plan. The major incident plan identified staff responses to different types of incident. Staff we spoke with were aware of their role in the event of a major incident and the implications for their ward area.

Are medical care services effective?

Requires improvement

The trust performed worse than the national average in the Myocardial Ischaemia National Audit Project (MINAP) (20012/13) and the heart failure audit for 2012/13.

The endoscopy service attained Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation, while the trust was worse than the England average for 13 of the 21 patient-related questions in the September 2013 National Diabetes Inpatient Audit.

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

We observed good multidisciplinary team working across Cheltenham General Hospital.

Evidence-based care and treatment

- The Joint Advisory Group on Gastrointestinal Endoscopy (JAG) defines and maintains the standards by which endoscopy is practised. The service at Cheltenham General Hospital had been assessed and met the accreditation standards framework.
- Patients with heart failure did not always receive treatment in line with National Institute for Health and Care Excellence (NICE) guideline CG187, which states, "Ensure that all people being admitted to hospital with suspected acute heart failure have early and continuing input from a dedicated specialist heart failure team."

Pain relief

- Patients told us their pain was regularly assessed and managed.
- The Abbey Pain Scale tool was used to assess whether patients were experiencing pain when they had difficulty communicating.

Nutrition and hydration

- Patients were assessed for their nutritional and hydration needs and referred to a dietician if required.
- Patients were mainly positive about the food provided. They told us there was sufficient food and drink, and that they were offered a choice. Sandwiches were available if choices were not available. Food was always hot.
- Meal times were protected on wards, and dining tables were available in the bays on Woodmancote Ward for patients to use at meal times. Patients were encouraged to sit at the dining tables to aid their recovery.
- On several wards we audited whether patients had a drink within their reach and whether the fluid charts had been completed. We found that 100% of patients could reach a drink. A fluid balance chart for one patient had not been completed.

Patient outcomes

- The trust participated in the National Heart Failure Audit 2012/13 and performed below the national average. For

example, 26% of patients had input from a specialist doctor compared with the England average of 78%, and 55% of patients received an echocardiogram compared with the England average of 91%.

- The Myocardial Ischaemia National Audit Project (MINAP) showed that 81% of patients were seen by a cardiologist or member of the team, compared with the England average of 94%, 41% were admitted to a cardiac unit or ward compared with the England average of 53%, and 95.2% were referred or received an angiography compared with the England average of 73%.
- The standardised relative risk of readmission for elective clinical haematology was higher than the England average.
- The older person's advice and liaison team benchmarked results with other trusts and was part of the Acute Frailty Network to ensure outcomes for patients were met.
- The trust was worse than the England average for 13 of the 21 patient-related questions in the September 2013 National Diabetes Inpatient Audit. Results indicated issues regarding medication errors and foot care.

Competent staff

- All of the staff we spoke with told us they had recently received an appraisal.
- In the data sent to us by the trust, it was recorded that 80% of medical staff and 87% of nursing staff had received an appraisal from July to November 2014.
- Ward staff had appropriate training to meet the needs of the patients they supported. For example, the care of the acutely ill course enables nurses to develop further skills to care for patients.
- Staff on Avening Ward told us they had regular training to enable them to support patients with tracheostomies.
- Nursing staff told us they were encouraged to attend further training to develop their skills and knowledge, and were able to access study leave. However, non-clinical staff told us that access to further study and development was limited.

Multidisciplinary working

- Staff reported good multidisciplinary team working, with daily meetings to discuss patients' care and treatment.
- We observed two handover discussions about patients' needs, which included medication, 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) status, care planning, nutritional assessment and allergies.

Seven-day services

- Junior doctors told us that they covered six wards at night, and we observed this to be the case.
- We found access to seven-day medical services across the hospital was variable. Most services were working towards providing a seven-day service, and this had been identified on the medical division's risk register. Staff reported a lack of staffing resources to achieve this.
- There was a 24-hour a day, seven days a week rota for medical staff to provide cover for any patients who had gastrointestinal bleeds that might require further investigation.
- A dispensary was open for medication during the day at weekends. A pharmacist's presence on the ward at weekends was limited to new medical admissions to the ward. There was a 24-hour chemotherapy helpline. Patients were able to call the helpline and obtain advice and support from trained nurses and a medical registrar.
- There was an assisted discharge scheme for respiratory patients, which operated seven days a week. Two respiratory nurse specialists had recently undertaken a pilot scheme to offer support to patients seven days a week. However, one nurse told us that a seven day a week service was not sustainable in the long term, because they had to work over their contracted hours to ensure a seven-day service was provided.
- Weekend discharges were problematic. A review of weekend and the time of day discharges showed that few patients were discharged at the weekends. Recommendations were made that the seven-day-working project should include a focus on delivering discharges seven days a week.

Access to information

- Staff told us there was sufficient information in patients' care records to enable them to care for patients appropriately.

- Information was displayed on computerised screens by the nurses' station. Staff could access test results, care records and other relevant information about patients on the ward.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Ward staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005). They were clear about processes to follow if they thought a patient lacked capacity to make decisions about their care.
- We heard discussions during our visit about patients' capacity and how to support patients to make decisions about their care.
- Patients we spoke to confirmed that explanations were given by staff so they could agree to or decline tests or procedures.
- We saw documents in patients' records showing their consent to the care planned.
- We did not see any patients subject to Deprivation of Liberty Safeguards during our inspection.

Are medical care services caring?

Good

We saw that patients were treated with compassion and respect. All the patients told us they felt safe and were happy with the care provided by the staff.

We saw staff explaining treatment plans to patients and their families, and witnessed positive interactions between staff and patients.

Most patients felt they had enough information about their medical condition and treatment, and emotional support was offered.

Compassionate care

- Care was delivered in a kind and respectful way.
- We heard staff introducing themselves to patients and explaining what they were going to do.
- Patients told us they were happy with the care provided by staff. Comments included, "Staff are very kind," "Staff are wonderful and so patient," "Nothing is too much trouble," and "I never feel an inconvenience."
- Three patients commented that nurses were very busy but always had time for them.
- We observed staff with an agitated patient who was trying to leave the ward. They spent 15 minutes reassuring and reorienting the patient, and encouraged the patient to return to their room.
- Patients told us they felt involved in decision making about their treatment and care.
- We observed a therapy session assessing functionality at home. The patient and their family were encouraged to discuss options available.
- Patients and relatives told us information was clear and understandable.
- The medical division used the Friends and Family Test to capture feedback about patients' experiences at the hospital. Between April 2013 and July 2014, the average trust-wide response rate was 18.8% compared with the England average of 30.1%. The response rate for Cheltenham General Hospital was 19.8%. Between April 2014 and July 2014, monthly results for the Friends and Family Tests showed that over 70% of patients receiving medical care would be either likely or extremely likely to recommend the service.
- We audited whether patients could reach their call bells on three wards. We found that out of the 14 patients audited, 12 patients had their call bell within reach. This meant the majority of patients were able to alert staff using the call bell if they required assistance. We alerted staff to the two patients who were unable to reach their call bells.
- Patient-led assessments of the Care Environment (PLACE) 2014 scored the trust as 88 for privacy, dignity and wellbeing compared with the England average of 84.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- We heard nurses explaining to patients and relatives the treatment and care they were delivering. Information was provided sensitively, and patients were given time to ask questions.
- Patients and relatives told us that they were involved in decisions about care, treatment and discharge.
- We heard ward clerks answering phone calls from patients' relatives about their care, and relaying feedback following discussion with an appropriate nurse.
- The Cancer Patient Experience Survey 2013/14 showed that the trust was in the middle 60% of trusts for patients definitely being involved in decisions about care and treatment, and in the bottom 20% of trusts for the patient's family definitely having an opportunity to talk to a doctor. The trust was in the top 20% of trusts for hospital staff doing everything to control pain all of the time.

Emotional support

- The Cancer Patient Experience Survey 2013/14 showed that the trust was in the middle 60% of trusts for patient being able to discuss worries or fears with staff during their visit.
- Patients and relatives told us they would feel comfortable approaching a member of staff if they needed support.
- Patients had access to mental health professionals if required.
- Staff told us that they received emotional support from ward managers and peers.

Are medical care services responsive?

Requires improvement

The trust regularly had a bed occupancy rate of above 91%. It is recognised that bed occupancy rates above 85% can start to affect the general running of the hospital and the quality of care given to patients.

Tracking of patients out of hours was not always accurate, and although a pilot programme was in place to improve evening and weekend handover, the system had not been embedded and required monitoring and evaluation.

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

A mobile chemotherapy unit was available to enable patients to receive chemotherapy closer to their homes.

Service planning and delivery to meet the needs of local people

- The trust had a mobile chemotherapy unit. This meant patients were able to receive their chemotherapy medication closer to their homes and prevented the need for them to travel to the hospital on a regular basis.
- Some respiratory patients who were admitted to hospital were eligible for the assisted discharge scheme. Patients who were identified as suitable for care at home were given nurse and physiotherapy support in their homes.
- We observed a trust bed management meeting. These were held on twice daily; however, during our inspection, extra meetings were held because of the lack of availability of beds for patients. Immediate decisions were made to manage the bed situation across the trust. We saw a list of medical outliers, and discussions were held to ensure patients were in the optimal place for their care. The trust took part in a twice-daily teleconference between commissioners, the local authority and the trust. The aim was to discuss the availability of beds and the flow of patients and instigate any changes that might facilitate a more timely patient discharge.
- Respiratory specialist nurses provided a link between the hospital and home for patients who had long term respiratory disease. The nurse specialists monitored people in their homes, which prevented unnecessary admission to hospital.
- Patients with respiratory diseases were supported in the community. The nurses administered intravenous antibiotics and coordinated prescriptions to enable

patients to stay at home. If a patient was required to be admitted to hospital, the specialist nurses coordinated their care and monitored their outcomes whilst in hospital.

Access and flow

- The trust regularly had a bed occupancy rate of above 91%. It is recognised that bed occupancy rates above 85% can start to affect the general running of the hospital and the quality of care given to patients.
- The trust operated a single point of access system, which meant all admissions to the hospital went through the emergency department. The emergency department doctors decided which specialty was appropriate, and patients were allocated to the medical team in the acute assessment unit C medical wards or outlying wards.
- Ward and medical staff told us any medical outliers (patients admitted to a ward that was different from their specialty, for example a patient with a respiratory illness being admitted to a surgical ward) were identified electronically. A daily list was produced which all medical specialties had access to and which identified medical outliers.
- At night, a system was in place to enable the medical team to track patients in acute assessment unit C and the wards. The system was partly computer based and partly paper based. Patients remaining in acute assessment unit C were tracked on the computer system, and patients moving to a ward were logged on a sheet attached to a clipboard. The lists had to be married together to gather a complete list of patients. Staff were concerned that patients might slip through the system and "go off the teams' radar".
- Junior doctors told us there was no trust-wide induction to this tracking system. We were advised that a pilot programme was in progress to deliver a site-specific induction to the system.
- We saw minutes of the trust's raising concerns meeting dated 28 November 2014, where concerns were discussed about a lack of clarity about who was responsible for patients out of hours when they were discharged from acute assessment unit C to the wards. A driver diagram had been developed in January 2015 to show the handover process during the evening and at weekends, with a medical registrar leading the handover in the evening and at 4.30pm on Fridays for the weekend.
- Staff told us that discharge planning was started on the day of a patient's admission. During our visits, we saw that planned discharge days for each patient were displayed on the computerised board on each ward. We noted that some patients had not been discharged on the planned day. Staff told us there were often delays for more complex patients, due to lack of community placements and funding difficulties.
- There was an integrated discharge team within the trust to help facilitate patient discharges. The team consisted of nurses, physiotherapists, occupational therapists and social workers. Members of the team attended daily ward rounds to ascertain which patients were ready for discharge. The team supported patients to ensure they were able to be discharged home in a timely manner. For example, if a patient required mobility assessments prior to discharge, a physiotherapist ensured the assessments were completed. The team had requested more administrative staff to support the team.
- There was a discharge lounge with waiting chairs and three beds available in individual bays. The unit opened in November 2014 and was currently shared with the pre-assessment unit. The discharge lounge was open from 9am to 9pm and was staffed by a registered nurse and healthcare assistant.
- Staff told us that the discharge lounge was working well, although waiting times for transport sometimes delayed discharge. The trust had recently conducted a review into weekend and the time of day of discharges to improve the patient flow throughout the trust. The review concluded that obstacles to effective discharges were the lack of weekend discharges because of limited staff availability, a historic culture that discharges don't happen on a weekend, and difficulty in organising community placements or support for patients over a weekend. The report made recommendations, some of which were to improve the discharge of patients before 12 noon and the role of the ward coordinator to facilitate effective discharge.

Medical care (including older people's care)

- Staff told us that patients being transferred for cardiac surgery to hospitals that were out of the area, for example in Oxfordshire, were often delayed as a result of strict transfer criteria imposed by the receiving hospital.
- Since February 2014, the referral-to-treatment time performance had fallen, but it had been better than the England average since August 2014.
- The average length of stay for non-elective admissions to Cheltenham General Hospital was 6.1 bed days, which was a lower length of stay than the England average for non-elective admissions, of 6.8. The average length of stay for elective admissions at Cheltenham General Hospital was 4.1 bed days compared with the England average of 3.9.
- The cancer waiting time target for people waiting less than 31 days from diagnosis to first definitive treatment for all cancers was 93%. The trust was consistently above this target each quarter between April 2013 and December 2014.
- The cancer waiting time target for people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was 85%. Between April 2013 and December 2014, the trust had met the target in two quarters (quarter 1 2014/15 and quarter 2 2014/15). Figures for the latest quarter (October 14 to December 14) showed that the trust did not meet the target (only 78.6% waited less than 62 days).

Meeting people's individual needs

- We saw communication books being used for patients on a variety of wards**.** The books were used for patients who struggled to communicate verbally. Ward staff told us they would also use the books for patients who did not speak English.
- Each ward had posters and leaflets displayed informing patients about a variety of medical conditions. All the information was in English. Staff told us they did not have access to written information in other languages.
- The trust used a purple butterfly to help identify patients with cognitive impairment. Purple butterflies were in place on the main ward computer board to alert staff that patients might require extra support with some areas of their care. Most patients also had purple butterflies behind their beds to act as a reminder for staff. However, patients did not always have further documentation to support their care. For example, 'this is me' documentation was not always completed in a timely manner. (The 'this is me' document details information about each patient's likes and dislikes, previous life history, hobbies and so on. The document is used to enable staff to care for people who might have communication difficulties.)
- Senior staff on Ryeworth Ward told us the 'this is me' document was often given to patients' relatives to complete, and they were reliant on them providing the details.
- Most wards had dementia champions, who attended further training to enable them to support patients more effectively and cascade information when required.
- A range of leaflets were available on most wards, including information about ward-specific diseases and procedures, health advice and general information relating to health and social care and other services available locally.

Learning from complaints and concerns

- None of the patients we spoke with had any complaints about the care and support they received.
- Staff told us if they tried to resolve any complaints and concerns as they arose.
- In some wards across the hospital, a 'you said, we did' board was displayed. The aim of this board was to show the response of the ward to any complaints or concerns raised by patients and relatives who had visited the ward. We noted that the comments and complaints were the same on every board across the trust and did not reflect any particular information pertinent to individual wards.
- We read in minutes from the divisional quality board that complaints were discussed at a divisional level.

Are medical care services well-led?

Requires improvement

There was poor monitoring of the mortality and morbidity meetings. Specialties were required to notify senior management that the meetings had taken place; however,

we were not able to view any minutes of these meetings for the medical division. Therefore we could not be assured that meetings had taken place to enable any trends to be identified or learning to take place.

The directors of the medical division were passionate about providing a high quality service. The service was clinically led; however, they felt they lacked sufficient autonomy to enable them to drive improvements and instigate change. Significant problems existed which the leadership were not yet tackling effectively.

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

Vision and strategy for this service

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

Governance, risk management and quality measurement

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

Leadership of service

- Senior staff told us the division was clinically led, which meant the needs of patients were paramount in their day-to-day work and in the service's plans for the future. However, we were told that senior teams would like more autonomy in their decision-making processes and did not have the freedom to make decisions on a day-to-day basis. For example, we were told senior management were not able to arrange locum doctors if medical cover was required. We were told they had "the responsibility but not the power".
- All the managers we spoke with told us that their teams worked hard within a busy environment.
- All staff were aware of their immediate managers and felt supported by them.
- We were told that matrons were visible and easy to approach.

Culture within the service

- Staff were positive about working for the trust, although at times they told us they felt under extreme pressure because of the volume of patients in Cheltenham General Hospital.

Medical care (including older people's care)

- Nursing staff told us there was an open culture and they felt confident about raising concerns.
- Junior doctors consistently told us they often did not feel listened to when they raised concerns.

Public and staff engagement

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

Innovation, improvement and sustainability

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

Surgery

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

Information about the service

Surgical services provided at Cheltenham General Hospital are both elective and emergency surgery. The surgical specialties include general surgery, trauma and orthopaedics, breast, urology, vascular, ophthalmology and interventional cardiology.

The operating department at Cheltenham General Hospital has 15 theatres. There is a recovery room located in main theatres and at the other theatres located throughout the hospital. Cheltenham General Hospital has six surgical wards, two day surgery units and a surgical admissions unit for some orthopaedic patients.

We visited Prescott, Guiting and Dixton surgical wards, the preadmission clinic, Kemerton and Chedworth Suite (both day surgery units; one is for female patients and the other for male). We spoke with 25 staff, including theatre managers, the head of nursing, matrons, ward sisters, consultants, doctors, junior doctors and nurses. We also talked with healthcare assistants, pharmacy staff and physiotherapists. We spoke with 22 patients. We observed care and looked at five sets of patients' records. We reviewed data provided in advance of the inspection.

Interventional radiology is mentioned in this report; however, its management arrangements come under the diagnostic and specialties division at this trust.

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

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

Surgery

Summary of findings

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

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

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

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

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

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

The trust participated in national and local audits, including the national bowel cancer audit, in which the trust was above (better than) the England average. The trust had identified where it required an external review of one of its services for fractured neck of femur. The average length of stay was slightly longer at Cheltenham General Hospital compared with the England average.

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

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

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

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

Governance systems were in place for monitoring the services. These fed into the divisional management team, and any serious risks were shared with the executive board.

Surgery

Are surgery services safe?

Good

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

Incidents

- Staff told us they were encouraged to report incidents on the computer system. However, not all staff said they received feedback after reporting any incidents. The divisional surgical management team told us it was working on how to improve the feedback to staff following any incident reported, as the system gives no automatic feedback to the member of staff reporting the incident. All staff who worked for the trust had access to the system for reporting incidents on their computer system. To assist staff, a helpline was also in place. The divisional surgical management team felt that not all incidents were reported because of the changeover from paper reporting to the computer system and the disengagement of staff because of concerns with feedback. The divisional surgical management team had identified an area where reporting of incidents had reduced. The team told us that the management for this area were working with staff to improve this.
- All ward or unit managers, lead nurses and the director of nursing for the surgical division reviewed all reported incidents. One ward sister told us they would complete the investigation into some incidents, for example falls with harm. They then fed back any learning to the ward or unit staff at their meetings. Incidents were also discussed at the monthly clinical governance meetings for each division. Any incident that was rated as 'orange' was also examined by the risk manager for the trust.
- The divisional surgical management team told us about the learning that had been shared with all staff at both locations following a serious incident. The incident had highlighted some areas of concern that affected both Cheltenham General Hospital and Gloucestershire Royal Hospital. One of these was about nurses not feeling able to contact consultants if they were concerned about a patient. They told us they had discussed this with consultants at a recent meeting and with student nurses on induction. We spoke to ward sisters and staff nurses, who all told us they would contact a consultant directly if they were concerned about the condition of a patient.
- The manager for the central sterile services division told us if there was an incident with the equipment provided to theatres, it would be documented on the computer incident-recording system and they would be notified of it.
- The trust had reported one Never Event in December 2014 for interventional radiology, which was wrong-site surgery. This incident had been thoroughly investigated and an action plan was in place. The divisional surgical management team told us this incident took place in one of the specialist theatres, and changes to practice had been made with a World Health Organization (WHO) surgical safety checklist due to be implemented for these procedures. Interventional radiology staff told us the WHO checklist had been recently implemented but no audit of its use had been undertaken.

- Staff were able to tell us about the principles of the Duty of Candour regulations. They told us the aim was to be open and transparent with patients following incidents and to apologise to them.
- Within the surgical division, a total of 13 incidents were reported to the Strategic Executive Information System (STEIS) for the year January 2014 to December 2014. These incidents were, for example, pressure ulcers, slips/trips/falls and delayed diagnoses. We saw that these were discussed in the division's governance meetings and learning was shared with staff in ward or unit meetings.
- We saw records of the morbidity and mortality meetings. These were held for each of the surgical specialties, for example upper gastrointestinal surgery, general surgery and breast surgery. We saw presentations where each specialty discussed individual cases and the learning required.

Safety thermometer

- NHS Safety Thermometer information was routinely displayed in the ward areas. This tool enabled wards and units to measure harm and the proportion of patients that were harm-free from pressure ulcers, falls with harm, urinary tract infections with catheters and venous thromboembolism (VTE, or blood clots) during their working shifts.
- On the wards we visited we saw the wards' nursing metrics displayed. This included early warning scores and the actions taken by staff, the number of falls and staffing levels, including the number of trained and untrained staff. Some of the information was inconsistent. For example, the safety thermometer showed no falls but the nursing metrics stated there had been falls. It was difficult to see the explanation for this, as the font was very small, but the safety thermometer was taken on one day each month whereas the nursing metrics covered the whole month.
- On Dixton Ward the safety thermometer and nursing metrics was displayed. The safety thermometer stated the ward had had no falls, pressure ulcers or urinary tract infections and that all VTE assessments had been completed. The nursing metrics said the ward had a total of seven falls for the months January and February 2015. There was one medication error. There had been no complaints, pressure ulcers or staff vacancies.

Cleanliness, infection control and hygiene

- Cleanliness and control of infection were managed effectively.
- Each ward had information about hand hygiene and cleanliness scores on display. Hand hygiene scores for the surgical division had an average of 100%, with the trust's average being 97%.
- The surgical division dashboard for November 2014 said there was 10 cases of Clostridium difficile between December 2013 and November 2014. The overall trust's target maximum for the year was 55 cases.
- Although the trust did not have a trust-wide audit for methicillin-resistant Staphylococcus aureus (MRSA) screening to make sure patients were being screened prior to elective and emergency surgery, it did have systems in place to monitor this. For example, at a patient's first outpatient appointment, when the patient was reviewed by a consultant or registrar and the decision made to have surgery, an MRSA screen was taken. This was followed up at either the preadmission assessment or on admission. The admission records for patients asked for details about the MRSA screening process. The trust's audit plan from April 2015 will include an MRSA audit to assess compliance with policy, as its policy was updated in 2014.
- The surgical division infection control report for January 2015 (which had data from November 2014) said the division had had three patients identified post 48 hours with MRSA.
- All staff were 'bare below the elbows' in wards and theatre areas, in line with hygiene recommendations.
- The surgical site infection rate for Cheltenham General Hospital from October 2014 to December 2014 for total knee replacement surgery was 1.3% lower than the five year England national average of 2.2%. The rate for hip replacements was 1.3 % lower than the five year England national average of 1.3%. For the trust overall for total knee replacements was lower at 0.7% and for hip replacements they were lower at 0.2% than the five year England national average.

Environment and equipment

- Cheltenham General Hospital had one mobile theatre that was located away from the main theatre area.

Patients had to walk from the day surgery areas to the mobile theatre. A criterion for patients operated on in this unit was in place, and the unit only had 'low risk' patients.

- Resuscitation equipment on each ward and in theatres was checked daily, with records in place showing completion.
- Medication within the resuscitation trolleys was stored in tamper-evident containers. However, none of the drawers within the trolleys were themselves tamper-evident so medicines could be removed between checks without this being apparent.
- Staff told us surgical equipment was tracked and traced and we saw records of this in patients' notes. This was important in case any issues with patients or the equipment after surgery were identified and needed to be followed up.
- Equipment provided by the central sterile services division was also traceable. We saw the tracking stickers from this equipment in patients' notes.
- We were told by some staff that some kits, especially for orthopaedic surgery, often had missing contents. For example, prior to our inspection, plates and some screws for an orthopaedic patient were missing.
- The manager for the Central Sterile Services Department told us the majority of endoscopes used in Cheltenham General Hospital were cleaned in the endoscopy department because it had all the specialist cleaning equipment to undertake this task.
- The theatre manager told us they had issues with operations being cancelled due to lack of equipment/ prostheses, and at times had used loan equipment. The department now had a sole provider of all hip and knee prostheses to reduce the complexity of ordering and tracking this equipment.
- In theatre, a stock control manager arranged orders, loan kits, trays and specialist orders. The theatre manager told us this was an invaluable appointment, as the stock control manager made sure all the equipment required for operations was available to prevent operations being cancelled.
- Specialist equipment, including specialist anaesthetic equipment, was available to support bariatric patients.
- The equipment maintenance policy was under review at the time of our inspection.
- Both the Kemerton and Chedworth Suite day surgical units were not routinely supplied with sheets and bedding, as they used trolleys. When these units were used for patients out of hours and at weekends, the units had to arrange for beds and bedding to be delivered. Both units did have toilets and shower facilities for patients to use.

Medicines

- We were shown the pathway the trust had in place for patients who were taking warfarin in the pre-assessment clinic. This contained four protocols for staff to follow depending on the patient's condition and international normalised ratio results. The staff told us the anaesthetist decided which protocol to follow for the patient.
- We reviewed the medication arrangements for Prescott Ward. The trust had developed and printed its own style of controlled drugs register for patients' own controlled drugs. This was to make sure accurate records for such patients' medication were in place.
- Patents with their own controlled drugs were listed on a whiteboard on the controlled drug cupboard door to help ensure the patients took all their medicines home with them.
- Medicines dispensed for an individual patient but not labelled for discharge had an additional yellow label attached stating, "NON-STOCK DO NOT SEND HOME WITH PATIENT".
- Medicines, including controlled drugs and most of those requiring refrigeration, were stored in line with the trust's policies. Appropriate actions were taken when locks were broken or medicines were stored outside their recommended temperature ranges.
- Pharmacy staff, including pharmacy assistants, medicines management technicians and pharmacists, visited the wards on a planned basis from Monday to Friday, including a 'mop up' visit later in the day.
- Out-of-hours nursing staff could search the pharmacy computer system to identify other wards stocking a particular medicine, reducing the need to contact the on-call.

- When the pharmacy was not available to assist with discharge medicines, two nurses were able be involved in the discharge, and the ward had a stock of frequently required medicines as 'to take out' (TTO) packs.
- Not all medicines requiring refrigeration were stored securely; the refrigerator for storage of total parental nutrition was not locked in a public area. This meant unauthorised people had access to the medicines.
- A non-tamper-evident resuscitation and anaphylaxis trolley and a separate oxygen cylinder were available; records indicated these were checked daily. (Daily checking signature record stated 1st line drugs (sealed) ticked & anaphylaxis box sealed ticked. However, Pharmacy had stopped supplying the 1st line drug box two to three years ago.
- Not all the TTO packs complied with the labelling requirements for a medicine supplied against a prescription or the trust's own documentation. The TTO packs were of two types: where the medicine was a prescription-only medicine, the pack was 'over-labelled' with a label complying with the regulations (showing dispensing address, patient's name, date of dispensing, drug, form strength, quantity and directions, including cautions). Where the medicine was a pharmacy only medicine or general sales list medicine, whilst the drug, form strength, quantity, and directions including cautions were stated, the dispensing address, patient's name and date of dispensing could not easily be added.
- When a patient's discharge medicines were a combination of medicines available in the ward's TTO cupboard and the pharmacy, the pharmacy would dispense the pharmacy lines but not those in the TTO cupboard. The nursing staff would then supply the other required medicines from the TTO cupboard, which they found frustrating.
- We also reviewed the medication arrangements in the mobile theatre. We found that staff had highlighted the location of a reversal agent unique to theatres to aid them in obtaining it in an emergency.
- Intravenous paracetamol had been separated from intravenous metronidazole because of packaging similarities and to reduce the potential for any errors.
- Controlled drugs were stored securely and records kept.
- Whilst medicines cupboards were locked at night they were not secure (could be lifted off the wall).
- Not all reversal agents were available in the mobile theatre. This could potentially place patients at risk. When this was raised with staff, they resolved the issue.
- Whilst medical gas cylinders were kept in a locked compound, the cylinders were not stored safely and used and full cylinders were not segregated.
- The antibiotic compliance audit showed that three surgical wards were just below the 95% target.

Records

- Nursing records were held at the end of patients' beds and at the nursing station. Medical records accompanied patients to and from theatre.
- Records were comprehensive and included details of the patient's admission, risk assessments, treatment plans and records of therapies provided. Preoperative records were seen, including completed preoperative assessment forms.
- On Prescott Ward, we found that patients' notes were not stored in a secure trolley and they were positioned in the main corridor area where they were easily accessible to visitors.

Surgical safety

- We observed the use of the World Health Organization (WHO) surgical safety checklist in all theatres. The National Patient Safety Agency recommended that this process be used for every patient undergoing any surgical procedure. It involved a number of safety checks designed to ensure that staff avoided errors.
- The divisional management team told us it was revisiting the use of the WHO checklist. It was re-engaging staff in its use to make sure the checklist is not being used as a tick-box exercise.
- We saw the results of the WHO audit undertaken by the Matron for the theatres in December 2014. This had some areas rated as green and met the target; some areas were rated as amber or red. For example, clear announcement of safety checks was rated as amber. This related to silence during the checks. This meant not

all staff were following the safety procedures correctly. The trust told us this audit covered both the completion of the form and the clinicians input which was good practice.

- Interventional radiology had recently introduced the use of the WHO checklist for patients undergoing procedures. This was following a Never Event.
- Eyeford theatre staff had a team meeting every morning before theatre lists commenced to discuss the work for the day ahead.
- Following a Never Event in gynaecology, changes had been made in theatre to the swab boards (this was where details about swabs used in each operation were recorded). Each theatre had the same board to make sure there was consistent practice across the trust.

Safeguarding

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

Mandatory training

- Staff in the preadmission unit said they were at 98% for their mandatory training.
- We saw the training figures for nursing staff for mandatory and statutory training for the surgical division. This included fire, infection control, moving and handling and code of confidentiality. All these were over the trust's target of 90%. Basic adult resuscitation training was just under the 90% target, at 89%.

Assessing and responding to patient risk

- Some patients for elective orthopaedic surgery attended a preoperative assessment clinic where all the required tests were undertaken, for example blood tests and an electrocardiogram (ECG). MRSA screening was undertaken in the outpatient clinic prior to the patient's pre-assessment visit. Staff told us they needed to contact anaesthetists if they thought that patients required further medical assessment. The nursing staff checked on any test results, including MRSA. They also started the care pathway for the type of surgery the patient was receiving.
- On admission, patients had an assessment for the risk of venous thromboembolism. Evidence of the actions taken where risks were identified was recorded. For example, we saw patients had been prescribed anticoagulants or were wearing anti-embolism stockings. On checking these in several patients' notes we found these had been completed on admission and within the required timescale as directed on their form. The divisional management team told us it had identified issues with VTE, as this trust used to be rated as one of the top trusts but was now in the bottom 20%.
- We saw audit results for the surgical division for VTE assessments. These were done weekly and included day cases and inpatients. We saw for some weeks all wards and units had nearly met the 100% target, where on other weeks the scores varied.
- We observed patients being seen by the anaesthetist and surgeon/registrar before their surgery to assess their risk score for anaesthesia and to confirm the planned surgery.
- The trust used the National Early Warning Score (NEWS). This tool is used to aid recognition of deteriorating patients, based on scored observations including temperature, pulse, blood pressure and respiratory rate. A high total score activated an escalation pathway outlining actions required for timely review to ensure appropriate interventions for patients. These were clearly documented on the form. Staff explained how they used this tool and when they would contact doctors for additional support.

Nursing staffing

- The preadmission clinic told us it had the required allocation of staff.

- Kemerton and Chedworth Suite staff told us they had the correct number of staff for their allocation. Bank and agency staff were being used to cover the units at night and weekends when they were open due to pressure on beds. This meant that patients might not have had continuity of care and their needs met.
- The staff on Dixton Ward told us the ward had two trained nurses on a night shift. They said there had been three incidents between January 2015 and March 2015 where a trained nurse was removed from the ward and replaced with a healthcare assistant. They felt this was unsafe, because of patients being returned from theatre and this ward being all side rooms. This had been shared with their line manager and raised with one of the directors.
- Prescott Ward was five staff down due to maternity leave and being unable to recruit to fill the roles. The ward staff said they were working at their allocated numbers but the ward had a high number of patients with complex needs and often had admissions direct to the ward.
- The staffing levels for theatres, including anaesthetics and recovery for emergency activity, were not meeting the Association for Perioperative Practice (AfPP) guidelines. Staff told us this was on the risk register.
- The theatres on Eyeford Unit had lost four full-time members of staff in the last six months. They had recently employed two new staff, and a further two were due to start shortly. Every day, a team of staff was sent over from the main theatres suite for recovery and anaesthetics. They had their own dedicated scrub team.
- The mobile theatre unit had an extra member of staff rostered, because of its location which was away for the main theatre suite.
- The surgical division had a 4% nursing vacancy rate.

Surgical staffing

- This trust had slightly more consultants, at 42%, compared with the England average of 40%. It had 15% middle grade doctors compared with the England average of 11%. For the registrar group, it was slightly lower, at 33% compared with the England average of 37%, and the same for junior doctors at 9% compared with the England average of 13%.
- The on-call anaesthetist provided cover for the acute pain team at weekends and out of hours. They received a handover prior to the weekend so they were aware of patients who might require their support.
- The divisional management team told us they used locums to cover any vacancies for consultants and middle grade doctors.
- We were sent copies of the duty rotas for out of hours cover. This showed that junior doctors, middle grade doctors and consultants were on call to review and assess any patients admitted out of hours to their specialty.
- We spoke with some doctors from the orthopaedic team. They told us they received good teaching and support from the consultants.
- We spoke with some consultants who told us no consultant was routinely present at the handover for the weekend. There was also no formal mechanism for consultant handover, which was done over the phone or as a chat.
- Prescott Ward told us it had morning ward rounds that were led by the consultant. In the evening, it had a 'boardroom' with other doctors. Consultants were available by telephone if required.
- Another consultant told us they undertook ward round each morning and they reviewed unwell patients in the evening.
- The National 2014 General Medical Council (GMC) training survey highlighted four patient safety concerns over the medical staffing levels during the surgical 'take', especially out of hours. The trust told us it was redesigning the on-call rota and was bidding for advanced nurse practitioners to support trainees.

Major incident awareness and training

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

Surgery

Are surgery services effective?

Good

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

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

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

Evidence-based care and treatment

- Medical and nursing staff had access to policies and procedures based on National Institute for Health and Care Excellence (NICE) guidelines.
- The trust had documented on its risk register where it was failing to meet service-specific NICE guidance, for example in intestinal failure in adults and clinical guidance for lower limb peripheral arterial disease.
- The vascular service was exceeding the NICE guidance in relation to achieving a time from diagnosis to surgery of 10 days or less for **Abdominal Aortic Aneurysm repairs. The standard was 14 days.**
- The surgical division took part in local audits, for example of surgical site infection rates and venous thromboembolism (VTE).
- Interventional radiology took part in national and local audits, for example, the national percutaneous nephrolithotomy audit (percutaneous nephrolithotomy is removal of kidney stone).
- They also followed the NICE guidance in relation to the venous stenting trial.

Pain relief

- A dedicated pain team consisted of a consultant lead and three senior nurses.
- The pain team told us it was aware of patients who would require epidurals and patient-controlled analgesia prior to their surgery, as this was identified on the theatre lists.
- The team provided support and advice to ward staff and patients regarding pain control and for patients with epidurals and patient-controlled analgesia.
- A pain assessment tool was used, and we saw ongoing pain management to assess whether the level of pain relief was appropriate in meeting each patient's pain.
- The vast majority of patients we spoke with about their pain told us it was well controlled and they would ask the nurses if they needed more pain relief. However, one patient told us that the nurse on the ward they were on kept them waiting for long periods of time for their pain relief, so they felt they were in "agony" by the time they got it.

Nutrition and hydration

- Patients were assessed on admission using the Malnutrition Universal Scoring Tool (MUST). Patients who were for day surgery were not assessed as they were felt not to be at risk. The patients' records we reviewed showed that none of the patients were at risk of malnutrition. Staff told us that if they had any concerns about nutrition for patients they could make a referral to a dietician.
- Fluid charts were used to record input and output and the amounts were added up at the end of the shift. This was so staff could assess the balance of fluid going into and out of the patient. None of the patients we saw were on food charts.
- Staff at the preadmission clinic told us there was guidance for patients about when they should be 'nil by

mouth' from, depending on their operation time. It also mentioned that patients should not have sweets or chewing gum. Patients were able to have water up to two hours prior to surgery. Information about fasting was also included on the trust's website.

- Some patients told us the food was good, whereas others felt it was not. All said they had a choice for their meals. They told us they chose their meals the day before, from a menu.
- Patients told us they had access to water and that hot drinks were brought around at frequent intervals throughout the day.
- On Dixton Ward, we observed that all patients we visited were able to reach their drinks.
- One patient told us they felt their nausea and vomiting was not very well controlled following their surgery. They were prescribed for anti-sickness medication, but they felt it took time for the nurses to administer it to them.
- Patients were able to be referred to a dietician if required.

Patient outcomes

- The trust performed above the England average in most of the national audits in which it took part.
- The trust's performance in the national bowel cancer audit was above the England average for all areas except one. The number of cases discussed at multidisciplinary team meetings was 98.4% compared with the England average of 99.1%.
- In the lung cancer audit, the trust performed worse than the England average for cases discussed at multidisciplinary team meetings, at 93.6% compared with the England average of 95.6%. The number of patients receiving a computerised tomography (CT) scan before bronchoscopy was 82.2% compared with the England average of 91.2%.
- The hip fracture audit related to Cheltenham General Hospital only. Findings were better than the England average for all areas except surgery on the day of or day after admission, for which the trust was 50.2% compared with the England average of 53.6%. A consultant told us they had difficulties in getting these patients to theatre in the recommended timescale, because of the number of theatre sessions: Cheltenham General Hospital only had eight, compared with Gloucestershire Royal Hospital which had 17.
- The trust was identified as having a mortality outlier. This was in relation to head of femur replacement. The trust had reviewed all deaths between July 2014 and October 2014 to find out why there was an increase in mortality between these dates and to indicate which hospital patients were admitted to. The divisional management team told us it had commissioned an independent review by the Royal College of Surgeons, as their own investigations had not been able to identify the reasons for the increase.
- The trust performed better than the England average for varicose vein patient-recorded outcomes.
- The length of stay at trust level for elective surgery was 3.2 days compared with the England average of 3.3 days; for non-elective surgery it was 5.3 days compared with the England average of 5.2 days. This was for trauma and orthopaedic surgery, colorectal surgery and urology.
- Cheltenham General Hospital the average length of stay for elective surgery was 3.8 days compared with 3.3 days for the England average. This was for trauma and orthopaedics, urology and vascular surgery.
- For non-elective surgery for trauma and orthopaedics, general surgery and urology, the average length of stay was 5.4 days compared with 5.2 days for the England average.
- The standardised relative risk of readmission for the trust for elective surgery in trauma and orthopaedics, urology and upper gastrointestinal surgery was lower than England average at 86 compared with the England average of 100. (A value below 100 means fewer observed readmissions than expected.) For non-elective surgery, the trust was lower in general surgery, urology and trauma and orthopaedics, at 93 compared with the England average of 100.
- At Cheltenham General Hospital, the standardised relative risk of readmission for elective trauma and orthopaedics, ophthalmology and urology surgery was 89, lower than England average at 100. The non-elective

surgery standardised relative risk of readmission was 88, lower than the England average of 100 for the same specialties. This means fewer readmissions were observed.

Competent staff

- Staff working in the CSSD they had a local induction tailored to the department and a trust induction programme. Staff also had a number of competencies that had to be completed for each area within the central sterile services division. We were shown records of these. There was also online NHS e-learning in relation to decontamination that all staff needed to complete. The manager told us that all new staff had mentors to guide and support them.
- Healthcare assistants in the pre-assessment clinic completed a number of competencies, as they were trained to take on extra roles, for example venepuncture and electrocardiogram (ECG) monitoring.
- The ward and unit staff told us they had link nurses for specific areas, for example pressure ulcers and dementia.
- The surgical division was not meeting the trust's target of 90% for appraisals, with nursing appraisals at 87% and medical/dental at 79%.
- For the surgical division, 1,336 staff had completed training in dementia awareness level 1; 635 staff had completed training in dementia awareness level 2.
- Of staff from the surgical division, 412 had also completed e-learning training for patients with a learning disability.
- The surgical division's percentage for nursing appraisals was 87%, and for medical/dental appraisals was 79%. The trust's target for appraisals was 90%.

Multidisciplinary working

- We spoke with physiotherapy staff, who told us they liaised with nursing staff and doctors about the patients who were referred to them to make sure patients' care was coordinated and meeting their needs.
- Some wards had a multidisciplinary team meeting several times a week to update all professionals involved in the care of patients. This included representatives from the nursing staff, occupational therapists, social workers and physiotherapists.
- Prescott Ward had a multidisciplinary team meeting on a Tuesday morning that included nurses, social workers, physiotherapists, occupational therapists and the integrated discharge team. This was to make sure patients' care was coordinated between the professionals and to help with discharge planning.
- Another wards told us the staff discussed the patients with the multidisciplinary team twice weekly.
- For patients who had complex needs and required detailed planning prior to their discharge, a discharge liaison team was available to provide assistance for the ward staff. For example, they would liaise with external professionals, including care homes.
- One consultant told us that it was difficult to get radiologists at some of the regular multidisciplinary team meetings for head and neck patients; they said they could get an opinion from a radiologist but they had no dedicated radiologist.

Seven-day services

- Not all services provided by Cheltenham General Hospital were available seven days per week.
- Some surgical patients were reviewed daily by a consultant and at weekends.
- CSSD provided seven days a week cover. There was also an out-of-hours on-call system that covered both locations.
- There was no out of-hours cover for occupational therapy.
- For physiotherapists, criteria were place for weekend visits. This included for elective orthopaedic ward patients, new patients and patients needing to be discharged. A physiotherapist was also on call at nights.
- The dedicated pain team did not work weekends. Any support required was provided by the on-call anaesthetist.

- Theatres, including anaesthetics and recovery, had staff on duty out of hours and at weekends to cover any emergencies.
- Staff told us they had access to out-of-hours pharmacy and imaging. The pharmacy was open on Saturday morning and Sunday morning from 9am to 10.30am. Some staff felt this was too early to get medications ready for patients to take home.
- We saw the out-of-hours rota for the surgery for each specialty. It included junior doctors, registrars and consultants. A consultant was on call at all times for each of the specialties, alongside a registrar and junior doctor. Some junior doctors covered more than one specialty. Some doctors we spoke with told us a junior doctor covered all surgical wards, with another one to cover admissions. A more senior doctor told us they worked until midnight but were on site in the hospital. There were a registrar and consultant on call but not always based in the hospital.
- Some consultants felt that the on-call rota was not sustainable, because of the lack of consultants.
- The trust had identified and included on its risk register that there was no formal out-of-hours interventional radiology input for vascular and urology.

Access to information

- When patients were transferred between wards, all their nursing and medical records were transferred with them. Staff told us they always provided a verbal handover as well as the written records.
- We observed a handover between theatres and the ward staff. Staff in theatres told us they needed to make sure they handed over all relevant information, for example about the last time the patient had pain relief, how the operation had gone and whether the recovery time had been satisfactory.
- Staff told us that when a patient was discharged to other services, they completed a letter that included details of the patient's needs and what support and treatment was needed from the new service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The hospital used four different types of consent form, including one for children and one for patients who lacked capacity to consent to their procedure/ operation. The consent forms we saw that were completed in full and had been signed by the doctor and patient were for patients who were able to consent. These included details about the procedure/operation and any possible risks or side effects
- Training figures up to 31 January 2015 for the surgical division showed that 93% of staff had completed Mental Capacity Act awareness training and 93% had completed Deprivation of Liberty Safeguards awareness training. The trust's target was 90%.

Are surgery services caring?

Good

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

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

Relatives were able to be involved in these discussions.

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

Compassionate care

- Each ward had details about its Friends and Family Test results. For example, on Dixton Ward, for January 2015 it had a response rate of 55%, and of these responses it had a positive score of 95.2% and a 0% negative score. It had 30 patients who were extremely likely to recommend the ward to their friends and family, 10 likely and one who was neither.
- Guiting Ward had 95% positive scores and no negative scores. The ward had 126 eligible patients and, of these, 20 replied.
- We observed that staff maintained patients' privacy and dignity, for example using the curtain around patients' beds, and knocking on doors before entering. Patients told us they had no concerns about how staff maintained their privacy and dignity.

- Staff on one ward told there had been one single-sex breach, male and female patients in the same area, in the six months prior to our inspection. This was due to the pressure on beds. It had not happened since.
- A patient on Dixton Ward told us the staff at lunchtime offered to wash their hands before patients ate, which they felt was good. We also observed staff asking patients whether they wanted to wash their hands.
- One patient we spoke with told us that some staff had an "attitude" and often didn't do what they had asked of them.
- We spoke to patients on all the wards we visited, and they all had positive comments to make about the staff. For example, "Staff are friendly and caring," "Staff made me feel very special" and "Staff are delightful."

Understanding and involvement of patients and those close to them

- Patients were involved with their care and with any decisions taken. They were able to ask staff any questions about their condition and surgery.
- One patient told us staff had already started to discuss their discharge arrangements with their family, as they may need additional support on their discharge.
- We spoke with four patients who were waiting for their operations. They told us that the surgeon had explained in detail about the operation, any risks and what to expect after their operation. They said they were given time to ask any questions.
- One patient told us they had attended a meeting with physiotherapists and occupational therapists, who told them about the aids they might need following their planned surgery.

Emotional support

- Spiritual support was available from within Cheltenham General Hospital, as the chaplaincy and a team of spiritual advisors were on call at all times. Patients were able to have support from their own local connections and networks.
- Patients had support from nurses with additional knowledge; for example, there were nurses with link roles in matters relating to mental health, learning disabilities and dementia. Nursing staff said carers, families and care workers were encouraged to come into the unit to provide emotional support and were helped to overcome any of their own anxieties so they could provide comfort to confused, scared or disorientated patients.
- Specialist nurses, for example colorectal and stoma care nurses, were also available to review and counsel patients.

Are surgery services responsive?

Requires improvement

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

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

The trust had recently centralised vascular services at Cheltenham General Hospital to help improve patient outcomes.

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

A system was in place to identify patients who required assistance with eating and drinking. Patients were offered a choice of menu to meet their needs.

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

Service planning and delivery to meet the needs of local people

Surgery

- The trust told us it was planning to reconfigure some more of its services. (This is where the trust moves a specific service to one location rather than being at both hospitals.) It said that prior to any decisions being made, it would consult with staff and the public. This had taken place in the past as ear, nose and throat (ENT) is located at Gloucestershire Royal Hospital, and ophthalmology is at Cheltenham General Hospital. Cheltenham General Hospital had a specialist eye department, which includes a ward for day surgery and outpatient clinics. By having the facilities on one site, the trust was able to have enough consultants, doctors and nursing to meet the needs of these patients.
- The vascular service had been centralised at Cheltenham General Hospital and had also been taking extra work from another local trust. The surgical division's management team told us that the number of beds on Guiting Ward had to be increased meet the demand of this new service.
- We attended a bed meeting where both hospitals discussed a number of areas, including pressure on beds, where beds where closed, and how many patients were in A&E. They discussed the actions they had to undertake and when they planned to review their situation.

Access and flow

- The trust had declared an internal major incident in December 2014 and January 2015 because of increased demand on its services. Kemerton and Chedworth Suite day surgery units had been opened at night prior to the major incident to help ease the pressure on beds. Staff told us patients were contacted the day before their surgery if it was going to be cancelled. They said they tried to get patients booked back in with the 28-day timescale.
- Staff in the preadmission clinic told us they had cared for some trauma patients who were more able, for example they were mobile and independent whilst they waited for treatment. This was to help ease pressure within the hospital.
- We spoke with four patients who were due for their operations. They all had previous dates for their operations, but these had been cancelled. One of these patients was at the hospital when their first operation was cancelled – they told us, because of a shortage of beds. The other three patients had been cancelled prior to their original admission date.
- The trust sent us information on how many elective patients had their operations cancelled more than once due to non-medical reasons. Between December 2014 and February 2015, 501 patients were cancelled more than once.
- The bed occupancy levels for this trust had been running at over 91%. The England average is 85%.
- From 4 January 2015 to 14 January 2015, the trust cancelled 436 operations, and of these 43 were cancelled on the day due to intense pressure on the trust's services. For Cheltenham General Hospital in this period, 217 operations were cancelled out of 1,600.
- The information on the NHS England website for quarter 2 in 2014/15 stated the trust cancelled 245 operations. Of these, 11 were not rebooked within the 28-day timescale. For quarter 3 in 2014/15, 327 operations were cancelled, and of these 19 were not rebooked within the 28-day timescale.
- The trust was meeting the referral-to-treatment time for general surgery, trauma and orthopaedics, ear, nose and throat (ENT), oral surgery and thoracic medicine. It was not meeting the referral-to-treatment time for urology and ophthalmology. This information was from March 2013 to November 2014.
- Trauma lists took place at the St Pauls theatres. Every afternoon and all day on Friday they had a trauma list. Trauma lists also took place in the morning at weekends. An elective list took place every Saturday.
- Some consultants told us that since the A&E department had become nurse led in the evenings, they had found patients being admitted directly to the wards without them being told. They also said that when Gloucestershire Royal Hospital became full, the patients were transferred to Cheltenham General Hospital. An example was given of when, just prior to our inspection, a patient with a fractured neck of femur was admitted directly to a ward without a doctor being informed.
- Some consultants felt there were not enough emergency theatre lists, which they referred to as CEPOD lists (National Confidential Enquiry into Patient Outcome and Death lists), now urology and vascular were based at Cheltenham General Hospital.
- The trust's average length of stay for elective surgery was 3.2 compared with the 3.3 England average for trauma and orthopaedics, colorectal surgery and urology. For non-elective surgery in the same specialties, the trust's average length of stay was 5.3 compared with the England average of 5.2.

Surgery

- The average length of stay for Cheltenham General Hospital for elective surgery in trauma and orthopaedics, urology and vascular surgery was 3.8 days; slightly worse compared with the England average of 3.3 days.
- For non-elective surgery, the average length of stay was 5.4 days compared with the England average of 5.2 for trauma and orthopaedics, general surgery and urology. Again this is slightly worse.
- Kemerton and Chedworth Suite day surgery units had been opened at nights due to the pressure on beds. Kemerton Suite was opened 42 times between 19 January 2015 and 10 March 2015. Chedworth Suite was opened 33 times from January 2015 until 10 March 2015. Staff said that, at times, they have felt unable to meet their needs of patients on Kemerton Suite. (These were medical patients.)

Meeting people's individual needs

- Staff told us they had access to translation services, both in person and by the telephone. Staff in the preadmission clinic told us that translation services were usually booked by the admissions team.
- Staff told us about the learning disability liaison team, who supported staff to care for and support patients with complex needs and their carers. The preadmission clinic staff told us they assessed patients with learning disabilities to find the most suitable place for them pre and post operation. Patients had a 'this is me' document, which told staff about the person's needs and how to meet them.
- Patients who were living with dementia were highlighted on the trust's 'purple butterfly' system. We saw this on the main board where information about patients was stored. Staff told us this was to highlight to them that these patients required more support and care.
- Staff on Dixton Ward told us about a patient who was transferred at midnight to another ward because of bed pressures. Moving patients late at night can cause them to become disorientated in their surroundings.
- They also told us about a patient who was moved four times during their stay in hospital. The patient had complained to their doctor about this. Moving patients this many times during their hospital stay can lead to lack of continuity of care and their needs not being met.
- Staff told us they had different-coloured trays to help identify patients who needed more assistance with their meals or who were on a special diet. We saw a notice that stated these trays had to be seen by a member of staff prior to being taken away.
- One patient told us they were a vegetarian and the hospital provided an option for them.
- Chedworth Suite had recently obtained a microwave so staff were able to reheat microwave meals obtained from the oncology department.

Learning from complaints and concerns

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

Are surgery services well-led?

Good

Staff were aware of the trust's values and visions. A number of staff we spoke with had been working at this trust for over 15 years and said it was a good place to work. Some staff told us that if incidents took place, they wanted to be

open and transparent with patients about any failings. The culture of learning from incidents was promoted among staff, and they told us they were encouraged to report incidents.

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

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

Appropriate governance systems were in place. Risks were identified and discussed at divisional level, and these were recorded on each specialty's risk register and included in the surgical division's risk register. Interventional radiology had its own governance systems that fed into its management structures. Serious risks were shared with the executive team.

Vision and strategy for this service

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

Governance, risk management and quality measurement

- CSSD had internal governance arrangements, and it was also audited by an external governing body. This was to make sure it was compliant with a number of areas, including its policies and procedures, maintenance of equipment and decontamination systems. This enabled the CSSD to provide their services to other health care institutions, for example, community hospitals and GP surgeries.
- The divisional management team told us about the top risks. We examined the risk register and found that all of these were included on it, for example inability to provide a formal out-of-hours interventional radiology rota for vascular surgery and urology, and failure to meet certain National Institute for Health and Care Excellence (NICE) guidance. A member of staff responsible for the monitoring these risks was included on the risk register. Dates of review were also included.
- Each specialty had its own risk register, for example trauma and orthopaedics. These fed into the surgical division's risk register. We saw that some of these were also on the corporate risk register, for example inappropriate use of day surgery/recovery for patients requiring to stay after operations.
- Appropriate governance systems were in place. For example, each specialty had governance meetings, and these reported into the divisional governance meetings. Any issues from these were reported into the trust's quality governance meetings. These meetings included a number of topics, for example review of all serious incidents, complaints received and the patient experience.
- Interventional radiology took part in its department's monthly governance meetings. The meetings discussed, for example, incidents and complaints. Feedback to other staff took place following these meetings.

Leadership of service

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

- Some staff also told us about the executive walk-arounds and how they had taken part in these and fed back any issues.
- All staff spoke highly of their immediate line managers and felt well supported by them.
- One member of staff felt there was a barrier between the frontline staff and the executive board.

Culture within the service

- The management teams we spoke with said they encouraged staff to provide the best and safest care possible to patients. They were aware that their staff were under great pressure, especially due to the increased high demands on their services. They all liked to be visible to staff, and they also work on the wards. Staff said they felt supported by their line managers.
- A number of staff we spoke with said they had worked for this trust for over 15 years, and all said it was a good place to work**.**
- Staff told us they would report any concerns they had, and most were aware of the 'say and see' telephone line. Others said they would use their internal intranet site to find out details on how to report concerns. Staff were also aware of the trust's whistle-blowing policy and raising concerns policy and where to find them.
- Staff told us there was an open culture that was not about blame. They were encouraged to report incidents, as incidents were seen by the trust as important learning opportunities.

Public and staff engagement

- Patients were able to feed back their views on the ward via the Friends and Family Test. They were asked whether they would recommend the ward to their friends and family. We saw results of these on display in the wards.
- Some staff told us they had been involved in the executive management team walk-arounds of wards and departments. They all said they felt able to express any concerns they had with the member of the executive team.

Innovation, improvement and sustainability

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

Critical care

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

Information about the service

The department of critical care at Cheltenham General Hospital supports patients who need intensive care (described as level 3 care) or high dependency care (described as level 2 care). The unit has 12 bed spaces. The number of patients accommodated depends on what level of care is required. The unit will not exceed a maximum of nine patients who require level 3 intensive care, but can accommodate up to 12 patients if there is a mix of level 3 patients with level 2 high dependency patients.

The unit has eight bed spaces and four side rooms, two of which provide specialist isolation facilities. There are two central nurses' stations alongside one another facing the patients. Each bed area is screenable by curtains and the unit has windows and natural light.

The number of patients admitted to the unit in 2014 was around 630 patients aged 16 years and above. Children's services are provided at the hospital trust's Gloucestershire Royal Hospital, but the unit has the facilities to admit a child under 16 years either prior to retrieval to a paediatric intensive care unit or for emergency specialist care.

On this inspection, we visited the department of critical care on Thursday 12 March 2015 and on an unannounced visit in the late evening of Friday 20 March 2015. We spoke with a full range of staff, including consultants, doctors, trainee doctors and nurses from different grades. We met the general manager, the matron and lead consultant for critical care, who are responsible for both the services of critical care in Cheltenham General Hospital and Gloucestershire Royal Hospital, which are both managed by Gloucestershire Hospitals NHS Foundation Trust. We spoke with physiotherapists, nurses from the outreach team, one of the cleaning team, the lead pharmacist, a dietician and a volunteer. We met with patients who were able to talk with us, and with their relatives and friends. We observed care and looked at records and data.

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

Critical care

Summary of findings

We have judged the overall critical care service at Cheltenham General Hospital as outstanding.

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

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

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

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

Some improvement was needed to ensure that one stock of a specific controlled drug was clear and that consumables were within their expiry date. The patient harm data was low, but the internal and external recording and display of some information could be improved.

The critical care service responded well to patients' needs. Bed pressures in the rest of the hospital sometimes meant that patients were delayed on discharge from the unit, but incidences were below (that is better than) the NHS national average for similar units. Some patients were discharged onto wards at night, when this was recognised as less than optimal for patient wellbeing, but this was also below (better than) the NHS national average rate. There was a very low rate of elective surgical operations being cancelled due to unavailability of a critical care bed.

The facilities in critical care were excellent for patients, visitors and staff, and met all the modern critical care building standards.

Patients were treated as individuals, and there were strong link nurse roles for all aspects of patient need, including learning disabilities, dementia and mental health. There were no barriers to people who wanted to complain. There were, however, few complaints made to the department. Those that had been made were fully investigated and responded to with compassion and in a timely way. Improvements and learning were evident from any complaints or incidents.

Critical care

Are critical care services safe?

Good

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

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

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

Of the large quantity of well-rotated stock, there were a small number of consumable and disposable items of medical stock that were past their use-by date. There was also a lack of clear recording for one of the controlled drugs, although that for the others was accurate. The patient harm data showed good results, but the internal and external recording and display of some information could be improved.

Incidents

- Staff were open, transparent and honest about incidents. All staff, including the domestic staff and ward clerk, said there were no barriers to reporting incidents and they were encouraged to do so. A number of the nursing staff said they recognised clear incidents and reported these through the trust's reporting system and internally within the department. However, they accepted there might be times, albeit infrequently, when they might not remember or think to report an incident onto the incident reporting system. In talking with some of the nursing staff, we heard and saw evidence of occasional events and/or near misses not always being recognised as reportable incidents, and thus not being reported. The trust was below the NHS England average for reporting incidents, which could be an indicator of staff not reporting incidents as frequently as they should.
- All staff said they felt they were not blamed for errors or omissions. They were listened to, able to be fully honest and open, and treated fairly. Staff said this meant they were not afraid to speak up when something went wrong or could have been done better.
- Incidents were reviewed and investigated. The environment, circumstances, systems and processes were examined to see why something had occurred and how, if possible, to avoid any repeat. Staff competence was considered if there was evidence of it needing improvement. The clinical nurse educator was engaged in this process to ensure update training or teaching was delivered where necessary. There was a formal process for serious incidents requiring investigation. We reviewed three from 2014 involving category 3 pressure ulcers acquired by patients. The investigations undertaken were extensively reported upon and presented through the trust's safety experience review group for shared learning.
- Learning from incidents was shared between clinical staff, at divisional level, and across sites. Incident reports were a standing agenda item on the Gloucestershire critical care business meeting. The moderate- through to major-graded incidents were discussed. Learning points and requests to check for recurring themes with emerging trends were discussed and minuted.
- Incident reports were produced to identify any trends and learning required. From a review of the incidents,

we saw themes being highlighted and, where patterns were identified, evidence of learning being disseminated to staff; for example, staff hand-outs were produced about the documentation of pressure ulcers and the checking of intravenous fluid bags to avoid medication errors. The reporting and learning was shared between the sites, as they were managed by the same leadership team and nursing staff worked flexibly at both sites.

- Staff in the critical care division were aware of the new regulation to be open, transparent and candid with patients and relatives when things went wrong. From November 2014, NHS providers are required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2009. Although this was a relatively new requirement, senior staff in critical care were aware of their duty to inform all relevant parties of notifiable patient safety incidents. Staff were aware of the requirement to be open, transparent and candid and to issue a meaningful apology to the relevant person or people. We saw in serious incident report templates requirements to inform and apologise to the family.
- Patient mortality and morbidity was reviewed and discussed each quarter. This was undertaken at critical care division level as part of the service's multidisciplinary team meetings. Minutes of the meetings showed that the cases reviewed were well considered. Any actions arising were attributable to a member of the team, and there was evidence to show any lessons from the reviews were learned and changes made if required.
- There was clear oversight of incidents. All incidents were discussed at the appropriate divisional committee. This started with the specialty clinical governance group, moved through to the divisional health and safety committee, then the divisional quality assurance group, before being presented to the divisional board.

Safety thermometer

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

Cleanliness, infection control and hygiene

- Rates of unit-acquired infection were low. Data reported by Cheltenham General Hospital to the Intensive Care National Audit and Research Centre (ICNARC) (an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally) supported this evidence. All rates of infection had, over time, been almost continually below (better than) the national average. There were no unit-acquired Methicillin resistant Staphylococcus aureus (MRSA) infections from January 2011 to September 2014 (the most recent data available, and from when the unit started consistent reporting). There were no events of unit-acquired Clostridium difficile in the last two years, and the last reported incident was towards the end of 2013. There had been no unit-acquired bacteraemia infections in blood in the four years to September 2014.
- At the time of our inspection the unit and equipment were visibly clean, well-organised and tidy. Bed spaces were visibly clean in both the easy- and hard-to-reach areas. Bed linen was in good condition, visibly clean and free from stains or damage to the material. The cleaning of the unit was audited and checked each week. The unit had scored above the 95% target on all but six of the weeks for the 12 months of 2014. The majority of results were around 98%.
- Used and new equipment was stored and sealed to prevent cross-contamination. All disposable equipment was in sealed bags in drawers or cupboards where possible, to prevent damage to packaging.

- Used disposable items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers. None of the waste bins or containers we saw were unacceptably full, and nursing staff said they were emptied regularly.
- We observed doctors and nursing staff following policy in washing their hands between patient interactions, using antibacterial gel and wearing disposable gloves and aprons at the bedside. All staff were 'bare below the elbows' (had short sleeves or their sleeves rolled up above their elbow) when they were within the unit. Results for hand hygiene, compliance with uniform policy, and the use of personal protective equipment were good. The department scored 100% in almost all hand-hygiene and personal protective equipment audit observations from April 2014 to January 2015.
- Visitors were required to follow infection control protocols. They were asked to use alcohol gel when arriving on the unit, and this was freely available and clearly visible. Visitors were asked to consider their own health when visiting and to not come to the unit if they were unwell or becoming unwell. There was a policy of limiting the amount of property left with the patient in the hospital, for reasons of infection control. Staff explained this upon admission to the unit, and it was also described in the leaflet produced by the department for patients and visitors.
- There was induction for all clinical staff when newly working on the unit. The service had produced an extensive guide detailing the clinical procedures that can increase the risk of infection if not performed correctly.
- There were guidelines for both doctors and nurses in relation to their responsibilities around protection from cross-infection for certain procedures. The document explained whether these procedures were treated as surgical (therefore masks and hats to be worn along with other standard personal protective equipment) or used a non-touch aseptic technique. Care provided was audited against best practice on a monthly basis. For example, with urinary catheter audits, the need for a catheter and whether it was removed at the earliest opportunity were questioned. For peripheral venous cannula insertion, the audit included whether the site was reviewed at least every day, and whether the dressing was dry and intact. Most results were good, and the majority at 100% for completed documentation. Where this was not the case, action plans were produced and staff were accountable for improvements in results.
- Monthly infection control reports were produced for the divisional board meeting, based on surveillance data. There were reports for the division (critical care was part of the surgery, anaesthetics, pain and critical care division), and there were reports for the various services within the division.

Environment and equipment

- The beds, mattresses and chairs for patients met the requirements of the Core Standards for Intensive Care Units. Each bed was capable of attaining different positions for patient comfort and to assist staff. All beds had air mattresses to relieve pressure to the body when a person was lying in the same position for long periods. There were a variety of chairs for patients to use when they were well enough to sit up out of bed.
- The unit had appropriate equipment for use in an emergency. There was a difficult airway intubation trolley divided into different trays according to the intubation strategy and equipment to be used with the patient.
- There was a standard resuscitation trolley. The trolley had been checked each day and the check recorded. The trolley had a list of equipment to be carried. All the kit listed was as required within the checklist.
- Staff were trained and competent to use equipment. The nursing staff maintained good training records for equipment and competencies. There was extensive training for trainee doctors on the equipment used in the department. The competencies were reviewed and signed off by the consultants.
- A few items of consumables were out of date in the store in the general unit. The stock in the equipment cupboard was said by the matron to be routinely checked for being near or past the expiry date. These items were removed and disposed of and a more thorough check instigated.
- There was good storage space for equipment to enable the environment to be free from clutter and equipment used infrequently. Most was stored in cupboards and storage spaces.

- The unit was secure on entry from the main corridor. There were close-proximity cards (which offer better infection control than swipe cards or keypads) for staff to use to gain access to the clinical areas. When we visited on 12 March 2015, we observed there was clear glass in the doors leading into the clinical area, and people were in the vestibule directly after entering from the corridor. The unit could be looked into from both this area and also from the corridor. When we returned on our unannounced visit on Friday 20 March, this had been addressed and frosting added to the glass to prevent patients and the unit being overlooked by visitors. When we visited at night, the blinds on the windows looking out over the road outside had been closed to prevent the unit being visible to people passing by.

Medicines

- Medicines, including those requiring cool storage, were stored appropriately, although some liquids were not locked away. There was, therefore, a risk from tamper. Records showed that medicines were kept at the correct temperature and so would be fit for use. Refrigeration temperatures were checked each day, as required, and recorded. Medicines were stored in locked cupboards in a clinical area, and their location was marked on the doors. Controlled drugs were kept in a suitable standard metal cabinet.
- A senior pharmacist visited the unit every weekday. They attended daily ward rounds to provide support with prescribing and use of medicines. There were appropriate stocks of medicines to make sure patients had access to them when they needed them. The visit of the pharmacist helped to ensure medicines were used safely. There was a pharmacy top-up service for the unit's stock, and other medicines were ordered on an individual basis. The pharmacy team provided an on-call system to make sure advice was provided at all times.
- Patients' medicine records were well managed using standard drug charts. There was a mix of standard pre-printed charts for intravenous medicines which were often administered following standard protocols. The main drug charts were written up by the medical staff. All of those we reviewed were complete, relatively legible and clear.
- The senior pharmacist for critical care followed antibiotic protocols, and compliance was audited. Audits were carried out of drug charts and patients' notes against various indicators. This included, for example, any allergies to antibiotics being clearly documented, whether the date for stopping or reviewing was documented, and whether antibiotics were being given in the most appropriate way (such as orally or intravenously). The results for April 2014 to January 2015 were almost all 100% (89% in October 2014).
- Controlled drugs were recorded clearly and stocks were accurate in all those records we checked, with the exception of one error we picked up and unclear recording of another. There was some confusion about recording for one specific controlled drug (Midazolam) as to how it was booked into and out of the unit in certain strengths. We investigated this with the Matron and lead pharmacist and found that policy had not been strictly adhered to. Shortly afterwards, the pharmacist reissued staff with the policy for the storage of this drug. With another drug, an error had been made in the calculation of the stock levels. The pharmacist investigated this and made a correction to the book.

Records

- There were clear, legible and ordered patient notes. We reviewed six random sets of notes and checked current and historic information. Documents were clearly written in chronological order, and were dated, timed and signed. Contributors printed their name and added contact details. All results were documented, and abnormalities were identified with a clear written plan of action. Records demonstrated personalised care and multidisciplinary input into the care and treatment provided. A rolling audit carried out over the three years prior to our inspection showed the 'daily goals' sheet was being used throughout.
- Records demonstrated communications with the patients' relatives. A relatives' communication sheet recorded all the details of the family that could be ascertained. Communication was recorded on this sheet by any member of the team who had spoken with or attempted to contact a relative.
- The patient's treatment plan was clear and could be followed through the records. This included the

prescription of medicines, which were then tracked to the drug chart. Any requested reviews from the physiotherapist were recorded, and we noted these reviews had been carried out. Nursing care plans were up to date and all interactions had been documented.

- The standard daily observation chart was designed by the department for bespoke use. One of the nursing team was responsible for the large observation chart used for each patient in critical care. This was reviewed with a departmental consultation every six months to enable new assessments or changes to existing procedures to be added. This made the chart as relevant and current as practically possible.
- Patients' paper notes were stored to ensure their confidentiality and security. The notes were in a trolley which was closed and could also be locked for additional security. At no time did we see patients' confidential information being left visible and unaccompanied on any screens or boards.

Safeguarding

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

Mandatory training

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

Assessing and responding to patient risk

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

Critical care

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

Nursing staffing

- There was a safe level of nursing staff. The nursing staff levels were based upon the dependency (acuity) levels of patients. This followed the Faculty of Intensive Care Medicine Core Standards recommendations for safe nurse-staffing levels. Therefore, when a patient needed intensive care, there was one nurse for each patient. When a patient needed high dependency care, there was one nurse looking after two patients. There were a maximum of eight nurses per shift, with one supernumerary as the unit nursing lead. However, each shift was planned against patient acuity and expectations, and staffing levels were adjusted in real time to meet the acuity levels. We reviewed staffing rotas for two months and how they were planned for the coming weeks, and found this to be the case. Senior nurses reviewed the actual staffing levels each month and produced reports on any shortages in staff. Staffing levels had generally not met the plan because of the acuity of patients being less than anticipated, or elective surgery having been cancelled. On our visits, including the unannounced visit, there was a safe level of nursing staff.
- The nursing staff had a flexible working system in order to raise and lower staffing levels to meet patients' needs. This gave staff the opportunity to not work a shift, or part-shift, when the acuity level did not demand

it, but to come into work to cover increases in acuity levels or unplanned staff absence. A policy for this, which supported both safe staffing and a work–life balance, had been agreed with the nursing staff. All the nurses we met said this was an effective system which meant the critical care department rarely needed to use agency staff. There was a stable bank staff cohort of around seven nurses, which meant that when bank shifts were necessary, these were fulfilled by regular, experienced staff.

- Patient care was not compromised by high levels of bank of agency staff. The Core Standards for Intensive Care Units recommends that never more than 20% of any shift is staffed by agency or bank staff workers. The use of agency or bank staff rarely exceeded 2%, and between June 2013 and November 2014 had been 1% on average.
- Senior nursing staff were not counted in the staffing numbers (they were supernumerary) in order for them to manage the nursing teams. The Core Standards for Intensive Care Units recommend that a supernumerary clinical coordinator is on duty at all times for a unit of this size. The staff rotas demonstrated there was at least one band 7 supernumerary nurse on duty at all times.

Medical staffing

- The experienced consultant presence on the unit followed the recommendations of the Core Standards for Intensive Care Units. There were eight consultant intensivists (consultants trained in advanced critical care medicine) working in rotation in critical care and on call. There was a good consultant-to-patient ratio. A consultant was on duty or on call across the unit for a maximum of 12 beds, although the average number of beds was closer to eight. This was better than the core standards' recommended ratio of one consultant to a maximum of 15 beds.
- There was a good commitment of consultant time on the unit. The eight consultant intensivists worked 45% of their time in critical care and 55% as anaesthetists. The core standards require consultants to have a minimum of 15 programmed activities of consultant time committed to critical care each week, and this was met or exceeded. There had been no requirement to use a locum doctor in the unit for at least 10 years.
- There was full coverage from consultants. They were on duty from 8am to 6pm or later to complete the evening ward round, then on call at home in the evening. Consultants regularly attended the units out of hours (around two or three times a week was usual) and frequently took calls from staff. This arrangement was in place seven days a week, with no difference in the level of cover at weekends. When consultants were on duty or on call, this was only for critical care and not extended elsewhere in the hospital. A doctor was on duty in critical care overnight – usually an anaesthetist trainee or experienced staff grade doctor. The minimum amount of experience required for the trainee was six months on the anaesthetic rota before working in critical care. In practice, the doctor on duty had a much higher degree of experience. Also, the medical rotas were organised in advance to ensure there was always a registrar or airway supervisor on duty with any less experienced staff. On our visits, including the unannounced visit, there was a safe level of medical staff.
- Excellent support was given to trainee doctors. There was an extensive guide to all aspects of working in critical care, written by one of the experienced intensivists. Each trainee was evaluated for their competence and not signed off until this was demonstrated. There were two trainee doctors on rotation in the department working on day shifts. We observed good training and education at the ward round. The trainee staff we observed came across as confident and were encouraged to ask questions and look for guidance. The trainees we spoke with said the department had a high reputation for excellence in teaching and practice. In accordance with the Core Standards for Intensive Care Units, no foundation year one (FY1) doctor would be left in charge of the department. In this department, just one foundation year doctor worked out of hours. The local training panel of the Postgraduate Medical Education School of Acute Care (part of Health Education South West) had rated the training in the trust's critical care departments (including Cheltenham General Hospital) as A – excellent. This was based on comments from trainee doctors, such as "busy job but well supported", "excellent post, good rotas", and "excellent training opportunities".

Allied healthcare professional staffing

Critical care

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

Major incident awareness and training

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

Are critical care services effective?

Outstanding ☆

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

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

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

Evidence-based care and treatment

- The relevant guidance from professional bodies was incorporated into policies and followed in practice. For example, the policy for how to respond to a deteriorating patient was based on the guidance of the

Royal College of Physicians (July 2012), National Institute for Health and Care Excellence (NICE) guidance 50: Acutely ill patients in hospital, and guidance from the NHS Litigation Authority.

- Cheltenham General Hospital had a policy for responding to acutely ill patients in ward environments. The policy was based upon national guidelines and developed as recommended by the Royal College of Physicians to standardise the assessment of the severity of acute illness in the NHS. The basis of the policy was completion of the patient National Early Warning Score (NEWS) by ward/unit staff. Outreach nurses said the policy was followed in practice by ward staff, and critical care was informed of patients who triggered a risk. Nursing staff said the NEWS result would be overridden if there was clear evidence the patient was very unwell, but the NEWS result did not necessarily trigger action.
- The consultant team members were trained in advanced investigative practices. Patients in critical care were enabled to be moved to the imaging department to have magnetic resonance imaging (MRI) scans within the hospital, with all appropriate portable supportive equipment taken with them. There were also four consultants trained in echocardiography scans, enabling both thorax and heart scans to be undertaken at the patient's bedside. The scans could be videoed and reviewed also by the consultants with echocardiography technicians.
- The physiotherapy team followed a programme of evidence-based treatment. Patients were assessed in terms of their physical and non-physical presentations. They were scored against assessment criteria which, depending upon the score determined, led to a treatment pathway being commenced. Patients were given physiotherapy 'rehabilitation prescriptions' which would leave critical care with the patient when they were discharged. They were designed to ensure that physiotherapy continued if the patient went onto the ward, to community settings or home.
- The unit followed NHS guidance when monitoring sedated patients. Each patient who was sedated was subject to a 'sedation hold' each day using the recognised Richmond Agitation Sedation Scale (RASS) scoring tool. This involved the doctor or nurse discontinuing the sedation infusion and monitoring the patient's response. Sedation was then continued or adjusted depending on how the patient reacted to the change. The results were recorded in the patients' notes and on the daily care record used for each patient.
- The average length of stay on the unit was lower (better) than the national average. It is recognised as suboptimal in social and psychological terms for patients to remain in critical care for longer than necessary. Length of stay was measured by the Intensive Care National Audit and Research Centre (ICNARC) (an organisation reporting on performance and outcomes for around 95% of NHS intensive care units nationally). The average length of stay was lower for all types of admission (that is, ventilated patients, patients admitted with severe sepsis, emergency surgical admission patients, and patients admitted with trauma, perforation or rupture), with the exception of elective surgical patients, where the length of stay was just above the national average. The mean length of stay for all admissions was 3.7 days, compared with the national mean of just over four days.
- Patients admitted to the unit were formally assessed for delirium. The Faculty of Intensive Care Medicine Core Standards recommended that all patients were screened for delirium with a standardised assessment tool (usually the confusion assessment method, often called CAM – ICU). Clinical staff recognised the need for delirium screening, as the condition was often one of the first indicators of a patient's health deteriorating.
- The nursing staff followed national guidance for oral care. The unit used the Adapted Halstead Oral Assessment Tool for the 'awake' patient to determine how oral care should be provided. There was also a protocol to follow based upon the use of chlorhexidine gel (a chemical antiseptic) and how, when and when not to use it.
- The unit participated in and led on organ-donation work for the trust. The trust had a clinical lead for organ donation and was supported by a specialist nurse for organ donation. The trust was part of the UK national organ donation programme and followed National Institute for Health and Care Excellence (NICE) guideline CG135: Organ donation for transplantation. We were given up-to-date data for the period from 1 April 2014 to 18 March 2015, which showed rates of donation were small but were increasing. There had been 12 patients in

critical care eligible for organ donation during this period. Of these, four families were approached to discuss donation. All families (100%) were approached, with the involvement of the specialist nurse, against a national average of 78%. Evidence has shown there is a higher success rate for organ donation if a specialist nurse is involved in discussions with the family. Two patients went on to be organ donors, and 10 organs were retrieved for donation and transplanted to nine people. This included one heart donor. The specialist nurse for organ donation commented on the strong support for organ donation from the department and the trust.

Pain relief

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

Equipment

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

Nutrition and hydration

- Patient nutrition and hydration needs were assessed, and the provision was effective. The patients' records we reviewed in the general intensive care unit (ICU)/high dependency unit HDU were well completed, and safe protocols were followed. Fluid intake and output were measured, recorded and analysed for the appropriate balance, and any adjustments necessary were recorded and delivered. The method of nutritional intake was recorded and evaluated each day. A rolling audit over the last three years showed that appropriate enteral feeding was undertaken. The malnutrition universal

screening tool (MUST) was used for all patients. Nutrition and hydration regimes were designed to meet patients' needs and reflect individualised care. Checks were carried out for nutrition and hydration as part of the critical care unit's daily record.

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

Patient outcomes

- The unit produced data to determine patient outcomes against recognised national indicators. It demonstrated continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards. This participation provided the unit with data benchmarked against other units in the programme (95% of NHS hospitals) and units similar in size and case mix. The data returned was adjusted for the health of the patient upon admission to allow the quality of the clinical care provided to be identified from the results.
- Few transfers were made to other critical care units for non-clinical reasons, such as a bed not being available at the right time. There had been two in the nine months to September 2014.
- Mortality levels on the unit were better than the national average. Expected death-rate ratios fluctuated, but over time were either better than or at anticipated levels. The latest ICNARC Case Mix Programme data for the intensive care unit (ICU) covered 1 July to 30 September 2014 and was for 169 patients. Unit mortality ratios in the most recent reporting period were below (that is better than) expected levels. Post-unit hospital deaths were almost always below those of similar units. In the July to September 2014 quarter, there was one death (just below 2%) against a national average of just over 5%. These were patients who died before ultimate discharge from hospital, excluding those discharged for palliative care.
- Patients were not discharged prematurely. There was a fluctuating ratio of patients needing readmission to the unit, but over time this was mostly below average. Early readmissions to the unit (those readmitted within 48 hours of discharge) for the latest ICNARC period were zero against a national average of around 2%. Late readmissions (those readmitted later than 48 hours following discharge, but within the same hospital stay) were around 2% (three patients), which was below (better than) the national average of 4%. However, those patients readmitted were for a new condition.
- Patients being admitted or discharged from critical care were carefully managed. There was a policy for patients being discharged onto wards with tracheostomies to ensure that they were only placed on wards where staff had the skills to deal with these patients. This policy had been adopted following a serious incident on a ward and learning from an investigation into what improvements could be made. There was seven-day input from the mental health team for safe discharges of patients where risks of possible self-harm had been identified. Any patients admitted to the hospital from a local specialist neurological rehabilitation hospital who had a tracheostomy were admitted only to critical care. Their physician or surgeon was aware of this and would support them on the unit. Admissions to the unit could only be approved by a consultant under clear criteria and either from a direct or telephone consultation.
- Local audit work to reflect national guidance was regularly undertaken. A calendar of audits were planned for 2014/15, which were assigned to a clinical lead. Audits were used to judge quality and effectiveness of care and treatment or demonstrate continuous improvement. The majority of audits were done monthly and included recognised outcomes. These included the incidence of ventilator-associated pneumonia, incidence of central venous catheter infection, incidence of Clostridium difficile infections

and MRSA, and percutaneous tracheostomy audits. Any shortcomings were then followed up by being raised at monthly clinical meetings, and actions agreed. Re-audits were undertaken to improve patient outcomes and the unit's performance. Results were all at the high end of the scale – showing a high compliance with good outcomes.

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

Competent staff

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

December 2014 and January 2015. This had dropped back from 94% in the previous two months. All staff knew who was responsible for their appraisal, and this was recorded in the electronic staff system. Reports could be produced at any time, and these included a list of all staff who were falling due for appraisal in the next two months. All the staff we talked with said they had been appraised in the last year, and the process was respected and taken seriously.

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

Multidisciplinary working

- There was strong and cohesive collaborative working by all staff contributing to the units. We observed a common sense of purpose among staff from all disciplines. Staff genuinely and proactively supported one another, with a focus on improving patient care. We observed no obstructive hierarchical structure, and all staff were valued for their input and roles. Staff who were visiting the unit to review patients who, for example, were postoperative, or who came to perform tests or take patients for tests, knew who to speak with or ask for. Visiting consultants were proactive when calling into the unit for advice about a patient or to review a patient they had discharged into the care of the unit. We spoke with a consultant cardiologist and consultant surgeon. We observed how they had come onto the unit to review their patients and also to feed back to staff how discharged patients were doing clinically out on the ward. The staff in critical care said they had excellent communication with doctors from other areas of the hospital, who were always available and supportive.
- There was active input from the rehabilitation team. Each patient coming onto the unit was assessed with a short assessment scoring tool used to address immediate needs. There was a daily round for each patient, which included reviews of ventilation, mobility, nutrition and communication. The weekly physiotherapist-led rehabilitation ward round had multidisciplinary team input. This took place each Wednesday at 2pm, and all staff involved were aware of the need to attend, including the senior nurse, senior physiotherapist, and consultant or nominated doctor. We saw comprehensive notes from these rounds, which included a focus upon moving the patient forward and goal setting.
- There was appropriate support from the microbiologists (healthcare scientists concerned with infection prevention and management). They visited the unit three times a week and undertook a round with the consultant intensivist and other staff as required.

Seven-day services

- There was good cover from the consultant intensivist team out of hours. Consultants all lived within a 30-minute journey of the unit when they were at home but on call.
- There was good cover from the allied health professionals across the whole week. Physiotherapists were on call when not present on the unit. Pharmacists provided a full service during the week and on Saturday and Sunday mornings. They were also on call at other times for any urgent prescriptions or discussions.
- Examination services were available during the week. This included x-rays, computerised tomography (CT) or computerised axial tomography (CAT) scans, electroencephalography (EEG) tests to look for signs of epilepsy, and echocardiograms (ultrasound heart scans).

Critical care

Access to information

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

Consent and Mental Capacity Act

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

Critical care

Are critical care services caring?

Outstanding ☆

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

People's cultural and religious, social and personal needs were respected. This was particularly so with patients who were at the end of their life or had passed away. There was a bereavement team and advice and guidance for staff to provide appropriate and sensitive care. Innovative support for patients, such as the development of patient diaries, was encouraged and valued.

Compassionate care

- Patients and relatives we met spoke highly of the service they received. Due to the nature of critical care units we often cannot talk to as many patients as we might in other settings. However, the three patients we were able to speak with said staff were kind, thoughtful and caring. One patient who had been on the unit for a short stay following surgery said they, "cannot fault them" and "I give them 10 out of 10 for everything." Consultants, doctors and nurses were said to be respectful and compassionate. Cards and comments displayed on the unit and in the visitors' book, without exception expressed thanks to staff for the care and kindness to the patient or their family and friends.
- We observed excellent attention from all staff to patients' privacy and dignity. We saw curtains drawn around patients, doors or blinds closed in private rooms when necessary, and voices lowered to avoid confidential or private information being overheard. The nature of risk and ensuring patient safety in critical care units meant there was often reduced opportunity to provide single-sex wards or areas. However, staff said they would endeavour to place patients as sensitively as possible in relation to considering privacy and dignity and also respect for other cultural or religious needs.
- The unit was sensitive to patients' needs. Staff said they had arranged for long-stay patients to have their hair cut; they made sure patients who wanted to be were shaved every day; patients had been taken outside for fresh air when possible; and a patient's dog had come to the hospital to visit. Staff had investigated the use of an app for use in communication for hospital patients; patients could bring their tablet computer to the unit and use the app to communicate. Information about this app was posted on the visitors' noticeboard. One patient had already tried the app and used it successfully.
- Visiting times were flexible, but prioritised the needs of the patient while being supportive to relatives. There were no set visiting hours, but visitors were encouraged to visit from mid-afternoon if possible and to refrain from visiting between 1pm and 3pm to allow patients to rest. There was limited space in the unit, and visitors were asked to restrict numbers where possible, as too many visitors had been recognised as tiring for patients in critical care. However, staff said they would accommodate visitors as much as possible at all times.
- Care from the nursing staff, medical staff and allied health professionals such as physiotherapists and dieticians was delivered with kindness, patience and warmth. Nurses talked quietly with patients and reassured them continually. We saw them holding the hands of patients while they spoke with them. The atmosphere was calm and professional, without losing warmth and reassurance for everyone concerned. All staff introduced themselves to patients and their visitors. Nurses were observed talking to patients and explaining what care they were delivering, even if the patient was not conscious. Staff said it had been recognised that patients might well be able to hear conversations or pick up words or even atmospheres, even when minimally conscious. Staff kept this in mind, particularly with difficult conversations with relatives and friends, and these took place where possible away from the patient's bedside.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed as to how they were progressing and encouraged to ask and have things explained things in their own words. They were told about any tests or examinations being arranged, how long they were expected to be staying on the unit, and the treatment provided or planned. We observed staff giving good explanations to patients of what was happening around both small and bigger things.
- Staff made sure visitors were identified, and only gave information to them if they were entitled to have it or the patient was able to give permission.
- Friends and relatives of patients were kept informed and involved with decisions when appropriate. Staff said they were aware that the unit could be overwhelming for visitors, and therefore would give information as sensitively as possible. A doctor and a nurse mentioned how they would look for signs of anxiety or distress when delivering difficult news to relatives and friends and make sure the person was supported.
- Patients and relatives were enabled to communicate. There were communication boards so patients with tracheostomies could write words either in pen or with magnetic letters. We observed caring and compassion shown to a relative who was in distress over some particularly bad news. Staff spoke quietly with the relative and comforted them while giving them time to absorb the bad news, ask questions, and express their distress. We also observed a nurse contacting a patient's relative on the patient's mobile phone at their request. The patient was not able to talk, but the member of staff was able to understand the patient and pass the messages of reassurance to the patient's family.
- Patients and relatives said staff asked appropriate questions about the patient to get to know them. This included, for example, what the patient wanted to be called, whether they had any specific interests, and what foods and drinks they preferred. We saw this reflected in patients' notes.
- Relatives were approached with compassion when a patient was a possible eligible organ donor. We met the specialist nurse for organ donation and were impressed with their knowledge, experience and genuinely warm character.

Emotional support

- Psychological support was available from within the hospital. Staff from that service would visit patients if requested by the clinical staff, the patient or a relative. There was also support from the chaplaincy and a team of spiritual advisors who were on call at all times. The matron said the unit would bring in support from anywhere if they thought it would benefit the patient or their relatives. This included spiritual or other support from the patient's own local connections and networks.
- There were formal assessments for patient depression and delirium screening. Research has shown that patients might get depressed or anxious or have other mental health issues for which they might need additional support following long stays in intensive care units (ICUs).
- Patients had support from nurses with additional knowledge. There were nurses with link roles in matters relating to mental health, learning disabilities and dementia. The staff told us they all understood how being admitted to a critical care unit could often provoke anxiety in patients without any mental impairment, so it was likely to be even more difficult for patients with mental health needs. Nursing staff said carers, families and care workers were encouraged to come to the unit to provide emotional support, and were helped to overcome any of their own anxieties so they could provide comfort to confused, scared or disorientated patients.
- The department used some of the latest innovative ideas for patient support. Patient diaries were in use and had been developed through a multidisciplinary review led by one of the consultants in intensive care. A report from the review by the critical care team around the use of the diaries highlighted how research has shown that patients sedated and ventilated in critical care suffer memory loss and often experience psychological disturbances post discharge. Patient diaries were introduced to provide comfort both to patients and also their relatives during the stay and post discharge. Diaries were said to not only, "fill the memory gap, but also provide a caring intervention, which can promote holistic nursing". There was criteria for the use of patient diaries and advice for staff on the format to use and on encouraging friends and relatives to make entries. Photographs were also known to help patients,

and these could be used with appropriate consent. If the diaries were not passed to the patient or relatives (for any of a number of reasons), they would be kept secure for six months so either the patients or relatives could see them if they wished.

- The department had a strong focus upon bereavement and care in the last days of life. There was a link nurse for bereavement and a bereavement team within the department. The trust had produced a care plan to be used in the specific circumstances of a patient approaching death. The bereavement team had specific responsibilities and would speak as often as possible to the relatives and friends of a patient who had died. Relatives were given a card when they left the department saying someone from the team would call them in six to eight weeks to provide support for any questions that had not been asked or comments that were unsaid. A remembrance card was also sent to the family a year after the death of a patient within critical care. We saw two patients' records where all the communications with the families about bereavement were recorded and follow-up information was recorded.

Are critical care services responsive?

Good

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

The facilities in critical care were excellent for patients, visitors and staff, and met all of the modern critical care building standards.

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

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

Service planning and delivery to meet the needs of local people

- There was a good response from consultants when new patients were admitted. The shift patterns were established so all patients were seen by a consultant intensivist within 12 hours of admission.
- The environment in the unit was designed to meet patients' and visitors' needs. As recommended by the Department of Health, there were separate entrances for visitors and patients. There was an intercom and CCTV at the main entrance, although the CCTV was only a telephone screen and not good quality. Staff were able to see patients in the open bed space areas, and patients in the side rooms in the unit were supported by and visible to staff working in the immediate area. Side rooms were, as recommended, square or rectangular, and not L-shaped, where visibility could be reduced. Doorways and corridor spaces were wide enough to allow equipment to pass through easily. When we visited the unit, the air temperature was comfortable. The bed spaces and side rooms were of a good size and each had lockable storage for patients' medicines and valuables. There were work surfaces and chart stands for staff to use, and each bed space was fully screenable from the next.
- Patient and relative facilities were good. There was a large relatives'/visitors' waiting room with plenty of comfortable chairs, kitchen facilities and information about the unit. There were toilet facilities for visitors close to the waiting area. There were two smaller visitors' rooms with chairs and a sofa bed for one person to be able to stay overnight. These rooms could be used for more private conversations with visitors. All areas were suitable for people using wheelchairs or other aids for disabilities.

- There were good facilities for staff to work and rest. There were staff offices and changing rooms. Senior staff shared offices, but said there was always somewhere available for private conversations.
- The hospital had the ability to temporarily increase its capacity to care for critically ill patients in a major incident, such as a pandemic flu crisis or serious public incident. This would involve using the recovery unit in theatre, where staff were trained in caring for critically ill patients and would be supported by the critical care team.
- There was a range of booklets and information for both patients and families. This included leaflets that could be given to visitors and information on the trust's website. The leaflets were designed by the unit and explained aspects of the environment and specific treatments, such as use of a tracheostomy, intravenous cannulas, and information on preventing blood clots (venous thromboembolism) and pressure ulcers. There was a helpful booklet designed for patients about leaving hospital. It included advice on how to remain hydrated and nourished. Information extended to explaining how sleep patterns might change, and possible mood swings. There was a contact number for the unit, and patients were encouraged to remain in touch. There was also a list of support groups, their contact details and website addresses. There was, however, no reference within the leaflets to how to obtain the information in another language or format.
- There was support for patients who were homeless when they were admitted or who had dependency upon drugs and/or alcohol. Staff would involve the local social services team with anyone who had social needs and liaise with any established key workers or the mental health crisis team. There were links with support workers for the homeless and with addiction charities.

Meeting people's individual needs

- Patients were treated as individuals. There were telephone translation services for both patients and relatives where English was not spoken or not easily understood. There were communication boards on which patients with tracheostomies could write messages or point at symbols and images. Staff spoke about equality and diversity and had knowledge of different cultural and religious needs. In each conversation with staff they spoke about treating patients as individuals and wanting the best outcomes for patients, including respecting their individuality.
- To meet individual needs, the unit had a wide range of nurses with link roles. At least 15 link roles were identified in the unit. They included nurses leading on such subjects as tissue viability, infection control, nutrition, pain management, and patients with learning disabilities, among others.
- Patients with a learning disability were supported by trained and experienced staff. There was a link nurse with a special interest in people with a learning disability. They were part of the hospital-wide team directed by the lead for supporting patients with a learning disability. The trust had developed a resource for staff for caring for and supporting patients with a learning disability. This covered areas such as mental capacity, behaviours that challenge, and guidance about behavioural strategies. There was a guide with the 'top 10 tips for consultation for people with a learning disability'. The speech and language team had provided guidance about swallowing and safe nutrition regimes. There was also information on communication and discharge arrangements. Patients who came to the hospital from a community care setting were asked to bring or produce a 'hospital passport'. This is a recognised document used for people who live with a learning disability, so staff are able to know as much about them as possible should they have difficulty with communication.
- People with a dementia were given additional support using national guidance. A specific care plan was designed for the patient experiencing memory loss and disorientation and known to have dementia. The care plan referenced the Department of Health National Dementia Strategy 2009 and Mental Capacity Act 2005. Patients were to be assessed for memory loss, orientation and comprehension. The mental health liaison team was highlighted as a source of additional support for staff. If it had not already been done, carers were asked to complete the 'this is me' document, which would be used to plan patient care against specific needs or characteristics.

Critical care

- There was natural light from the windows and large clocks visible to patients, although they were not 24-hour clocks. It is well recognised in critical care units that patients can become disorientated, particularly around day and night.
- Patients' rights were observed. Where possible in the circumstances, there was fast-tracking for patients who were deemed to be at the end of their life and wanted to go home to die.
- At the time of our inspection, there was no critical care follow-up clinic. These sessions were a part of National Institute for Health and Care Excellence (NICE) guidance for rehabilitation after a critical illness, but were recognised as taking time to arrange and hold, and with only limited uptake from patients. As part of its future strategy, the department was looking at holding telephone follow-up consultations with patients around two to three months post discharge.

Access and flow

- The discharge of patients from critical care was mostly achieved at the right time for the patient. Studies have shown discharge at night can increase the risk of mortality, disorientate and cause stress to patients, and be detrimental to the handover of the patient. Intensive Care National Audit and Research Centre (ICNARC) data for discharges made out of hours (between 10pm and 7am) placed the unit almost always below (that is better than) the national average for night-time discharges for similar units. Approximately 2% (four patients) of all discharges took place at night in the latest ICNARC period of 1 July to 30 September 2014.
- Similar to most critical care units in England, for this unit ICNARC reported a high level of delayed discharges from the unit. However, this was significantly below the NHS average. On average for the last four years, around 15% of all discharges were delayed by more than four hours from the patient being ready to leave the unit. This had crept up in the quarter 1 July to September 2014 to just below 30%, but this was in contrast to an NHS average of above 50% for similar units. Four hours is the indicator used for comparison with other units and set by ICNARC. It is used to demonstrate the ability or otherwise to move patients out of critical care in a timely way. Although patients remained well cared for in critical care, when they were medically fit to be discharged elsewhere the unit was not the best place for them. This was recognised by staff, who were aware that the unit could also be a difficult place for visitors. The delays were, however, mostly less than 24 hours, and none were more than three days.
- Patients who needed a critical care bed were rarely not accommodated. This was demonstrated by the low rate of transfers to other hospital units and low rate of early discharges, although, when unavoidable, some discharges were made at night to be able to accommodate unplanned admissions. Also, because no ward beds were available, discharges were often delayed, but no more so than in other NHS critical care units. Any patients who were waiting for a bed could be cared for in the post-anaesthetic recovery unit, where they would receive care by appropriately trained staff supported by the intensivists. Twice each day, the department completed a potential admissions and discharge document for the bed management team, to highlight the status of the department, although there was no face-to-face meeting with this team.
- Occupancy levels on the unit were increasing. The number of admissions to critical care had been relatively stable at around 150 each quarter since 2011 to the date of this inspection, although it had reached 170 in the third quarter of 2014. In the ICNARC data from 1 July to 30 September 2014, few patients were transferred into the unit from a high dependency unit (HDU) or intensive care unit (ICU) in another hospital. This rate was below, that is better than, the national average for similar units in the third quarter of 2014. Few patients had been admitted to the unit from other units for non-clinical reasons – that is, admitted to the unit because there was no bed capacity in another hospital unit. The unit was therefore mostly managing its own patients and predictable admissions. Patients were not often transferred to other units for clinical reasons. Usually transfers out were for patients to be accommodated closer to home or for specialist care. There was one non-clinical transfer for the ICU in the latest ICNARC data period (when a bed was needed in another unit because the unit was full), which was the same as the national average.
- There was a very low rate of urgent operations being cancelled due to a lack of an available bed in critical care. A significant number of cancelled operations were

reported to and published by NHS England for this trust, but this had not been because of the lack of availability of a critical care bed. The rate of cancellations because of the lack of a bed in critical care was also lower than in NHS units of a similar bed capacity.

- There was a low rate of patients being discharged from critical care too early onto wards (that is, when they were not quite well enough) to make way for new admissions. In the ICNARC data from 1 July to 30 September 2014 and the previous quarter, no early discharges were reported, against the national average of around 2%. In past years, the unit had only rarely been above the national average, and was mostly well below.

Learning from complaints and concerns

- There had been very infrequent complaints to the critical care department. Information was available in visiting areas and on the trust's website outlining how to make a complaint and how it would be dealt with. We looked at complaint, concern and compliment statistics for August 2014 to February 2015 (excluding November), and there were no complaints or concerns in this period, but 18 compliments.
- The service managed complaints well and learned from things that went wrong. We reviewed a past complaint relating to poor communication. The relative who contacted the department was given a full explanation in response to their concerns and a fulsome apology. An action plan was attached to the complaint with lessons learned from the complaint and a record of how and when these were communicated to all staff.

Are critical care services well-led?

Outstanding ☆

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

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

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

Vision and strategy for this service

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

trainee doctors that had been recognised. The lead consultants attended the trust-wide 'Futures Group'. This was to ensure that the impact upon critical care of any changes proposed for the hospital was considered.

Governance, risk management and quality measurement

- There was a clear structure for clinical governance. This demonstrated how the critical care department fed into the hospital trust structure and how assurance was made through the various committees into the divisional board and then trust board.
- Sufficient time and resources were given to governance and safety, quality and performance review. There was a dedicated consultant intensivist governance lead for the unit and a dedicated band 7 nurse for nursing governance and investigation of serious incidents. There were other staff with lead and link roles. This aspect of risk management and quality measurement was strongly promoted, and staff were enabled to suggest any aspect of care in the department for which to take a link or lead role.
- A comprehensive review of the department was held each month within the anaesthetics, critical care and pain team. There was an extensive presentation of audit and governance information. We looked at the presentation from the previous meeting and the one being prepared for the next. Information included actions from the last meeting, identifying those that could be closed or remained open. Patient experience was discussed along with any complaints, comments or concerns. The meeting then covered safety issues, audit performance, the risk register, assessments under National Institute for Health and Care Excellence (NICE) guidance, objectives and how they were progressing, business cases in development, capital requirements, and staff metrics (such as sickness, training and appraisal compliance).
- A wide-ranging set of audits and performance measures of aspects of care and safety within the unit was carried out with a high frequency and in accordance with an approved divisional audit calendar. There was a programme for standardised audits – such as ventilator-associated pneumonia incidence, or central venous catheter line checks – to demonstrate or show the need for continuous improvement. Performance data and quality management information was collated and examined by the unit to look for trends, celebrate good performance or question any poor results.
- The unit understood, recognised and reported its risks. The divisional risk register was being used to raise those identified risks and concerns relating to critical care. Staff were proactive when raising risks, and we saw that these were monitored and actions taken to reduce them. The risks around delayed discharges had been escalated to the register, as well as the lack of a seven-day outreach service. The business case to increase the outreach team had received board approval, and staffing was being increased to provide full coverage for attending patients. Any risks scored at 15 or above were escalated to the trust's corporate risk register.
- There were extensive investigations into any serious incidents and actions taken to prevent recurrence. We reviewed three root cause analysis reports for two pressure ulcers acquired in 2014 and a serious incident involving a patient transfer. The reports had clear actions and we saw evidence of how the changes to practice that had been identified had been put in place. The reports also extended to include notable good practice found during the investigation. We also saw how a serious incident not directly involving critical care had been shared, and learning from this event had been taken on board by the department.
- The unit participated in a national database for adult critical care as recommended by the Faculty of Intensive Care Medicine Core Standards. The unit contributed data to the Intensive Care National Audit and Research Centre (ICNARC) Case Mix Programme for England, Wales and Northern Ireland. ICNARC reported that the data supplied was well completed and of good quality. There was evidence from governance reports of the findings from these respected reports being presented to the executive team and divisional board to demonstrate the strong outcomes for patients therein.
- Staff were included in and informed about the running of the unit. A wide range of unit and divisional meetings were held at regular intervals. All meetings were minuted. The meetings had a range of staff input depending upon the nature of the meeting. For example, there were clinical governance meetings for

the department of critical care across both hospitals. These were held each quarter. There were monthly clinical governance meetings for the department of anaesthesia, critical care and pain. Other meetings for which we saw and read minutes included: critical care departmental meetings for all nursing staff grades led by one of the sisters, band 7 nurses, band 5 nurses and healthcare assistants, cross-site band 7 nursing meetings (held quarterly), and an infection control meeting. The minutes were carefully recorded for each meeting and covered a range of subjects including clinical matters, budget discussions, staffing levels and skills, the risk register and any serious incidents arising.

- Audit information was made available at clinical governance meetings, including the mortality and morbidity meetings. This included the quality indicators from ICNARC; whether the department had met the Core Standards for Intensive Care Units or doctor and nurse cover (it consistently had over the three years in the latest report), whether there had been structured handovers (there had), multidisciplinary rounds (there were) and appropriate isolation performed (there had been), and whether the daily goals sheet for patients was in constant use (it was).

Leadership of service

- The leadership of the service by the clinical lead consultant intensivist and the team of experienced staff was strong and committed. There was a commitment to an outstanding service and clinical governance that was delivering a consistently safe, effective, caring and responsive service. The nurses we spoke with had a high regard and well-earned respect for their medical colleagues and the allied health professionals, and worked as a cohesive and collaborative team.
- The nursing leadership of the service was strong. The matron and senior nursing staff demonstrated a strong commitment to their staff, their patients and one another. They were visible on the unit and available to staff. The Matron, who was relatively new in the post and had been promoted from within the department, was respected by all the staff we met. The Matron was described as “amazing” by one member of staff. The Matron said they were encouraged to have a strong voice and raise awareness of their unit with the nursing management. The consultants we spoke with had a high regard and respect for the Matron, the nursing team, and the allied health professionals. The nursing team was described by the lead consultant as “fantastic”. All the leadership within critical care praised the support of their general manager, and the nursing team spoke highly of their relationship with the director of nursing.
- The leadership was fully supportive. We judged that the leadership of the service would defend the staff when needed and take responsibility for any rare mistakes. The leadership ensured staff were supported at these times and took the lead on making any changes to avoid errors in future. The consultants talked of fully respecting the skills and experience of the nursing team. They looked at continually empowering the nurses to develop skills and knowledge, with close supervision, all in order to benefit safer, more effective patient care.
- The trust ran a leadership development programme called ‘i-lead’. This involved all service directors (including critical care) getting together to discuss whatever they chose. In recent meetings they had been joined by some of the executive team, who had seen the value of these meetings and recognised how they could learn from them and offer support and motivation.

Culture within the service

- The team that worked in critical care had strong shared values, and there were longer-term safety, quality and performance objectives for the team. The Matron said their priorities were excellent care to patients and their relatives, a happy team with good resources and support, and an environment of which to be proud. The Matron said the general manager was aware of these priorities, as were all the staff reporting to the Matron, who shared and supported the priorities. The priorities for the lead consultant were to mirror the cohesion of the nursing staff among the doctors across the two sites, and to maintain and allow the strong culture to flourish.
- There was a collaborative approach to changes and improvements. The consultant intensivists had recognised the need to use one type of ventilator for patients to improve safety and effectiveness. There had been a debate and various presentations among consultants around different options, before the group had made a decision on the equipment to move to and this had been approved by the whole team.

- Staff said they were encouraged to raise concerns and had no fear of any retribution. They said they did not feel they were or would be blamed when things went wrong, and were subsequently not discouraged from speaking up.
- A strong culture of teamwork and commitment was spoken about among staff in the critical care department. Staff spoke of being proud of their unit and the care they were able to give. Patients and relatives also commented on the positive nature of the staff they met. Staff said they felt valued, with a number of staff describing the unit as a family. One of the band 5 nurses in the team had recently been given a trust-wide award for caring. This had been publicised in the trust's newsletter.
- Trainee doctors were well supported on the unit. We were told consultants were easy to contact when trainee doctors needed advice. Nurses were also supportive and helpful to trainee medical staff.
- Staff were supported at difficult times. Nursing staff said their team leaders called them at home to check whether they were okay when they had worked a difficult shift, or equally when something had gone particularly well. Staff could also contact their team leaders at home themselves. There was a coaching service for senior staff, and counselling services were available for all staff.

Public engagement

- The unit had access to charitable funds. The unit could apply for these, and had done so in the past. Funds were available for items such as education, relatives' facilities, and anything relating to patient care.

Staff engagement

- Staff told us they were able to meet formally with the trust's divisional board if required or warranted. They said these meetings were well attended and they felt offered both a safe and supportive environment in which to raise any concerns or share learning or innovation. Staff said they felt they would be listened to if they had concerns and could take these to the highest level and be heard.
- There was an away-day for band 6 nurses in September 2014 and another arranged for April 2015. There was an agenda with guest speakers on various subjects including organ donation and safeguarding, and the clinical lead and Matron talking about plans for the future.

Innovation, improvement and sustainability

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

Maternity and gynaecology

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

Information about the service

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

Cheltenham General Hospital provides maternity and gynaecological services to the local community of Gloucestershire and the surrounding areas. Gynaecological oncology is provided on Prescott Ward, a 35-bed ward taking a variety of specialty cases, with close links to the oncology department. A surgical termination of pregnancy service operates from the Chedworth Suite. All terminations are carried out by a different provider, not inspected as part of this inspection.

Cheltenham Maternity Unit is a stand-alone midwife-led unit nine miles from the main obstetric unit at the Gloucestershire Royal Hospital. The unit comprises five birthing rooms, two of which are fitted with birthing pools.

The ground floor of the maternity unit houses an antenatal clinic, used by visiting consultants to provide antenatal care from Mondays to Fridays. In addition, there is a maternity assessment centre comprising four reclining chairs and one couch, which operates from Monday to Friday, from 8.30am to 12.30pm, and an early pregnancy assessment centre, which is open three days per week. The birth centre comprises five birthing rooms, a clinic area and a clinic room.

Between 1 April 2013 and 31 March 2014, and from 1 April 2014 to 30 November 2014, the breakdown in births across the whole service was as set out below:

April 2013 – March 2014

Cheltenham - 399

Home (trust wide) -187

April 2014 to November 2014

Cheltenham - 270

Home (trust wide) - 106

During the inspection, we spoke with one patient and 12 staff. These staff included senior managers, midwives, nurses, specialist nurses, junior doctors, healthcare assistants and midwifery support workers. We held a variety of focus groups, including one attended by nine midwives. In addition, we reviewed four patients' healthcare records and observed care being given. Before and during our inspection we reviewed the trust's performance information.

Maternity and gynaecology

Summary of findings

We rated the maternity and gynaecology service at the Cheltenham General Hospital good in all domains, providing safe, effective, caring, responsive and well-led care.

There was a good culture of incident reporting, openness and learning, with good governance processes to support this. Women were provided with one-to-one care in labour and patient risks were well managed. Care was delivered in line with national guidance in a caring and compassionate manner with high levels of patient satisfaction. The provision of gynaecology oncology services in Cheltenham ensured timely access to ongoing oncology support and treatment. The maternity service meant women were able to have normal midwife-led care closer to their homes. The services were well-led by a long established cohesive team.

However there was no process to identify if equipment had been cleaned and was ready for use and medicines were not securely stored nor held within tamper proof containers.

Are maternity and gynaecology services safe?

Good

Safety within the maternity and gynaecology service was good.

There was a good culture of incident reporting, openness and learning. Whilst trust-wide midwifery staffing levels were worse than the England average, there were sufficient staff to meet patients' needs and provide one-to-one care in labour; however, nurse staffing levels on Prescott Ward fell below the expected numbers at the time of our inspection. Risks were managed well and staff were trained to manage care in the event of an obstetric emergency.

There were no processes to identify whether equipment had been cleaned and was ready for use. Medicines were not securely stored nor held within tamper-proof containers.

Incidents

- All grades of staff we spoke with were aware of the incident reporting system, which was available in the clinical areas although not immediately accessible to staff working in the community. Staff reported easy access to incident reporting. Staff told us they felt confident to report incidents.
- There was a trust-wide list of incident categories, and maternity-specific categories had been devised. This gave staff clear guidance on what constituted an incident, for example third and fourth degree tears, postpartum haemorrhages and maternity transfers to the obstetric unit in Gloucester.
- Less serious incidents were investigated at ward and department level by the midwife or nurse with lead responsibility for that area. The nurse consultant/lead nurse for gynaecology was informed of all incidents that occurred on Prescott Ward. All incidents described as 'moderate' were reviewed by the lead nurse/midwife for quality and governance. Actions identified were monitored for completion through the maternity clinical governance and the gynaecological clinical governance groups. These were fed up into the divisional board

governance meetings and onward to the trust-wide safety experience review group, a subgroup of the board with overall responsibility to review safety measures were in place.

- No serious incidents had been identified in the previous year; however, there was a clear process for reporting, investigating and monitoring actions.
- Staff received feedback following moderate and serious incidents. This occurred at ward and department meetings as well as via newsletters such as the 'maternity and newborn' newsletter. The newsletter also detailed activity, birth outcomes and changes to practice, for example the commencement of intermittent auscultation (listening to the foetal heartbeat) stickers for use in labour, which reduced risks by providing action prompts for midwives. Learning from incidents on Prescott Ward occurred at ward meetings, and learning as a result of incidents that occurred on other sites within the trust was evident. For example, for every vaginal pack used, a pink band was placed on the patient's wrist. Each time a pack was removed, a pink band was taken off, providing a visual aid to ensure all vaginal packs were removed.

Duty of Candour

- Staff were aware of the Duty of Candour and told us how women were informed of incident investigations and outcomes. Letters were sent to women at 10 days in line with the trust's policy. Serious incident investigations within the wider maternity service detailed how patients and relatives had been informed and supported throughout the investigation.

Safety thermometer

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

Cleanliness, infection control and hygiene

- Cleaning audits were not on display within ward areas for staff, patients or the public to see.
- No system was in place to indicate when a piece of equipment had been cleaned and was ready for use; however, signs had been created on the birth unit which were placed on the doors of delivery rooms once they had been cleaned.
- Antibacterial hand disinfectant was available at the entrances to the wards and departments. It was also present within each birthing and examination room.
- Staff were seen to be 'bare below the elbows' in clinical areas in accordance with the trust's infection control policy, and were observed washing their hands prior to and after carrying out patient care.
- Aprons and gloves were readily available, and we saw that staff used them when carrying out the specific duties for which they were required. However, we noted one staff member carrying a full container of urine without wearing gloves. However, good practices were seen elsewhere.
- Patients on Prescott Ward with infections were nursed in side rooms. We saw a sign on the door – 'stop, think, infection control' – advising all who entered of the infection control risks and need for additional precautions. We saw staff entering this room with aprons and gloves on, and removing them before leaving. Staff were then seen washing their hands, reducing the risk of infection being spread to other patients.

Environment and equipment

- Patients on Prescott Ward were seen to have good access to call bells. Emergency call bells were in place and all areas were equipped with emergency resuscitation trolleys.
- Birthing rooms were equipped with piped oxygen and suction, and staff reported that sufficient resuscitaires were available to support neonatal resuscitation.
- Rooms at the birth centre were spacious and calming. Birth couches were provided rather than beds, and two rooms were equipped with pools. In addition birthing stools, balls and mats were available to facilitate mobility in labour. All rooms had en suite facilities, and emergency evacuation equipment was available for use

in the event of a maternal collapse in the pool. Transfers out of the pool were practised, and manual handling was included in the mandatory training programme for all maternity staff.

- Equipment was serviced regularly by the trust's maintenance department, which held an inventory of when equipment servicing was due. We reviewed the service dates on a variety of pieces of equipment, including resuscitaires and monitors, and saw these to have been serviced within the last year.
- Doors into all wards were locked with a buzzer entry system and CCTV.
- Staff in all areas had access to emergency equipment, which was stored in wards, departments and the birth unit.

Medicines

- Not all medicines were securely stored. Medicine cupboards were locked on all wards and departments; however, medicines stored on adult and neonatal emergency resuscitation trolleys were neither securely locked nor stored within tamper-evident drawers/boxes. This meant there was a risk they could be removed or tampered with.
- There were processes for checking the drug fridge temperatures, and we observed that temperatures were recorded daily and fell within acceptable limits.
- Midwives were able to administer some medicines under patient group directives. This included medicines for the emergency treatment of severe bradycardia (low foetal heart rate) in labour and also severe postpartum haemorrhage while transfer to the main obstetric unit occurred. Training for this was included during the midwives' preceptorship programme and included in mandatory training updates.

Records

- During the inspection we reviewed four sets of care records. These contained all relevant risks assessments, such as venous thromboembolism (VTE), falls and pressure ulcer risks. This information was held within a document entitled the 'Gloucester patient profile' for patients on Prescott Ward. We saw that maternity notes recorded risk assessments regarding place of birth.
- Women carried their own records for the duration of the pregnancy. Once delivered, women were issued with postnatal records for their care to be documented, and a child health record (red book). These were completed by the midwife or midwifery support worker at subsequent visits.
- Access to past medical records was described as good. Within the maternity service, old records were routinely obtained when the woman was booked for care.
- Midwives conducted audits of record keeping as part of their annual supervisory review. Their records were audited and reviewed by their supervisor of midwives and any remedial actions identified.

Safeguarding

- Staff received training in safeguarding vulnerable adults and children and recognising abuse. Where appropriate, staff within the maternity service were trained to safeguarding level 3. Staff on the gynaecology ward had safeguarding training to level 1 or 2, dependent on their role. There was an 80% compliance rate within the maternity service. Midwives we spoke with were aware of processes to follow in the event of a safeguarding concern.
- Systems were in place to identify women and babies at risk, including risk of domestic violence.
- The maternity unit employed a lead midwife in safeguarding as well as midwives specialising in substance misuse and teenage pregnancy. These were available to provide support and advice to midwives working in Stroud and the surrounding community.
- Community midwives attended safeguarding case conferences and strategy meetings in partnership with the local authority.

Mandatory training

- Staff reported good access to mandatory training.
- Mandatory training also included a 'prompt' skills drills training day and a one-day maternity update for staff working within the maternity unit. The trust employed practice development midwives, who monitored attendance at mandatory training across the whole of the maternity service. Staff were automatically booked onto mandatory training annually. Failure to attend was escalated to managers for action.

- Mandatory training attendance was noted to be 92% for the skills and drills training and the maternity update day for midwifery staff.

Assessing and responding to patient risk

- All staff used a communication tool known as RSVP, which stood for 'reason, summary, vital signs and plan'. RSVP stickers were seen on telephones.
- Staff completed the early warning score on Prescott Ward to record patients' vital signs and identify concerns. We saw that where concerns had occurred, they had been escalated to medical staff.
- Risk assessments were completed for place of birth at booking. These were reviewed at 36 weeks' gestation and again when the woman was admitted in labour. This ensured the protocol for low risk midwife-led care was followed.
- In line with other units in Gloucester and Stroud, women identified as being high risk but who requested midwife-led care were seen by a supervisor of midwives and a complex care plan devised in agreement with the woman and in discussion with an obstetrician. These plans were stored within the woman's notes and also on the supervisor of midwives' shared computer drive to ensure each supervisor of midwives and all band 7 midwives were fully aware of the agreed plan of care.
- Staff working on the birth centre were able to administer medication to cease contractions in the event of a prolonged fetal bradycardia (low heart rate) and also in the event of a severe postpartum haemorrhage, whilst transfer to the obstetric unit in Gloucestershire Royal Hospital occurred. Women experiencing third and fourth degree perineal tears were also transferred for perineal repair in theatre.
- All transfers to the main obstetric unit were incident reported, and reasons reviewed.
- On Prescott Ward, we saw evidence of completed World Health Organization (WHO) surgical safety checklists in postoperative notes.
- We saw evidence of actions as a result of risks identified. For example, intentional rounding had occurred hourly and risk assessments had been reviewed as a patient's condition changed.

Midwifery/ Nurse staffing

- Trust wide, the funded-midwife-to-births ratio was 1:31.5. While this had improved from 1:34.1 in October 2014, this was worse than the Royal College of Obstetrics and Gynaecology guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007), which states there should be an average midwife-to-births ratio of 1:28. The funded-midwife-to-births ratio was also worse than the England average of 1:29. A risk assessment was in place and the risk was monitored via the risk register.
- However, staff described providing one-to-one care for women in labour 100% of the time. Two midwives and one midwifery care assistant were on duty during each shift. In addition, community midwives were called to provide additional support during peaks in activity. During the inspection, we saw three women in labour. Community staff had been called in to provide midwifery care and also support during the transfer of a woman to the main obstetric unit. This flexibility ensured one-to-one midwifery care.
- Acuity was monitored using the birth rate plus acuity tool, with acuity monitored four hourly. This meant midwifery managers were able to benchmark staffing against patient acuity.
- There was a clear escalation policy that detailed how additional staff were to be obtained in the event of increased sickness or high activity and/or acuity within the maternity service. This included additional support from the senior midwifery team and supervisors of midwives. When additional support was needed, incident forms were completed in order to monitor the frequency of this happening.
- There were currently no whole-time-equivalent midwifery vacancies across the service. Sickness rates within the maternity service at Cheltenham General Hospital were low, with a rate of 2.4% among midwives in the birth unit and 1.4% in the community. This was the lowest across all three areas within the trust, where the average midwifery sickness was 3.6% for December 2014. Sickness across the gynaecology service as a whole was also better than the national average, at 3.8%.
- Expected and actual staffing levels were not displayed within the maternity unit; however, they were displayed on Prescott Ward. There was a difference between the

number of staff detailed on the safer staffing boards and the actual number on duty, the latter being fewer. This ward cared for a mixture of general surgery and gynaecological patients.

- The trust had its own bank of nursing and midwifery staff. Agency midwives were not used, and few agency staff were required to cover the gynaecology service.

Medical staffing

- Medical staff provided outreach antenatal clinics only at Cheltenham General Hospital. All other maternity care was midwife led. Midwifery staff referred patients to the obstetrician on call for the maternity unit at Gloucestershire Royal Hospital in the event of concerns. On-call cover was provided there 24 hours per day, seven days per week.
- Junior medical cover was provided for gynaecology patients on Prescott Ward seven days per week, from 8.30am to 8.30pm. Outside these hours, medical care was provided by the surgical team on call for the hospital. Consultant gynaecologists were on call providing 24-hour cover, seven days per week. Medical staff we spoke with described good support and access to consultants for advice.
- Medical handovers, however, were described as 'weak'. No formal handover mechanisms were in place between the gynaecology team and the 'covering' surgical team out of hours. Handovers were unstructured, which meant there was a risk that patients' care needs would not be discussed and handed over to the covering doctor.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Good

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

Care and treatment delivered was evidence based, with policies and guidelines developed in line with national guidance. Outcomes were monitored and actions changed as a result.

Postoperative pain was managed with patient-controlled analgesia, and women in labour were able to access a wide range of pain relief, including the use of water in which to birth.

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

Evidence-based care and treatment

- Policies and guidelines were developed in line with both National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecology (RCOG) guidelines. Policies, guidelines and protocols were available for staff to access on the trust's intranet site. However, the service reported current non-compliance with NICE clinical guideline 63, on diabetes in pregnancy, although glucose tolerance tests were due to commence for all women with a booking body mass index greater than 30.
- Policies and guidelines were subject to review through the Gloucestershire obstetric guideline group chaired by a practice development midwife. We observed that policies and guidelines were maintained and up to date.
- Babies born with tongue tie were seen in midwife-led clinics. Across the whole service, approximately 600 babies were treated annually.
- Regular audits were undertaken, with findings presented monthly.
- Findings from audits were shared across the whole maternity service in the 'maternity and newborn' newsletter.
- Research had shown the first stage of labour to be shorter for women who were upright or walked around,

which reduced the likelihood of medical intervention. Midwives in all areas, including the Cheltenham maternity unit, promoted this with the 'Mums Up and Mobile' (MUM) programme.

- Following an audit of transfers to the obstetric unit for retained placentas, staff had promoted physiological management for the third stage of labour. A subsequent review had shown a fall in the number of women transferred, which correlated with an increase in the numbers experiencing physiological management.

Pain relief

- Women in both the maternity and gynaecology service had a full range of pain relief options available. Pain scores were monitored on Prescott Ward. Pain relief available ranged from simple analgesia (paracetamol) to patient-controlled analgesia administered via a pump. Patients we spoke with told us their pain was well managed.
- Women in the birth centre were encouraged to remain mobile and active during labour to reduce pain. Essential oils were available, and all midwives undertook a half-day study day in their use, with training updates covered within the mandatory study day.
- Nitrous oxide for pain relief was piped into all birthing rooms.
- Women were able to have epidural analgesia only on the delivery suite in the obstetric unit. The birth centre did not provide epidurals, as the birth centre was for women of low risk who requested normal midwifery care. Information about this was provided to women when they chose their place of birth. Transfer to the delivery suite was required if a labouring woman on the birth centre requested an epidural during labour.
- Use of water for pain relief and birthing was promoted, and the number of water births was reported on the service dashboard. We saw that 43% of all births (a total of 175) occurred in water during 2014.

Nutrition and hydration

- The maternity service employed an infant feeding specialist midwife and had achieved UNICEF Baby Friendly Initiative accreditation. All maternity staff underwent initial training in breastfeeding followed by annual updates during the maternity training day.
- The breastfeeding induction rate was 75% against a target set by the commissioners of 78%. To support and further promote breastfeeding, all community midwives had a 'breastfeeding toolkit' and lesson plans to ensure consistency of education in the antenatal period. Of mothers, 71.7% were exclusively breastfeeding on discharge from the midwife.
- Community midwives routinely weighed babies in the community. All babies who had a weight loss of greater than 12% in the community were admitted to the Gloucestershire Royal Hospital for observation.
- Dietetic advice was available to women on Prescott Ward.
- All women were encouraged to remain hydrated in labour. Women in labour had access to kettles in their rooms.

Patient outcomes

- Information relating to outcomes for patients using the service was collated within performance dashboards for both the gynaecology and maternity services. All maternity staff received the performance dashboard monthly via email. In addition, dashboards were presented and monitored within the clinical governance meetings and the divisional board. These fed up into the safety experience review group.
- The maternity performance dashboard for year 2014/15 showed that between 70% and 75% of all births occurred within the obstetric-led delivery suite. Overall, there were approximately 10–16 home births per month.
- Transfer rates from midwife-led care were also reported within the dashboard. Transfer rates of approximately 22–25% were reported from midwife-led units into the obstetric unit, slightly below (better than) the Birthplace survey findings of 26.4%.
- Year to date figures across the whole maternity service showed that 91% of women were booked for antenatal care by 12 weeks and six days' gestation, marginally higher than the national target of 90%. (It was noted that on three months, performance had fallen below 90%).
- Family of origin questionnaires were completed to identify women at higher risk of sickle cell disease and thalassemia. The percentage of these women being screened under 10 weeks' gestation was not reported

on the dashboard. Staff told us that following two audits, they had identified that only 33% of high risk women were completing the family of origin questionnaire, and therefore opportunities for early screening undertaken before 10 weeks' gestation were missed.

- The gynaecology dashboard showed that postoperative readmissions were monitored, as were any missed diagnosis of patients attending the early pregnancy assessment clinic, patients returning to theatre and intraoperative complications.

Competent staff

- All staff received a trust induction when commencing employment, which included basic life support, health and safety and fire training.
- Newly qualified midwives were appointed as band 5 midwives. They then underwent a 23-month preceptorship programme during which they increased their skills and competencies by, for example, undertaking cannulation, episiotomies and suturing. They then became eligible to apply to become a band 6 midwife. Newly qualified midwives were not placed to work immediately in the birth unit.
- There was a band 6 development programme to support staff to develop into the band 7 roles in both nursing and midwifery.
- Midwives undertook annual skills drills training in obstetric emergencies such as postpartum haemorrhage, breach delivery and the management of shoulder dystocia.
- Additional skills and education could be obtained, although it was recognised that funding would not always be available. Additional support and training was provided from a training budget provided from ongoing research.
- All midwives were assigned a supervisor of midwives. A supervisor of midwives is a midwife who has been qualified for at least three years and has undertaken a preparation course in midwifery supervision (rule 8, Nursing and Midwifery Council (NMC) 2012). Supervisors of midwives are referred to for advice, guidance and support. The supervisor of midwives monitors care by meeting each midwife annually (rule 9, NMC, 2012). Other supervisor of midwives roles include auditing midwives' record keeping and investigating any reports of problems or concerns in practice. All the midwives we spoke with had received an annual supervisory review.
- Data provided by the trust indicated that supervisory reviews had been conducted within the last 12 months for 81.6% of midwives trust wide. The trust's supervisor-to-midwives ratio was 1:15, which equalled the recommended ratio. Each supervisor of midwives was allocated 7.5 hours per month in order to undertake their supervisory duties.
- There was a SoM on call at all times to support midwifery staff. The supervisor of midwives rota was evident on the birth centre, and midwives described the SoM attending when called for support and guidance.
- Midwives did not formally rotate into the delivery suite. As a result of only providing low risk care, skills to undertake technical tasks in the event of an emergency, such as cannulation, were rarely required. Several midwives had developed a 'buddy' system to allow them opportunity to rotate into the main obstetric unit to maintain and update such skills.
- Junior medical staff at ST1/ST2 level were only allocated to work during the day (8.30am to 8.30pm) within gynaecology in order to allow for training and educational development opportunities. Medical staff we spoke with described being well supported with regards to workload and training.

Multidisciplinary working

- Midwives worked well with obstetric and paediatric colleagues, referring women and babies as required. Within gynaecology, there were good relationships with surgical and oncology services.
- There was cohesive working with outside agencies such as social services and the mental health liaison team, to promote the safeguarding of mothers and babies.
- Gynaecology cancer nurse specialists worked cohesively with the wider multidisciplinary team. Multidisciplinary team meetings occurred to discuss cases and develop treatment plans. We saw these in patients' notes, and staff we spoke with described how the outcomes from these meetings were fed back to women and their families.

- Advanced nurse practitioners in gynaecology were in post to undertake roles such the management of a nurse-led early pregnancy assessment clinic. Clear referral processes were in place for onward referral in line with agreed pathways, for example in the event of a miscarriage requiring surgical intervention.

Seven-day services

- The birth centre operated 24 hours per day, seven days per week, with staffing consistent across that time.
- The maternity day assessment unit was open from Monday to Friday, from 8.30am to 12.30pm. Medical review during those hours was provided from the antenatal clinic, which was adjacent to the unit.
- The early pregnancy assessment clinic ran three days per week. Out of those hours, assessment occurred in the Gloucestershire Royal Hospital.
- Consultant gynaecologists were on call at weekends and undertook ward rounds for their patients.
- Cancer nurse specialists were available for support and advice from Monday to Friday only.

Access to information

- Staff had access to medical records. When a woman was booked in, medical records were obtained for use during the pregnancy. Staff reported no problems with access to medical records within the gynaecological service.
- Women carried their own pregnancy records, which were provided when booking in. These were used by all clinicians who the woman had contact with during their pregnancy. When women were discharged home following the birth of their baby, new records were made for use in the postnatal stage. These included all information relating to the pregnancy and delivery and baby.
- Medical records were created for each baby at birth so that their healthcare could be documented and linked to them, rather than being recorded only within the mother's notes.
- Notes were held in the office on the birth centre; however, notes on Prescott Ward were stored in an unsecure trolley in the centre of the ward.
- Staff used the RSVP ('reason, summary, vital signs and plan') communication tool when handing over from one to another, to ensure effective communication occurred and plans of ongoing care were clear.
- Staff had access to up-to-date policies and guidelines on the trust's intranet site. Changes to key policies were also communicated via the 'maternity and newborn' newsletter and email, for example as new or amended guidance was released from the National Institute for Health and Care Excellence (NICE) or the Royal College of Obstetricians and Gynaecology (RCOG).
- Staff received performance data updates on a monthly basis. This was either emailed or produced in paper format and displayed in ward offices.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are maternity and gynaecology services caring?

Good

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

Care was delivered with kindness and compassion. Women were involved in decision making, and staff ensured understanding and involvement of patients and their partners/relatives and emotional support through good communication. Friends and Family Test results showed

that whilst responses were low, 93.2–100% of people were likely or extremely likely to recommend Prescott Ward. Comments seen in the visitors' book on the birth centre described positive experiences.

Compassionate care

- On Prescott Ward, we spoke with one patient who described feeling cared for and looked after. We observed care being delivered with kindness and compassion by staff at all levels.
- We were unable to talk to any women on the birth centre at the time of our visit, as all were in active labour. However, all midwives interviewed spoke of a strong commitment to providing a high standard of midwifery care.
- Friends and Family Test results were displayed on the wall in the entrance to Prescott Ward. Response rates were 33% for November 2014, 46% in December 2014 and 44% in January 2015. Of those results, 93.2–100% of patients said they were likely or extremely likely to recommend the ward to friends and family. While the maternity unit collected responses, these were not displayed for members of the public to view, nor were they included on the maternity dashboard. Whilst results were variable across antenatal, birth, postnatal (wards) and postnatal (community services), they were generally above the England average.
- The birth centre held a visitors' book in which women and their partners attending were encouraged to add comment. We reviewed the book and saw many positive comments, such as, "Thank you for a fantastic birth experience. An incredibly relaxing atmosphere and very friendly staff," and "The care and attention provided … was amazing."
- Results from the CQC survey of women's experiences of maternity services (2013) reported outcomes across the trust that were about the same as for other trusts, with three questions scoring better than most trusts. These all related to care during labour and birth, and were 'being spoken to in a way you could understand', 'being involved enough in decisions about care' and 'being treated with respect and dignity'.

Understanding and involvement of patients and those close to them

- Staff were observed explaining procedures. Records reviewed indicated that patients and their relatives were involved in decision making. Within the maternity service, women were supported in their choices through clear discussions of the risks associated with their choices, which were documented, for example when electing to deliver at the birth centre.
- We spoke with one patient on Prescott Ward who described being well informed of their care and treatment needs with regular updates from her consultant, supported with written information.

Emotional support

- Women transferred into the delivery suite from home (in the event of a home birth) or the birth centre were accompanied by the midwife who had been providing their care. This midwife remained until care had been handed over, remaining as their 'familiar face' and continuing to provide emotional support.

Are maternity and gynaecology services responsive?

Good

Maternity and gynaecological services were responsive.

Women were able to make choices on where to have their babies. The service ran home births as well as births in the birth centre. Outreach obstetric-led multidisciplinary clinics were held, and there was access to assessment clinics and an early pregnancy assessment clinic.

Only gynaecological oncology services were provided at Cheltenham General Hospital. This ensured direct access to the oncology service for ongoing support and treatment.

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

Service planning and delivery to meet the needs of local people

- Most routine antenatal care was carried out by community-based midwives. Outreach consultant-led clinics were held at Cheltenham General Hospital, which meant local women could access services in a location closer to their homes.

- The maternity service dashboard for 2014/15 reported that the birth centre had not closed and the home birth service had not been suspended.
- Staff we spoke with told us that while most gynaecology was provided at the Gloucestershire Royal Hospital, they felt it appropriate that in the case of gynaecological cancer, surgery should be undertaken at Cheltenham General Hospital because it ensured effective team working with the wider multidisciplinary team and direct access to support services through the oncology centre.

Access and flow

- The maternity day assessment ward was open from Monday to Friday, from 8.30am to 12.30pm. This was for women requiring glucose tolerance tests, scan reviews and blood pressure assessments. In addition, it acted as a maternity triage centre. Women attending for scan reviews outside these times were required to attend the birth centre in order for a midwife to review the scan.
- Midwives were trained to undertake the newborn screening examination. This could occur in the birth centre or in the community.
- Discharge information was communicated to GPs and midwives when all women were discharged home. Discharge summaries were written and sent to GPs to ensure they were aware of the care and treatment undertaken.
- Prescott Ward was a mixed ward but complied with mixed sex guidance. One end of the ward was described as the male end, and the other the female end. Each was equipped with separate toilet and bathing facilities. Staff said that, although it had occurred, it was rare they would need to increase the number of beds for either men or women and encroach on the other area.

Meeting people's individual needs

- Translation services were provided by a telephone translation service. Staff told us leaflets were available in alternative languages, although these were not immediately available for midwives or nurses to give to women but had to be ordered in.
- The antenatal clinic area was shared with the sexual health service. This meant that at times it could become crowded. The layout was open, which gave little privacy for telephone conversations and discussions. A small room was used for counselling and breaking bad news. Staff we spoke with told us they were hoping to secure charity funds to change the décor, as the room was very much as an 'office'.
- Partners were able to stay with women on the birth centre. Rooms were equipped with tea and coffee making facilities for partners as well as women to use.
- The birth centre held two antenatal drop-in clinics each week, as well as postnatal clinics at weekends. This gave greater choice to women as to where to have their care delivered.
- No patient information leaflets were on display in the antenatal clinic at the time of our inspection; however, the trust's website provided access to patient information leaflets, virtual tours and information regarding public access to supervisors of midwives.

Learning from complaints and concerns

- The number of complaints received was monitored on the service dashboards. Complaints were processed centrally and sent to relevant areas for investigation and the formation of a response.

Are maternity and gynaecology services well-led?

Good

The maternity and gynaecological services were well-led.

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

The women's and children's divisional management team had been stable since 2006. Staff were positive about the support from senior staff and immediate managers and described an open culture. The maternity service had good public involvement.

Vision and strategy for this service

- Staff were aware of the trust's vision for safe, effective and personalised care to every patient, every time. In addition there was a clear vision for the birth centre, with a desire to have more women booked for delivery there.

Governance, risk management and quality measurement

- There were clear governance processes across both services, which fed into the women's and children's division. Service-wide meetings were held that oversaw activity, performance, quality, safety, audit and risk. These in turn fed into the division and onward into sub-committees of the board. There was divisional representation on these committees. Specialist midwives were employed to support the governance function of the service.
- Practice was reviewed and learning shared, for example following a serious incident involving cardiotocography (CTG) monitoring in another area of the maternity service. (CTG is a technical means of recording the fetal heartbeat and the uterine contractions during pregnancy.)
- We reviewed the service-wide risk register. This contained a description of the risks, the date they were added to the risk register and the date they were due for review. The service was in the process of migrating risks from one electronic system onto another. Risk assessments were reviewed and each demonstrated actions put in place to mitigate the risk. The highest risks identified on the risk register were staffing, the ageing scanning equipment and, following a trust-wide change in mobile telephone service providers, poor coverage, contact and communication within the community. We saw from meeting minutes that this had been reported divisionally and trust wide and changes were about to be implemented to improve overall coverage. Staff told us they would escalate risks identified to their managers for inclusion in the risk register.

Leadership of service

- Medical, nursing and midwifery staff described the visible presence of the director of nursing, who was said to be approachable and supportive.
- Midwifery leadership was also visible. All staff we spoke with were positive about the support they received from the senior staff and immediate managers.
- Teams were described as cohesive and supportive.
- The women's and children's divisional management team had worked together in that capacity since 2006. The team described a supportive team around them that allowed them to function well.

Culture within the service

- There was an open and positive culture across both services, which promoted loyalty and teamwork.
- Staff described being happy to raise concerns.
- The opening of the maternity unit in 2010 had seen the bringing together of two smaller obstetric-led units successfully into one. Staff described holding a ball to encourage teambuilding and integration. This had proved to be a huge success, and staff felt it had been key in bringing the two teams together. As a result, the maternity service continued to hold either a ball or to put on a review each year. The next ball was planned for May 2015.
- Despite feeling part of a cohesive service, at times midwives described feeling like "the poor relation" to Gloucestershire Royal Hospital in terms of funding for refurbishment, particularly with regards to the antenatal clinic area.

Public and staff engagement

- The maternity service had service user representation within a number of groups. There was also a trust Facebook page with links to the maternity service. A group known as 'Cheltenham Happy Birthers' promoted the birth centre.
- The public had been asked to provide suggestions for a new name for the birth centre. From public suggestions, the name chosen was Aveta (the goddess of fertility, childbirth and midwives).
- Staff were asked to provide ideas for improvement, through the maternity and newborn newsletter. The newsletter detailed actions that had occurred as a result

of staff feedback, for example skills drills were now held in the birth centre as well as on the delivery suite following requests for training to be focused in the normal setting as well as the high risk care setting.

- Coffee mornings were held in the birth centre for women to attend in order to promote the centre as a choice for place of birth. The most recent had seen 24 women attending.

Innovation, improvement and sustainability

- Staff actively promoted the Mums Up and Mobile (MUM) project, which had also been presented nationally at midwifery conferences.
- Staff had recently undertaken a project looking at estimation of blood loss in the birthing pool. This had recently been accepted for national publication.

End of life care

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

Information about the service

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

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

We visited 11 wards and three specialist departments. We met seven patients, spoke with two relatives and reviewed 12 care records. We talked to 21 staff about end of life care. These staff included the specialist palliative care team, ward nurses and doctors, the chaplaincy team and bereavement and mortuary staff. We observed care being provided to patients and relatives. Before and during our inspection we reviewed the trust's performance information.

Summary of findings

We found end of life care was caring, effective and responsive to individual patients' needs, particularly in the last days and hours of life. Patients were prescribed appropriate medicines to manage end of life symptoms and pain. The relatives of patients we spoke with told us they had been involved in decisions, care was good, and staff were respectful and kind. It was, however, unclear how patients' mental capacity had been assessed, particularly in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. This was a breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

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

Improvements were needed to identify patients who were potentially in their last year of life in order to better plan care. Discharge procedures needed to be evaluated to identify whether patients achieved their preferred place of care. There was no end of life strategy, and governance processes were inconsistent. The priorities for the service were not fully understood or articulated at trust board level.

End of life care

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

Are end of life care services safe?

Requires improvement

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

We reviewed 20 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms. These should demonstrate or link to a reference of patients' mental capacity, and this was not obvious or easily accessible in other records. Explanations for the reason for the decision to withhold resuscitation were not always clear, and records of discussions with patients and their next of kin, or of reasons why decisions to withhold resuscitation were not discussed, were not documented in five of the records we reviewed.

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

Incidents

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

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

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

Safety thermometer

- There was no safety thermometer directly relating to palliative care.
- The specialist palliative care team attended ward areas as and when patients' needs dictated. As such, they did not directly participate in the safety thermometer on wards, as the team's input was not predictable and consistent.

Environment and equipment

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

Medicines

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

Records

- We reviewed 12 sets of patients' records. We saw that discussions between clinical staff and patients and relatives were recorded legibly and sensitively.
- Patients' records reviewed by the specialist palliative care team included detailed conversations noting explicitly what patients and relatives understood or wanted to be informed of, and their concerns and wishes. Action for staff to take in accordance with these wishes and advice for ward staff were clearly documented and reviewed by the specialist team.
- Most clinical staff we spoke with were familiar with the trust's shared care record for the expected last days of life. This document was re-launched trust-wide during January 2015. The record provided prompts for clinicians which emphasised supporting patients' comfort and dignity. For example, in addition to guidance to manage pain and other symptoms, the document included actions to maintain mouth care and provide spiritual support.
- The shared care record included risk assessments of patients' nutrition, mobility and skin integrity. We saw that risk assessments were documented and were reviewed appropriately.
- For those patients who did not yet have a shared care record in place, we observed that pressure care, mobility and nutritional risks had been assessed and reviewed appropriately within nursing records.
- We reviewed 20 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) forms on five wards. These were all attached to the trust's 'unwell/potentially deteriorating patient plan', known as UP forms. The UP/

DNA CPR records did not document or link references to patients' mental capacity, and this was not obvious or easily accessible in other medical or nursing records. The Mental Capacity Act 2005 Code of Professional Practice states the following; "It is good practice for professionals to carry out a proper assessment of a person's capacity to make particular decisions and to record findings in the relevant professional documents." The General Medical Council (2010) advised clinicians to follow one of two DNA CPR decision-making models based upon whether a patient was assessed as having mental capacity or not having mental capacity to make their own valid decisions. For patients who had mental capacity this involved, where possible, the patient being included in discussions and the decision regarding the appropriateness of resuscitation. For patients assessed as lacking mental capacity this involved checking if there was any legal proxy or legally binding advance directive for healthcare decisions, and/or consulting the patient's main carers. As it was not evident which patients had or did not have mental capacity regarding making decisions around resuscitation, it was not possible to audit how decisions had been made; if advance decisions had been respected; if legal proxies had been consulted; or national guidance followed.

- There was no trust guidance to support staff completing the UP form. It was defined within the trust's DNA CPR policy as a "document which clarifies decision making in the acutely unwell inpatient through the timely definition of ceilings (limits) of treatment" and that these decisions should be recorded. We observed nine of the 20 UP/DNA CPR forms noted the patient's diagnosis rather than an explanation of the decision. For example, the following were used as the only reasoning or explanations on the forms for limits of treatment and withholding resuscitation: "breast cancer", "stroke", "frailty" and "infective carditis". Whilst the benefits and risks of CPR may have been reviewed by the doctor in line with national guidance, this was not recorded on the UP/DNA CPR form or within the patients' records we reviewed.
- We observed for five of the 20 UP/DNA CPR forms no discussion had been recorded as taking place with either the patient or their relatives. Whilst there may have been appropriate reasons for not having discussions, no explanations for this were documented.
- The trust's policy states that a healthcare professional (junior doctor or senior nurse) involved in the patient's care can sign to verify a DNA CPR decision until the consultant or senior physician signs the record at the next available opportunity. We looked at the dates when DNA CPR records had been signed by a healthcare professional and the dates when consultants had next reviewed the patient's care. The latter was between one and five days later. The policy had not been followed for six of the 20 DNA CPR records, as these had not been countersigned.
- The trust had completed a retrospective audit and review of the UP/DNA CPR forms during August 2014 using 69 randomly selected patients' records from 14 specialties across both hospital sites, Cheltenham General and Gloucestershire Royal Hospitals. This identified some improvements on the previous two years' evaluations; for example, consultant involvement with the UP/DNA CPR decisions was 65% in 2014 compared with 58% in 2013, and 21% in 2012. In addition, with all patients who had died, each had an UP form completed by staff that documented the limits of care that should have been provided. The audit showed that further work was required, as only 51% of the forms reviewed in the audit were completed 100% accurately. The action plan included feedback of the audit findings to a number of committees, teams, and within mandatory training, with continued annual re-audit to monitor progress.

Safeguarding

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

Mandatory training

End of life care

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

Assessing and responding to patient risk

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

Nursing and medical staffing

- The specialist palliative care consultant divided their time equally between work in the hospital and the community. The core specialist palliative care team at Cheltenham General Hospital consisted of 0.5 whole-time-equivalent (WTE specialist consultant), 0.8 WTE acting head of nursing (covering both hospital sites), one WTE advanced nurse practitioner and 0.7 WTE clinical nurse specialists, with a 0.3 WTE vacancy. In addition, there was one WTE consultant clinical psychologist and 1.1 WTE administrative support.
- The specialist palliative care team said that while it kept the skill mix of the team under review, staffing levels were not sufficient to manage the ongoing demands of complex referrals, staff training needs and planned work. The team was concerned its lack of capacity had contributed to the poor organisational and clinical key performance indicator outcomes identified in the National Care of the Dying Audit 2014.

Major incident awareness and training

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

Are end of life care services effective?

Requires improvement

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

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

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

Evidence-based care and treatment

End of life care

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

Pain relief

- Relatives said staff reviewed equipment used to relieve pain, such as pressure-relieving mattresses, and checked the comfort of patients. Relatives told us staff explained medicines and equipment to relieve pain and other symptoms and how these might impact on the patient, for example that some medicines could induce nausea so additional medicines were prescribed to counteract this.
- Patients and relatives were offered support with emotional and psychological pain through the specialist palliative care team, which included a specialist psychology service, and through the chaplaincy service, ward staff and the bereavement offices. Relatives confirmed how they had been offered or received support, and we saw this was documented in care records.
- Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them, and trained staff to set up this equipment. Staff said that if a patient was provided with a syringe driver and was subsequently discharged, the syringe driver was replaced by the community palliative care team, who returned the original syringe driver to the ward. Staff said this ensured that any patient's pain and symptoms were managed in a continuous and consistent way.
- Patients identified as requiring end of life care were prescribed anticipatory medicines. These 'when required' medicines were prescribed in advance of need to be available to promptly manage any changes in patients' pain or symptoms. Records showed that most of these patients (ten of the 12 whose records we reviewed) had been prescribed anticipatory medicines.
- Guidance on medicines was provided for clinical staff, and records showed pain was regularly assessed and reviewed. Staff demonstrated an understanding of how to assess patients' pain when they were not able to articulate their needs, by assessing body language or using a recognised assessment tool called the Abbey Pain Scale.
- Pain management guidance tools for clinical staff were included as part of the shared care record. Pain medicine information leaflets for patients and relatives were provided on wards or accessible via the trust's website. These had been developed by the specialist palliative care team.

Nutrition and hydration

- The patients' records we reviewed showed that nutrition and hydration needs had been evaluated and appropriate actions followed. These records documented subsequent discussions with relatives

around what to expect with the dying process. One relative of a patient we spoke with confirmed that ward staff had clearly explained all changes in care, including those relating to nutrition and hydration.

- The shared care record for the expected last days of life included ongoing review of patients' nutrition and hydration needs. We looked at eight patients' care records and saw their nutrition and hydration needs had been assessed and reviewed and subsequent actions clearly recorded.
- We observed that patients had drinks available, which relatives said were replenished throughout the day.

Patient outcomes

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

Date	% of referrals for cancer
August 2014	56%
September 2014	57%
October 2014	47%
November 2014	52%
December 2014	62%
January 2015	53%

Competent staff

- We saw evidence that the specialist palliative care team provided regular and ongoing training to different professional groups. These included qualified pharmacy staff, medical and nursing staff, pharmacy and medical students, and healthcare assistants. Training subjects included end of life care, organ donation, advanced communication, and care and management of patients who have had a stroke or cancer.
- During 2008, Macmillan Cancer Support offered finances for developmental (nurse educator) palliative care posts. The trust's board preferred alternative arrangements that were led by the specialist palliative care team, who developed an education package supported and facilitated by a local university. This enabled 36 nurses selected from the 40 different wards throughout the trust's two hospitals (Gloucestershire Royal and Cheltenham General Hospitals) to be trained as end of life ward champions. The modular course

provided successful candidates with either 60 academic credits at level 2 or level 3. These credits could be used at a later date as part of an associated diploma or degree course at the university. At the time of our inspection, there were 32 university-trained ward champions who remained in posts on the wards, across both hospitals. Their role was to act as a key link between the specialist palliative care team and ward areas, providing advice, support and policy updates, and to cascade training updates. There was, however, no further funding available to train additional nurses for the wards where there was no identified champion.

- Staff on the wards we visited knew who their end of life champion was, and said the additional advice and support given by this person helped to maximise patient care and gave staff increased confidence in sensitive situations.
- We spoke with one nurse end of life champion, and they explained how the training and continuing links with the specialist palliative care team had positively enhanced their knowledge, skills and confidence to support end of life patients and their relatives. We saw laminated resources and information flow charts that this nurse had developed to support team colleagues, and meeting minutes documenting updates on end of life care.
- One of the chaplains supported the specialist palliative care team by arranging and chairing bimonthly palliative care update sessions for the ward champions. Staff said these meetings ensured all new end of life practice and policy from the specialist palliative care team was disseminated. Staff said the chaplain was supportive, sending email updates, and was available to provide additional advice between meetings.
- The specialist palliative care team members said they took all opportunities to educate staff in practice by providing micro (short or brief) teaching sessions. This was done when any of the team attended any multidisciplinary team meeting or ward visit. Staff said recent micro teaching sessions had included symptom management and setting up syringe drivers.
- The bereavement service staff had appropriate training to support grieving visitors appropriately. This included counselling, bereavement care and conflict resolution training.
- The specialist palliative care team had developed a range of educational resources for staff, which were available via the trust's intranet or website. For example, these included decision charts to manage complex symptoms and an end of life diabetes care management pathway. Ward staff said the resources supported effective and safe end of life practice.

Multidisciplinary working

- The specialist palliative care team met every morning to discuss current work and new allocations. Work was allocated based on patient need and urgency. The team worked closely with the community palliative care team, transferring clinical management and follow up reviews of patients when they were discharged from hospital.
- The specialist end of life team had a weekly multidisciplinary meeting to discuss end of life patients in more detail and review care and treatment plans. The consultant completed ward rounds every week to review patients' care with other hospital staff.
- The specialist palliative care consultant worked half time in the hospital and half time in the trust's community services. Another specialist consultant worked the same hours but was based at the other trust hospital (Cheltenham General Hospital). The local hospice consultant also worked within the trust's community services. All the consultants met every month to review clinical and governance issues, and covered for each other when necessary. This enabled the consultants to input clinical expertise within a range of multidisciplinary teams, in different care settings, and provide consistent coordinated care.
- The team had extended multidisciplinary input from other specialties and services that attended the specialist team meetings when available and when required. These included: the consultant hospice medical director, the lead chaplain, and consultants from the pain service, respiratory and renal and general medicine, neurology, haematology and oncology. There were nurse specialists from 14 site- or condition-specific services, for example heart failure, Parkinson's disease, multiple sclerosis and the MIND (mental health) link. Staff said this ensured patients received holistic end of life care and support.
- The specialist palliative care consultants and nurses had been attending a range of condition- or site-specific

multidisciplinary meetings when possible, to advise on end of life care during patient reviews. The team said that, because of the ongoing demands of their own clinical caseloads, they would not be able to continue to attend these meetings.

Seven-day services

- The specialist palliative care team was available from 9am to 5pm, Monday to Friday. The specialist nurses provided an out-of-hours telephone advice service for clinicians. The Royal College of Physicians (2014) recommends that hospitals provide a face-to-face specialist palliative care service between at least 9am and 5pm, seven days a week, to support the care of dying patients and their families or carers. The team said it was not able to provide any further out-of-hours support without this impacting on their current clinical workload. Records showed that referrals to the specialist palliative care team had steadily and significantly increased. During 2010, the team had 754 referrals at Cheltenham General Hospital. During 2014, referrals totalled 1,305, an increase of 73%. Staff said the workload was maintained by the goodwill of the team, who regularly worked in excess of their contractual hours.
- The chaplaincy service was integrated within the specialist palliative care team and other services in order to provide and promote good end of life care. The team had an established group of volunteers and links with other faith groups. Staff said this ensured most patients' religious or spiritual needs could be met. The chaplaincy service operated seven days a week, 24 hours a day, in order to be responsive to patients' needs.
- A radiology service was available out of hours for palliative treatments, but this was limited because of staff providing an on-call service only.
- All the wards we visited said they kept stocks of common palliative medicines. The dispensing pharmacy was open from Monday to Friday during the week, and during the mornings on Saturday and Sunday. If wards required additional or alternative palliative medicines out of hours, clinicians could access a computer database and identify other areas that had stocks. These medicines were then obtained elsewhere until the pharmacy reopened. These systems supported end of life patients' fast-track discharge home or into community services out of hours, and ensured adequate pain relief was available at all times.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

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

Are end of life care services caring?

Good

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

Compassionate care

- The two relatives we spoke with said staff had been kind and compassionate and they had no complaints about care provided to their relatives who were patients.

End of life care

- Ward staff told us that, where possible, end of life patients were accommodated in side rooms to increase dignity and privacy for them and those visiting.
- Relatives of end of life patients told us ward visiting restrictions had been lifted and drinks were frequently offered to them, but there was no provision of snacks or meals. One family we spoke with said they ensured they had supplies of food so they did not have to leave their relative's bedside.
- The hospital had limited accommodation for relatives. All the relatives we spoke with said they would not choose to use these facilities, as they wanted to stay close to the patient. Alternative practical support was limited but available when people were visiting for long periods. For example, relatives were offered a pillow and a blanket but slept in high backed chairs.
- We observed nursing care to a patient was given emphasising dignity and compassion. Staff supported the patient at the patient's own pace, explaining all they needed to do and why. We observed that staff bent close to the patient's face so they could be seen and heard. Staff spoke respectfully and with kindness, checking the patient's and their relatives' emotional and comfort needs.
- Grieving relatives had found it difficult in the past to navigate from the bereavement office to the mortuary. Staff recognised that distressed relatives found it difficult to follow navigation instructions between the two services. To improve this, the mortuary staff had designed a white rose symbol used with arrows that marked an easy-to-follow route from the bereavement office to the mortuary. Relatives had since reported they appreciated these signs.

Understanding and involvement of patients and those close to them

- We spoke with three patients and two relatives of two end of life patients, who told us they felt they had been consulted about decisions and care and understood what was currently happening and why.
- We reviewed 12 care records and saw that clinicians had recorded discussions with patients and relatives. These included discussions relating to how certain medical treatments might improve symptoms or why they might not be appropriate. We saw records of actions staff should take in response to patients' and relatives' wishes, for example about requests to speak with a member of the chaplaincy team and who would explain care plans with extended family members.

Emotional support

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

Are end of life care services responsive?

Good

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

End of life care

Service planning and delivery to meet the needs of local people

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

Meeting people's individual needs

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

Access and flow

- Referrals to the specialist palliative care team were made by clinical staff using the trust's computer-based system or by telephone. Ward staff demonstrated they

understood how to make a referral to the specialist team and consistently reported that the team responded promptly, usually seeing patients the same day as referral or the following day.

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

Learning from complaints and concerns

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

Are end of life care services well-led?

Requires improvement

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

However, there was no strategy for end of life care, and governance processes were inconsistent. The priorities for the service were not fully understood or articulated at trust board level. The specialist palliative care team was concerned about its ability to sustain the service and work proactively on end of life standards and innovation because of a steady and increased rise in referrals and teaching commitments without a corresponding increase in its staffing.

Vision and strategy for this service

- The specialist palliative care team demonstrated an understanding of national policy and priorities for end of life care. The team recognised end of life care was "everybody's business", as in the Department of Health's End of Life Care Strategy 2008 and One chance to get it right from the Leadership Alliance for the Care of Dying People 2014. The team worked closely with community palliative care services and the clinical commissioning group (CCG) to reduce duplication and provide seamless care and services for patients who used both hospital and community services.
- The specialist palliative care team had not developed a written strategy for the hospital with defined work plan

priorities for the present and future. Therefore, it was difficult for the team to demonstrate how it was driving forward actions in a consistent way to deliver continued improvements in line with national policy. Consequently, other clinical staff in the hospital we talked with could not demonstrate an understanding of the vision of the service.

- Insufficient assurance was given to the board on matters relating to end of life care. While one view was that the shared care record would result in improved outcomes, no action plan was in place to systematically monitor, audit and evaluate this. No annual report or equivalent suite of governance information was produced. The approach to the service was reactive and focused upon short term issues. The issues and priorities for the service were not fully understood or articulated at senior level. This had impacted on the profile of end of life care and was reflected in the poor organisational and clinical key performance indicators in the National Care of the Dying Audit 2014.

Governance, risk management and quality measurement

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

Leadership of service

- The senior specialist palliative care staff were held in high regard by colleagues and described as experienced, supportive and knowledgeable about end of life practice.
- The specialist palliative care team had regular informal and formal supervision during daily and weekly meetings and regularly met with other specialists in the hospital and in the community.

Culture within the service

- The specialist palliative care team was dedicated to and passionate about the quality of end of life care provision in the hospital. The team had recently met with the newly appointed executive director, who was responsible for representing end of life at board level. This person had been appointed approximately nine months ago in response to the National Care of the Dying Audit. We were told further regular meetings were to be scheduled.
- The specialist palliative care team was committed to sharing knowledge and developing the skills of others. The team regularly held training events within the community and local hospice and in return, these services supported the education of hospital staff by facilitating training which hospital staff were invited to attend. The specialist palliative care team routinely provided teaching for other staff when they were requested to provide clinical advice. For example, the team explained rather than completing clinical tasks for others, they often suggested completing tasks jointly. In addition, the team provided opportunities for other staff to spend time shadowing clinical work to give individuals further opportunities for more in-depth learning and confidence.
- Members of the specialist palliative care team said they had established good working relationships with other

clinical staff throughout the hospital. All staff we spoke with on wards had high regard for the specialist palliative care team, valuing its professionalism and expertise and stating that the team was responsive, supportive and very helpful.

Public and staff engagement

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

Innovation, improvement and sustainability

- The specialist palliative care team worked collaboratively with other services to improve end of life care for patients. This included working with colleagues in different departments and specialties throughout the hospital, and working in partnership with community palliative care services and the local clinical commissioning group (CCG).
- The specialist palliative care team was concerned regarding team members' ability to sustain the current service and work proactively on end of life standards and innovation. The rate of referrals to the team had steadily and significantly increased. During 2010, the team accepted 754 referrals, and during 2014 the team accepted 1,305 referrals. This was an increase of 73%.
- The specialist palliative care team prioritised providing a responsive, effective and safe service to meet the needs of patients with complex needs, and teaching colleagues. In order to maintain these priorities, the skill mix of the team was kept under review when any staff vacancies arose. This resulted in some adjustments to hours and grades of staff in order to most effectively respond to service demands. However, commitments to supporting other colleagues and achieving some national standards could not be met. This included stopping attendance at condition-specific ward rounds and the development of seven-day face-to-face services. The team was further concerned regarding its ability to meet the needs of young adults with very complex end of life care needs during transition into adult services, as doing so often required increased clinical time.

Outpatients and diagnostic imaging

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

Information about the service

Gloucestershire Hospitals NHS Foundation Trust provides outpatient services for a population of more than 612,000 people. These services are provided in outpatient departments at Cheltenham General Hospital and Gloucestershire Royal Hospital. The general outpatient departments at both hospitals are managed by the same team of senior staff, and staff work between the two sites. Some outpatient departments are managed by the specialties themselves, for example orthopaedics, audiology and ophthalmology.

This report focuses on our inspection of the outpatient departments located at Cheltenham General Hospital. However, where the same team manages the outpatient and diagnostic services across both sites, there will be duplication between the two reports.

We visited a range of outpatient clinics in the west and east block, including surgical, medical, urology, gynaecology, orthopaedic, respiratory, ear nose and throat (ENT) and therapy outpatient clinics.

Additionally, we visited the cardiology department, including the cardiac investigations, phlebotomy and therapies department. In radiology, we visited x-ray and imaging departments, including nuclear medicine, magnetic resonance imaging (MRI) and computerised tomography (CT) scanning. We also visited the outpatients' booking office.

We spoke with 30 members of staff, including managers, sisters, nurses, healthcare assistants, apprentices, phlebotomists, consultants, radiographers, cardiographers, physiotherapists, technicians, receptionists, secretaries and members of booking team

We met and spoke with 29 patients to seek their views of the service provided to them.

Outpatients and diagnostic imaging

Summary of findings

There was an increased risk that patients would experience harm during the provision of care and treatment. Systems were not consistently followed to protect patients from the risk of medication that had potentially been stored at an incorrect temperature. Emergency equipment was not readily available in every department. Patients and staff were not protected from the risks associated with ongoing building work in areas accessible by the public.

Systems were in place to record and report safety concerns and incidents, and staff demonstrated a good understanding of the system. Staff were compliant with the trust's infection control policies and procedures.

People were at risk of not receiving effective care or treatment. Consent was not always obtained or recorded in line with relevant guidance and legislation. Equipment was not available to provide a full range of services to women within the urology clinic. Medication was not consistently administered in line with current legislation in the ophthalmology outpatient department.

The service was delivered by trained and competent staff who had been provided with induction, mandatory and additional training specific to their roles.

Patients received a caring service, as staff treated them with compassion, kindness and respect. Positive feedback had been received by the trust from patients using the outpatients and the diagnostic and imaging departments. We observed two incidents where the privacy and dignity of patients was compromised.

Outpatient services were not organised in a manner that responded promptly to ensure patients' needs were met. Some patients experienced long delays in receiving their first outpatient appointment. The booking team was taking action to address waiting times and monitored patients who did not attend for appointments.

Staff were responsive to patients' specific care needs and supported patients to be seen promptly on arrival at clinic if their medical conditions required this.

The leadership, governance and culture prompted the delivery of person-centred care. Staff were supported by their local and divisional managers. Risks were identified and addressed at local level or escalated to divisional or board level if necessary.

The trust promoted a good working culture, although some staff did not feel supported by their managers.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We found that safety required improvement for outpatients and diagnostic imaging. Building work that was ongoing in the imaging department posed a risk to patients and staff from the dust and dirt that entered public areas. Medication was securely and appropriately stored, with the exception of one fridge that stored radioisotopes, for which the temperature could not be measured. Therefore, it was not clear that the fridge provided storage at the correct temperature. The orthopaedic outpatient department did not have a resuscitation trolley located within the department.

We found that patients' personal and confidential information was stored securely prior to use in the outpatient clinics. Equipment servicing and maintenance was carried out promptly and regularly. Staff ensured that incidents were reported, and we evidenced that action was taken to follow up incidents and that learning was taken forward from the investigation.

Incidents

- Staff advised us they were encouraged to report incidents that occurred in their working area. All the staff we spoke with were confident to report incidents via the trust's electronic reporting system.
- We were given examples of incidents that had been reported by various outpatient departments and diagnostic and imaging departments; for some incidents, staff were able to inform us of the changes that had happened as a result of their report. Although staff understood that incidents were monitored, they said they did not consistently receive feedback on the outcomes and action taken as a result of their report. Learning was shared between Cheltenham General Hospital and Gloucestershire Royal Hospital, as the teams worked across the sites.
- Staff gave an example of an incident report following a medical condition not being identified after a diagnostic test. This had resulted in information being sent to all staff regarding action to be taken that would ensure that medical conditions were appropriately diagnosed. Additional support had been provided for the staff involved.
- We were advised of incidents reported regarding patients not being recalled for a repeat computerised tomography (CT) scan. This occurred because staff had not completed the saving process on the electronic system so that test results were available for review by clinicians. An amendment had been made to the system and a process was in place to enable staff to check their work. Audits carried out showed considerable improvement in the completion of processes.

Duty of Candour

- Information regarding duty of candour had been cascaded from the divisional managers' meeting to all staff teams.
- Staff told us that information had been made available on the trust's intranet regarding duty of candour and the responsibilities regarding being open and transparent with patients. One member of staff we spoke with demonstrated they were aware of this information and how to access it.

Cleanliness, infection control and hygiene

- The trust's policy was for all patients due for a surgical procedure to be screened for methicillin-resistant Staphylococcus aureus (MRSA) at their outpatient appointment. Monitoring of compliance with the policy had identified that 100% of patients due for surgery or admission through the outpatient department were screened for MRSA over the seven months in 2014 for which we were provided with data.
- Hand hygiene audits were carried out on one day each month and monitored the percentage of staff who washed their hands and applied antibacterial gel before and after providing care and treatment to a patient. The audits for West Block outpatient department showed that 100% compliance was achieved.
- Cleaning schedules were displayed in the department. These identified areas that needed cleaning and when, for example rooms and equipment that required daily, monthly or weekly cleaning. Staff signed a record to evidence the cleaning when it had taken place. This record was seen in use in the department during our inspection.

- Personal protective equipment, antibacterial hand gel and hand washing facilities were available in all clinical areas. We observed that staff used hand gel frequently, when entering clinical areas and between caring for patients.
- All areas of the hospital we visited were clean and tidy. The exception to this was an area in the imaging department where building work was taking place and dust and dirt were escaping into the corridor where the public and staff walked. We have reported on this fully in the next section of the report.
- General cleaning of the department was carried out in the evenings. Staff made no adverse comments on their experience of the cleaning provided.
- The nursing staff were responsible for cleaning the equipment in consulting and treatment rooms, for example trolleys and couches. The cleanliness of the department was audited, and records showed a good standard was reached.
- All staff in the departments and areas we visited worked in line with the trust's policy and were 'bare below the elbows' when in clinical areas.

Environment and equipment

- The outpatient departments were located in an older style building, which staff told us provided challenges regarding insufficient space in waiting areas. During our inspection we observed that some sub-waiting areas, some of which were in corridors, were necessary when clinics became busy. Staff would inform patients when their appointment was nearing so they could move to the main waiting area.
- The paediatric outpatient area was child friendly, with welcoming pictures on the walls and chairs and tables in child sizes. Toys and games were available throughout the department.
- Equipment available to staff in all outpatient departments was serviced and maintained by the medical electronics department. Staff told us any assistance with equipment was received promptly and, if possible, faulty equipment was mended in the department. This meant the equipment was available for use again promptly. The equipment displayed a sticker that was dated to identify when the next service was due.
- The paediatric outpatient department had equipment which was suitable for use with children, for example small cuffs to record blood pressure and appropriate-sized equipment on the resuscitation trolley.
- The stores department carried out routine stocking-up visits to ensure departments had plentiful supplies of equipment such as gloves, aprons and dressing packs.
- The outpatient department was busy during our visit, and signage pointed to only two toilets in the area. The disabled toilet was not easily accessible, as it was through two doors that had to be pushed open. Once in the toilet, there was no call bell should anyone require assistance.
- Diagnostic and imaging equipment was serviced on a regular programme by the manufacturers. When equipment was due to be serviced, notification was given to the manufacturer in advance and clinics were cancelled to allow access to the machine.
- Building work was being carried out in the imaging department in preparation for a new computerised tomography (CT) scanner to be installed. There was no signage to inform staff and patients of the potential danger of this area, although both groups had access to the area involved. The doorway into the room was covered with unsecured black sheeting; therefore, dust and dirt entered patient- and staff-accessible areas.

Medicines

- The trust provided staff with medication training, which included completion of a workbook. Policies and procedures were in place to provide guidance and information to staff regarding medication ordering, storage, administration, prescribing and disposal.
- Medication required for specific clinics was stored in the clinical room for the appropriate clinic in a locked cupboard. Staff were knowledgeable about the medication the department used. Processes were in place to check stocks and reorder as necessary on a weekly basis. This meant the department did not store large stocks of medication.
- Medication that required storage below room temperature was kept in designated fridges, the temperatures of which were recorded on a daily basis to ensure they were within the required limits. The

exception to this was within the nuclear medicine department, where no thermometer was available to measure the temperature of the fridge used to store radioisotopes.

- Doctors were able to prescribe medications for patients attending the outpatient department. There was an option to provide a prescription that could be used to collect medication in any chemist or one for medication for use only within the hospital. In the general outpatient departments we saw that the prescriptions were stored securely in locked cupboards; they were signed out to each doctor and then signed in again on return. The prescriptions for use in any chemist were numbered, and the used prescription numbers were also recorded following each clinic. This enabled staff to monitor and ensure the safety of prescriptions.
- Contrast media used for diagnostic tests such as x-rays, computed tomography (CT) and magnetic resonance imaging (MRI) were recorded when administered, together with the patient's name, details and dose.
- Patients attending the nuclear medicine department were provided with clear instructions regarding the use of radioisotopes in their treatment.
- Medication was stored in locked cupboards in the MRI department. We observed medication stored for patient use that had expired in November 2013. This was removed immediately by staff.
- A medication error had been reported by the ophthalmology outpatient department as a serious incident. This occurred in 2014 and was when a patient received an injection into the wrong eye. The incident had been investigated thoroughly and an action plan developed to reduce the risk of the error recurring. Within the ophthalmology outpatient department, 'patient protocols' were in place to enable registered nurses and healthcare assistants to administer eye drops. These patient protocols were in the style of a patient group directive (PGD). PGDs facilitate the administration of prescription-only medications by registered nurses. However, healthcare assistants cannot administer prescription-only medication under their own authority under a PGD. Therefore this practice was not in line with legislation.

Records

- The orthopaedic outpatient department obtained patients' medical records prior to the clinic. The records were stored securely in a closed reception area, and when needed were taken straight to the consulting room. This protected patients' private and confidential information.
- In the west block outpatient department, we observed that patients' notes were obtained prior to the clinic commencing and were sorted into the appropriate clinic areas within the department. Each clinic area had a lockable notes cupboard for the medical records to be placed in placed in prior to the start of the clinic. Once the clinic was in operation, the medical records were placed on the top of the cupboard for ease of access and monitored by the nurse or healthcare assistant running the clinic.
- Staff who worked in the outpatient department told us they completed incident reports when patients attended with no notes or their medical notes were unable to be found. It was not clear of any action that had been taken as a result of this reporting, as the issue continued and a number of patients attended outpatients without their personal records having been obtained.

Safeguarding

- Safeguarding training was provided electronically for staff at a level appropriate for their role.
- Data provided from the trust showed a high rate of compliance with safeguarding training. The level of training provided was role specific, and we found that where staff had not completed mandatory training at the appropriate level, a safeguarding awareness course had always been completed, which reduced the risk to patients. We saw from training records that out of 70 radiology staff, 96% had completed safeguarding children level 2 and 94% had completed safeguarding adults level 2. The manager for radiologists was aware of the requirement for this training and had access to training records in order to follow up staff who needed to update their training. The nursing staff who worked in the radiology department had all completed their safeguarding training.
- Staff we spoke with were aware of their responsibilities regarding safeguarding and we were able to give examples of when concerns had been raised, and describe how and to whom they had raised the concerns.

- We were shown pocket-sized prompt cards that staff were provided with which showed the action to take should a safeguarding incident be observed.

Mandatory training

- Induction training was provided for all clinical staff. This was specific to the department they worked in and their role. It was compulsory for all staff to attend corporate induction. We saw records held within the diagnostic and imaging department which showed that the induction records for new staff were comprehensive and up to date.
- A target for staff completion of mandatory training had been set at 90%. From December 2013 to December 2014, over 90% of staff had completed their mandatory training. A total of 99% of staff working within the outpatient department had completed the mandatory e-learning by February 2015. The completion of training was recorded on the departmental quality dashboard.
- Staff we spoke with were positive about the training provided and were confident they would be supported to attend additional training if they requested it.
- Phlebotomy staff had access to e-learning using a hospital computer, and were able to complete this in their own time and take time off in lieu. The compliance rate within the phlebotomy team for completing e-learning was 100%.

Assessing and responding to patient risk

- Waiting areas were divided into sub-waiting areas nearer to the clinic where the patient was due to be seen. Not all of these areas were in line of sight of the reception staff, and staff running the clinics were not always in the area.
- Resuscitation trolleys were available on each floor of the general outpatient department. The trolleys were placed in accessible areas and checked by staff on a weekly basis to ensure medication was in date and the equipment was available and fit to use. Staff informed us that the frequency of the checks had been discussed with the trust's resuscitation team and agreed.
- The orthopaedic outpatient department had no resuscitation trolley in the department. The clinical area was located next door to the emergency department, and staff told us that should a patient require the use of a resuscitation trolley, they would access the emergency department. We did note that this had been risk assessed and recorded on the departments risk register.
- When asked, all staff we spoke with in the imaging and diagnostic departments knew who their radiation protection advisor and supervisor was. Staff were aware of the local rules for each area and where copies of the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) could be found. Every employer who undertakes work with ionising radiation is required to produce local rules. The purpose of such rules is to set out the key arrangements for restricting exposure in a particular area and the responsibilities (in relation to the safe use of radiation) of the individuals who work there. IRMER 2000 is a regulation that protects patient and sets out that doses given to patients should be as low as reasonably practicable and as low as reasonable possible. All incidents over a certain threshold need to be reported to the CQC.
- Safety information was available in the computerised tomography (CT) department, including on the Ionising Radiations Regulations 1999 (IRR99) (IRR99 requires employers to keep exposure to ionising radiation as low as reasonably practicable; exposures must not exceed specified dose limits) and diagnostic reference levels (which help avoid giving a radiation dose to the patient that does not contribute to the clinical purpose of a medical imaging task).
- The imaging and diagnostic department had a health and safety and manual handling link person. Guidance and support were provided to staff to ensure their safety and the safety of patients during care and treatment in the department.
- Radiologists worked alone in the x-ray department after midnight. The department was located next to the emergency department, which only provided a minor injuries service after 8pm. Patients were risk assessed in the emergency department prior to being referred to the x-ray department.
- An emergency alarm was in place to summon staff from the emergency department and/or the night porter if required.

Nursing staffing

- Staff worked across all areas of general outpatients and worked additional hours, through the hospital bank nurse system, to cover gaps in the duty rota. The sister, band 6 nurses and the matron all had authority to organise bank staff hours when required. Rotas we reviewed showed that no agency staff were required within the department.

Outpatients and diagnostic imaging

- The phlebotomy team had four vacancies for phlebotomists, which were advertised. Cover to ensure the smooth running of the service was obtained by staff working additional hours and from staff who worked at Gloucestershire Royal Hospital.
- Specialist clinics were run by nurse practitioners and other professionals, for example a dietician or psychologist. The trust provided reception staff but not nursing staff for these clinics.
- Qualified paediatric nurses were available in the paediatric outpatient departments when clinics were running. The staff worked between Gloucestershire Royal Hospital and Cheltenham General Hospital to ensure sufficient staffing levels and the appropriate skill mix of staff to meet the needs of planned clinics.
- The diagnostic and imaging team had 11 vacancies in the radiology team. The team worked across both the Gloucestershire Royal Hospital site and Cheltenham General Hospital, depending on the identified staffing need. Assistant practitioners were in post to help fill the gaps in rotas whilst they were awaiting their registration as qualified radiologists. This meant they were limited in the work they could carry out prior to their registration. We were told that new recruits were to start work in three to four months.
- We were given examples of how the vacancies affected working practices in the computerised tomography (CT) department. We were told there used to be three staff (two experienced and one in training) for each CT machine. This had reduced to two staff for each machine. Staff were concerned that this impacted on patient safety during scans and presented a risk to staff regarding the moving and handling involved. Concerns were also raised regarding the 12-hour shifts: staff were concerned that accidents could occur due to them being tired. Staff told us they had completed incident forms regarding this and raised the concern with management, but had not felt listened to.
- Staff advised us that they were concerned about the turnover of staff; although turnover was still low, many experienced staff were leaving the department to work in other organisations.
- The therapy outpatient department had a full staffing establishment. There were potentially two vacancies that would be advertised in the near future, and the manager had a clear plan of how this would happen to ensure recruitment was effective and prompt.

Medical staffing

- Consultants and registrars provided cover for each other at times of annual leave or sickness, whenever possible. All medical staff we spoke with confirmed that cancellation of a clinic was a last resort.
- GP trainees were provided with the opportunity to run some clinics as part of their training. Support and guidance were available from a consultant during the clinic time if needed.
- The cardiography department required additional staff, and at the time of our inspection there was an advertisement to recruit two trainee cardiographers.
- An additional glaucoma specialist doctor had been appointed to assist with reducing the waiting times that patients experienced for appointments.
- The outpatient department was open from Monday to Friday. Additional clinics were arranged at the request and with agreement of the consultant to reduce waiting times.

Major incident awareness and training

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

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

People were at risk of not receiving effective care or treatment. Written consent was not always obtained or recorded in line with relevant guidance and legislation. Equipment was not available to provide a full range of services to women within the urology clinic.

Staff attended regional and national conferences to ensure their practice was in line with national recommendations and legislation. The service was delivered by trained and competent staff who had been provided with induction, mandatory and additional training specific to their roles. Staff worked as part of multidisciplinary teams that met frequently and were coordinated to provide effective care.

Outpatients and diagnostic imaging

Evidence-based care and treatment

- The outpatient departments had access to policies and procedures that were stored on the trust's intranet. Staff were knowledgeable about which policies and procedures were accessible to them and how to access them. We reviewed a number of policies and procedures and identified references to national guidelines and good practice. Staff we spoke with were aware of the National Institute of Clinical Excellence guidelines (NICE) and of the importance of working within the guidelines. We were told by staff that they were supported by their managers to attend regional and national conferences, which provided them with up-to-date information on practice that they cascaded to colleagues on their return.
- Care and treatment within the nuclear medicine department, including referral-to-treatment times, reflected NICE guidelines.
- The staff who worked in imaging and diagnostics departments were provided with up-to-date national guidance from professional organisations such as the Society of Radiographers.

Equipment

- The urology outpatient department provided a bladder scanning service including the measured flow of urine to assist with diagnosis of types of incontinence. However, this could only be used for men, as there was no seat on the machine to enable women to use it. Staff told us they understood that additional equipment was to be purchased to enable a full range of tests to be available to women, but were not clear about when this would be in place.

Patient outcomes

- Patients we spoke with expressed satisfaction with the care and treatment they had received during their visits.
- We received information from external organisations prior to our visits of patient dissatisfaction with waiting times, but this was not evident throughout our inspection.

Competent staff

- Completion of staff appraisals was monitored on the quality dashboard in the outpatient departments. A target of over 90% had been set by the trust. In December 2014, 95.6% of all appraisals had been completed. The figure had improved from December 2013 when only 84% had been completed.
- We spoke with four reception staff during our inspection. They all told us they felt well supported and had received an induction when appointed to ensure they were competent to carry out their roles.
- Mentoring was provided to new staff, student nurses and apprentice healthcare assistants working in the general outpatient department. Mentorship was provided by trained nurses or senior healthcare assistants who had been supported to obtain further qualifications such as a national vocational qualification (NVQ) assessor. One healthcare assistant we spoke with had been encouraged and supported by the trust to complete a diploma in health and social care through the local university. They were due to undertake a facilitated learning and assessment and training in practice course.
- Staff attended national outpatient departments and regional nuclear medicine conferences. This provided staff with an opportunity to network with other trusts and to update themselves on regional and national guidelines regarding good practice recommendations and legislation.
- The imaging and diagnostic teams had developed comprehensive competencies for staff to achieve. The performance of new staff was monitored following seven days in the workplace, at one month and again at three months. Staff were not permitted to work alone until their competencies were achieved.
- Fire drills were carried out regularly in the imaging and diagnostics department in the style of scenario training in which the department was required to be evacuated. We saw evidence that showed a satisfactory outcome at the last drill, which demonstrated staff would be competent to carry out their roles in the event of a fire.
- External training was provided for staff who carried out ultrasound scans, computerised tomography (CT) scans and magnetic resonance imaging (MRI) scans. However, we were told attendance depended on staffing levels at the time.

Multidisciplinary working

- Specialties worked together to provide a seamless system for patients attending the outpatient

department. For example, we saw evidence of how the cardiology department liaised with lung function specialists to provide tests on the same day so the patient did not have to return for additional visits.
- The cardiology specialist teams liaised with the Gloucestershire Royal Hospital outpatient teams and North Bristol NHS Trust to ensure patients was seen in the right place and at the right time.
- The phlebotomy teams at Gloucester Royal and Cheltenham General Hospitals attended team meetings for which joint minutes were provided to staff. This ensured that the departments worked well together and that staff worked between the departments when necessary.
- The dermatology skin clinic staff attended multidisciplinary team meetings that included health professionals employed both by the trust and other organisations, for example consultants, pathologists, a Macmillan skin cancer nurse, clinical assistants and GPs. This facilitated information sharing about patients regarding their planned care and treatment.
- Other external organisations held outpatient clinics on the Cheltenham General Hospital site. We spoke with staff from one external organisation, who informed us they had formed an "excellent relationship with the trust" and were "supported by them".
- The imaging and diagnostic staff worked collaboratively with medical and nursing staff from other areas, for example the wards and emergency department. Support was provided to nursing and medical staff by electronically adding a red line to an x-ray to identify fractures.
- The therapy services worked as an integrated team that included occupational therapists, physiotherapists and musculoskeletal physiotherapists. During a patient's course of treatment, additional professionals would be included as required.

Seven-day services

- The outpatient departments were generally in operation from Mondays to Fridays unless an additional clinic had been arranged to meet patients' needs. Additional ophthalmology clinics had been arranged for Saturday mornings to assist with the waiting lists for patients who required an appointment for the glaucoma clinic.
- The radiology department provided 24-hour cover seven days a week for reporting diagnostic tests.

Access to information

- The trust informed us that a recent audit carried out in the outpatient department had found that the full medical records for 1.69% of patients were not available in time for their appointments. We spoke with two consultants who were running clinics and both told us this had not caused them to experience difficulties when seeing patients.
- The trust had an electronic system in place for staff to request and track notes. Records for patients attending clinics were requested six days in advance to enable staff to have time to track any missing records. Tracing and requesting notes continued up until the day of the clinic.
- If a patient's notes were not available for their appointment, a temporary set of notes was put in place that provided the clinician with a copy of the referral letter, discharge summary or letter from a previous appointment, depending on the patient pathway. Clinicians were able to access test results electronically.
- Concerns were raised regarding letters to GPs and letters from previous appointments not being available in a timely manner. Staff told us this was due to limited administration support provided to consultants. This had been recognised by the trust, and more secretaries had been appointed to deal with the backlog of letters waiting to be typed. Auditing showed that the backlog had reduced from a three-month wait for letters to be available to three weeks over the past year.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had an up-to-date policy and procedure in place relating to consent to care and treatment. The policy and procedure informed staff that valid consent had to be obtained before treatment or examination, and set out how the consent was to be obtained and recorded.
- Records belonging to three patients who had attended the urology clinic for a cystoscopy (a procedure where a camera is inserted into the bladder) did not evidence that written or verbal consent had been obtained from the patients. Nursing staff informed us that the medical staff obtained consent, and medical staff said consent

was obtained by the nursing staff. Nursing staff were clear that verbal consent was obtained, and we heard full explanations being provided to one patient prior to the test commencing.
- We saw from patients' records and from discussion with patients and staff that consent had been obtained prior to treatment during the dermatology clinic.
- The Mental Capacity Act 2005 and consent formed part of the mandatory e-learning for clinical staff. Additional training was available in the form of a study day for specialist nurses who were involved in obtaining consent from patients.

Are outpatient and diagnostic imaging services caring?

Good

Patients received a caring service, as staff treated them with compassion, kindness and respect. Positive feedback had been received by the trust from patients using the outpatients and diagnostic and imaging departments. Feedback provided to us throughout the inspection was positive about the way in which patients were treated by staff and involved in their care and treatment. We observed two incidents where the privacy and dignity of patients was compromised.

Compassionate care

- We spent time in the general outpatient reception area. Patients were greeted by a polite and respectful receptionist.
- Positive feedback received from patients was recorded on the quality dashboard. The number of compliments received in 2014 had increased in number month on month, with a total of seven compliments received in December 2014
- Patient confidentiality was respected at the booking-in desks, with ropes placed for people to wait in turn a distance away from the desk to allow patients privacy when speaking with the receptionist. We observed receptionists speaking to patients kindly and patiently and listening carefully to their responses.
- We observed one patient who was brought to the outpatient department from a ward dressed only in a hospital gown, with no blanket, dressing gown or slippers. The outpatient staff immediately attended to the patient's dignity and covered their bare legs with a blanket. Staff advised us they did not consider this to be acceptable and planned to report the incident through the trust's electronic reporting system and communicate with the ward involved. This demonstrated that staff fully respected and promoted the privacy and dignity of patients attending the department.
- Concerns were raised by staff regarding the privacy and dignity of patients, as they were asked to wear gowns when attending for computerised tomography (CT) scans and waiting in public areas. They said this did not respect patients' dignity and that there was no clinical need for this to happen. Despite the concerns being raised by staff this practice had continued.
- The clinical room used for patients to have a cystoscopy did not have a sign on the door to indicate when it was in use. However, we noted that a curtain was pulled around the door to screen the patient from view if anyone entered the room during the procedure. The minor operations theatre had clear signage on the door advising when the room was in use and not to enter.
- One ophthalmology clinic we observed was consultant led. The consultant was seen to 'shout' the name of a waiting patient from his office. It was not clear where the patient was to go or who had called their name. However, we also spoke with two patients following their appointment with the same consultant, and they both agreed the consultant was "nice".
- We spoke with 23 patients who were waiting for an appointment in the outpatient department. They all made positive comments regarding the staff and the care provided to them. Patients said staff were "very kind", "considerate at all times", "all nice – that includes the clinical staff and receptionists" and "they checked I was all right while I waited from my appointment".
- We overhead one member of the medical team speaking to a consultant and in front of nursing staff in a loud voice regarding the care provided to a previous patient. This conversation could be overheard in the waiting room.
- One patient arrived in the general outpatient department two weeks early for their appointment. The reception staff carefully looked into why they could not find the patient's appointment, explained the situation and provided another letter detailing their appointment. This was all carried out in a kind, quiet and helpful manner.

Outpatients and diagnostic imaging

Understanding and involvement of patients and those close to them

- Patients attending for imaging and diagnostic tests were provided with information about their specific test, in addition to which staff verbally explained the procedure.
- We spoke with patients regarding their care and treatment. A patient said, "I get enough information about my care and the ongoing plan." A relative told us, "I have had really good information regarding the care needed and what will happen in the future."
- Patients who were provided with care and treatment by the dermatology clinic for removal of skin lesions that were potentially malignant were provided with a follow-up appointment if necessary to discuss their future care and treatment face to face with health professionals.

Emotional support

- The quality of nursing care was monitored on a monthly basis against key performance indicators. Data provided to us showed that 100% of patients who requested chaperoning during clinical care and treatment were provided with this service. Information relating to the availability of a chaperone was on display in some clinics but not all. One patient we spoke with was aware of this service but had not required it themselves.
- Information regarding support groups or access to additional information was available in waiting areas. For example, there was a newsletter regarding the Gloucestershire Chest Fund on the noticeboard for patients to see and obtain contact details.
- We observed staff on a number of occasions directing or taking patients to the area where they needed to be. This was always carried out in a polite and efficient manner.
- We spoke with relatives of patients who were attending clinics. One person said their relative had dementia care needs and the clinic was "most respectful of this; they are never late or early, so we arrive and go more or less straight in, which helps me as [patient] finds it difficult to wait."

Are outpatient and diagnostic imaging services responsive?

Requires improvement

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

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

Staff were responsive to patients' specific care needs and supported patients to be seen promptly on arrival at the clinic if their medical conditions required this.

Following the receipt of a complaint, the hospital had responded promptly and thoroughly, with staff informed of the outcomes to enable learning to be taken forward.

Service planning and delivery to meet the needs of local people

- Staff working within the outpatient department told us patients could use the 'choose and book' system to enable them to choose an appointment close to their home. A booking team was available to assist patients with the provision of letters to inform them of their appointment date and time and text reminders and telephone calls were in operation to serve as a reminder to the patient.
- For patients who did not attend the clinic, another appointment was booked. A second non-attendance was not rebooked. The booking team monitored rates of patients not attending and found that, within the trust, rates were similar to the national average.
- Clinics were arranged in different areas. For example, the majority of breast and urology clinics were held in Cheltenham General Hospital, but additional clinics were held in Gloucestershire Royal Hospital for patients who chose or who found it easier to access Gloucestershire Royal Hospital.
- An additional clinic had been arranged for a biopsy clinic to enable more patients to access the service. To make this clinic more responsive to patients' in respect of the time they waited changes had been made to the timings of the clinic.

- Delays in obtaining results from the histopathology laboratory had been experienced over the Christmas period. This had resulted in some patients waiting up to nine weeks for their test results. Staff we spoke with said this had been distressing for patients and had delayed treatment if their results showed that cancer was present. We were told this had been reviewed by the trust and the service had been given additional resources to address this. Patients now received their results within two to three weeks.
- A paediatric outpatient department was located at the hospital for children and their families who lived in Cheltenham and the surrounding areas.
- Three patients who were waiting for an ophthalmology appointment commented that the clinic they attended always ran late, and they sometimes waited up to an hour over their appointment time.

Access and flow

- Information from national data showed the trust had regularly not performed as well as the England average for the referral-to-treatment time standard since December 2013. The percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers was worse than the England average for 2013 and the beginning of 2014, although the waiting time decreased and became better than the England average during the middle of 2014. The diagnostic waiting times for people waiting more than six weeks were consistently better than the England average for 2013 and 2014.
- Booking for most outpatient clinics was through the trust's booking office, with the exception of some specialist clinics for which appointments were booked by the consultant. For example, respiratory clinic patients received their appointments from the ward prior to discharge or from the department's administration staff. The booking team followed the same system for booking appointments for all clinics, apart from some small differences that were usually consultant specific. These included some types of appointment not to be after a certain time of day, such as if an x-ray was needed, or new patients not being booked later in the clinics because they might need more time.
- The bookings team set an internal target of 11 weeks from referral to treatment, to meet the 18-week referral to treatment target, as this ensured they kept a review of the list. A weekly report regarding the referral-to-treatment time was produced by the booking team and provided to the manager of the specialty team for individual clinics.
- If a patient required a follow-up appointment within six weeks the clinic, receptionists booked the appointment. If the appointment time was to be more than six weeks later, the patient was referred to a 'pending' list that was then managed by the booking office. There were delays for some follow-ups. The booking team aimed to book the patient in, but if no appointments were free then they contacted the consultant to enquire whether more patients could be added to the clinic. This would result in overbooking of clinics, although some consultants would hold an extra clinic.
- Delays had been experienced by patients who required an annual review, which had extended their wait to three or four months more than a year. This meant there was a risk that the delay could lead to a missed recurrence of their disease, such as of cancer. This had been raised and was on the risk register.
- The national referral-to-treatment target for therapy was 18 weeks. However, an internal target of six weeks had been set, and monitoring of patients' records retrospectively showed this had been met. The therapy management meetings discussed targets and clinical governance, and information from the meetings was cascaded to staff.
- When clinics were cancelled at short notice, for example due to sickness, the booking team focused on contacting patients to tell them before they attended. The week of our inspection there had been four short-notice clinic cancellations across both hospitals, which we were told was a higher number than usual. Before a clinic was cancelled the booking team always checked with the relevant division to see whether it could be covered by another consultant, doctor or specialist nurse. We were shown evidence regarding a cancelled clinic that had occurred the previous week to our inspection. Two patients had not been contactable and had arrived for their appointments. The staff had arranged for them to be added to an existing clinic run by another medical professional.
- Waiting times for clinics were displayed on whiteboards or electronically in waiting areas. The urology clinic provided a same-day service for tests and treatment, which often resulted in patients having to spend long periods in the clinic. The staff clearly advised patients to

expect to be in the clinic for up to three hours to enable all tests to be completed. We also heard reception and clinical staff advise patients of the time they could expect to wait.

- The nuclear medicine department provided an initial appointment to patients within three weeks, although for oncology patients this was reduced to two weeks.
- The waiting lists for magnetic resonance imaging (MRI) scans had been reduced since a system of outsourcing appointments to a private provider had been put in place. We were informed that the last year there was a backlog of 800 MRI scans, which was now down to approximately 25.
- The cardiology clinic provided a 'one-stop shop' for patients who attended following sudden onset of chest pain. The clinics were run by a specialist nurse and provided the opportunity for patients to receive tests such as an echocardiogram, electrocardiogram or exercise test. Once the tests had been completed, the patient returned to the specialist nurse for the results and an ongoing plan of treatment. Although this meant patients spent longer in the hospital for their appointments, it reduced the number of visits the patient had to make to hospital for medical tests and reduced the waiting time for results.
- There were long waiting times of up to 45 weeks for new patients who required a consultant cardiology appointment. Staff informed us this was because there were limited numbers of clinics, with some of them only available for half a day a week or a month. Consultants were informed by the booking office when they were breaching recommended referral-to-treatment times.
- Staff raised concerns regarding the waiting times for new patients to attend the lung function clinic, particularly for the sleep clinic. However, they considered that follow-up appointments for tests required were provided promptly and patients did have a long wait to return to the clinic for their tests.
- Reception staff told us they had not received any complaints from patients regarding the booking system, and patients did not object to receiving a follow-up appointment in the post rather than before they left the department.
- Rapid-access outpatient services were available each day for patients who required chest pain assessment, emergency ophthalmology and ear, nose and throat (ENT) appointments, and fracture and plaster room treatments.
- Patients were able to access the physiotherapy clinic directly through a system of self-referral.

Meeting people's individual needs

- We observed that staff in the ear, nose and throat (ENT) clinic responded in a positive and kind manner to one person who had travelled a long distance to find the clinic had been cancelled due to sickness. New arrangements were made for the patient so that part of their treatment was carried out in another clinic on the same morning and an appointment was made in Gloucestershire Royal Hospital ENT clinic later that day. The patient was satisfied with this arrangement.
- A document for people with additional needs, for example learning disabilities, was in use and was known as 'tell us about you'. These were held by the patient and included information that outlined their needs during hospital visits. Patients were supported by their representatives and/or the staff to complete these booklets.
- Hearing loop systems were in operation within the outpatient departments, and signage advised patients of their availability if required.
- Private rooms were available throughout the outpatient department for difficult conversations or sharing bad news.
- The paediatric outpatient department was well equipped with toys and games to entertain children waiting for their appointments and to provide a distraction during tests and examinations. Children were seen in other clinics, and we found that whilst some toys were available, there was not a separate waiting area in the ENT or ophthalmology outpatient areas for children.
- One patient confirmed that although their appointment was not the exact time they wanted, they were offered options and could choose the time and place of the appointment.
- The audiology clinic had hearing loops fitted to ensure that patients with hearing problems could receive information regarding their care and treatment.
- Translator services were available, and information was displayed for patients and staff regarding this service.
- One patient we spoke with was positive about the assistance they had been given on arrival at the hospital to find the correct clinic for their appointment and to get there. Another patient commented they thought the

hospital displayed good signage to help people get to the correct department, and that when they had asked for help to find a clinic the staff had been particularly helpful.

Learning from complaints and concerns

- Information on how to make a complaint was displayed within waiting rooms and informed patients about how to contact the Patient Advice and Liaison service (PALS) to raise issues.
- We saw an example of a thorough investigation and response to the patient following a complaint regarding the waiting time experienced at a clinic. The patient had not been satisfied with the initial response, and the complaint issues had been reinvestigated by the outpatient staff.

Are outpatient and diagnostic imaging services well-led?

Good

The leadership, governance and culture prompted the delivery of person-centred care. Staff were supported by their local and divisional managers. Risks were identified and addressed at local level or escalated to divisional or board level if necessary.

The trust promoted a good working culture, although some staff did not feel supported by their managers.

Vision and strategy for this service

- The trust's vision of safe effective and personalised care for every patient, every time, all the time, was displayed in the outpatient department. Staff were aware of the national vision and strategy called Compassion in Practice. Compassion in Practice is based around six values: care, compassion, courage, communication, competence and commitment. Information was displayed within the department for patients and staff.
- The imaging and diagnostics department was working on succession planning due to the number of vacancies across both Cheltenham General Hospital and Gloucestershire Royal Hospital. Two members of staff were currently completing leadership courses.

Governance, risk management and quality measurement

- Incidents were reported when necessary, including to the CQC, and risk assessed to reduce the recurrence of any identified risk.
- The trust highlighted a topic each month for managers to ensure compliance against. We saw action had been taken in response to the findings. For example, staff had identified (anonymously) that they felt there were issues regarding communication within the outpatient's team. Changes had been effected in the way information was cascaded to staff, and meeting times had been altered. Staff had also commented that they did not feel they were consulted about changes that took place in their workplace, and additional staff meetings had been planned.
- The imaging and diagnostic department had risk assessments in place to protect patients and staff during care and treatment. For example, a risk assessment was in place for staff who were pregnant and for actions to be taken in the event of fire in the department.
- Governance meetings were held that were attended by managers throughout the outpatients and diagnostic and imaging departments from both Cheltenham General Hospital and Gloucestershire Royal Hospital. The outcomes from these meetings were referred to the diagnostic and specialties meetings led by the chief of service.

Leadership of service

- Information regarding the wider trust and from individual departmental meetings was provided to staff within email communication.
- Senior staff we spoke with reported good communication from the trust, and regular briefings were provided by the chief executive officer. Not all junior staff had the same view, and whilst they spoke highly of their immediate and departmental managers they were not aware of the role of the trust's board and information cascaded from the board.
- Staff we spoke with knew the director of nursing within the trust and told us this person visited their departments on occasions.
- Two members of staff we spoke with who worked within the imaging and diagnostic departments expressed concerns regarding their management, in that they did not always feel listened to. They told us they had concerns regarding working across all the departments

and being expected to multi-skill. We were told this led them to feel undervalued. However, not all staff expressed this opinion, and others were pleased to work across different areas and felt supported to do so.

Culture within the service

- Staff in the west block and specialist outpatient clinics told us they were proud to work for the trust and in their departments. Staff spoke to us about team working, and a number of staff gave us examples of when their team members had worked together efficiently, for example during periods of sick leave.
- Staff commented to us that in some areas embedded practices were difficult to address and change. We were given an example of patients being required to change into hospital gowns prior to some tests and then having to wait in public areas in the gowns, which did not promote their dignity. Meetings had been held with staff to change this practice, but it still happened.
- Joint meetings between management teams and clinical staff had been held, for example within the cardiology department, to encourage working relationships. (We were told that working relationships were, at times, strained.) This demonstrated a willingness to develop a positive culture to progress the service provided.

Public and staff engagement

- The trust's newsletter for staff included information on changes taking place trust wide, such as in how complaints were managed, and about information available to patients and significant events occurring within the trust, for example regarding this inspection. Information was also provided regarding specific departmental changes.
- Feedback from the last board meeting was provided to staff within the monthly newsletter.

Innovation, improvement and sustainability

- Staff were positive about the urology clinic, which had been developed to enable patients to attend the hospital on one day for a number of diagnostic tests and treatment, to reduce the need to return to hospital on several occasions.
- Staff in the therapies department were proud to work for the trust and were positive about the direct access to physiotherapy for patients.

Outstanding practice and areas for improvement

Outstanding practice

- Patient record keeping in critical care was outstanding. All the patients' records we saw were completed with high levels of detail. There were all the essential details to keep patients safe and ensure all staff working with them had the right information to provide safe care and treatment at all times.
- There was an outstanding holistic and multidisciplinary approach to assessing and planning care in the department of critical care. All the staff involved with the patients worked with one another to ensure that the care given to the patient followed an agreed treatment plan and team approach. Each aspect of the care and treatment had the patient at its centre.
- In critical care, there was an outstanding commitment to education and training of both nurses and trainee doctors. Nurses and trainee doctors followed comprehensive induction programmes that were designed by experienced clinical staff over many years. All the staff we met who discussed their training and development spoke very highly of the programmes on offer and of there being no barriers to continuous learning.
- There was outstanding care for bereavement in critical care. All staff spoke highly of how they were enabled to care for and support patients and relatives at this time. Bereavement care had been created with input from patients, carers, relatives and friends, and staff were particularly proud of the positive impact it had on bereaved people and on patients nearing or reaching the end of their life.
- The outstanding arrangements for governance and performance management in critical care drove continuous improvement and reflected best practice. There was a serious commitment to leadership, governance and driving improvements through audits, reviews and staff honesty and openness. All staff had a role to play in this area and understood and respected the importance of their work.
- The trust had a mobile chemotherapy unit, which enabled patients to receive chemotherapy treatment closer to their homes to prevent frequent travel to hospital.
- On the surgical division, we found the following outstanding practice: the trust had developed and printed its own style of controlled drugs register for patients' own controlled drugs. Patents with their own controlled drugs were listed on a whiteboard on the controlled drugs cupboard door to help ensure the patients took all their medicines home with them.
- Medicines dispensed for an individual patient but not labelled for discharge had an additional yellow label attached stating, "NON-STOCK DO NOT SEND HOME WITH PATIENT".

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

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

Outstanding practice and areas for improvement

- Develop clear protocols with regard to the care of patients queuing in the corridor. This should include risk assessment and the identification of safe levels of staffing and competence of staff deployed to undertake this care.
- Work with healthcare partners to ensure that patients with mental health needs who attend the emergency department out of hours receive prompt and effective support from appropriately trained mental health practitioners.
- Ensure that systems to safeguard children from abuse are strengthened and children's safeguarding assessments are consistently carried out. There must be a process to ensure all appropriate child safeguarding referrals are made.
- Ensure that senior medical staff in the emergency department are trained in level 3 safeguarding.
- Ensure that patients in the emergency department have an assessment of their pain and prompt pain relief administered when necessary.
- Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.
- Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.
- Ensure that patients' records across the hospital are stored securely to prevent unauthorised access.
- Ensure patients' mental capacity is clearly documented in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) and 'unwell/potentially deteriorating patient plan' (UP) forms. Improvements in record keeping must include documented explanations of the reasoning behind decisions to withhold resuscitation, and documented discussions with patients and their next of kin, or reasons why decisions to withhold resuscitation were not discussed.
- Review communication methods within maternity services to ensure sensitive and confidential information is appropriately stored and handled, whilst being available to all appropriate staff providing care for the patient concerned.
- Ensure that when medicines are issued from wards or departments the issued medicines comply with the relevant legislation and best practice.
- Ensure the administration of eye drops complies with the relevant legislation.
- Ensure that appropriate written consent is obtained prior to procedures being carried out in the outpatient department.
- Ensure that all patients (men and women) are able to access a full range of tests in the urology outpatient department.
- Ensure that systems are in place to ensure that all medication available is in date and therefore safe to use.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Review how staff perceive the feedback they get from incident reporting and the level of detail received.
- Ensure that patients, including children, are adequately monitored in the emergency department waiting room to ensure that seriously unwell, anxious or deteriorating patients are identified and seen promptly.
- Take steps to improve the experience for patients and visitors in the emergency department waiting room. This should include the provision of drinking water, a TV, and appropriate reading material and information about waiting times.
- Review the emergency department's nursing staff mix and training to ensure adequate numbers of staff are trained to identify, care for and treat seriously ill children.
- Continue to improve hospital-wide ownership of the emergency department's four-hour target, to ensure that delays in admission are minimised.

Outstanding practice and areas for improvement

- Identify suitable accommodation for the ambulatory emergency care and ensure that it is adequately staffed to provide a more comprehensive and effective service.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.
- For safety of the medicines and equipment inside, ensure resuscitation trolleys are secured in such a way so there is clear evidence if they have been opened between checks.
- Consider displaying feedback from patients and relatives for each individual medical ward.
- Consider a system to identify when patient equipment has been cleaned.
- Ensure all areas are clean and free from litter.
- Record all controlled drugs in critical care in line with the trust's policy.
- Capture and report safety thermometer data in the department of critical care alongside the other data on patient harm that the department collects.
- Ensure all items are within their expiry date.
- Maintain continuity of care for patients on the day surgical unit to ensure their needs are met when it is open 24 hours a day, seven days a week.
- Review the medical and surgical cover at weekends for the day surgery unit to make sure patients are reviewed and discharges not held up.
- Ensure patients who are admitted to the surgical day surgery unit can have their needs met by the staff team.
- Reduce the number of times patients are moved between wards for continuity of care.
- Review the security and safe storage of medicines in the surgical division, including medical gases.
- Review the security and records of equipment and medicines, including medical gases required for resuscitation and the treatment of anaphylaxis.
- Review the staffing levels of physiotherapists against the requirements of the Faculty of Intensive Care Medicine Core Standards.
- Ensure the specialist palliative care team can be sustained and are able to remain responsive to the evidenced increased demands of complex referrals, provide a face-to-face seven-day service and ongoing staff training in line with national policy, and make improvements to inconsistent governance, risk management and quality measures.
- Ensure a strategy for end of life care is developed.
- Ensure all patients who are referred by their GP with suspected cancer are seen with two weeks of referral, and treatment is started within 62 days of referral.
- Ensure that in maternity services, both service risk registers detail actions underway to mitigate risks.
- Ensure that cleaning schedules in maternity services are reviewed and systems devised to allow staff to know when equipment has been cleaned and is ready for use.
- Review the processes in maternity services to ensure early screening (pre 10 weeks' gestation) can occur where the need is indicated.
- Review the timeliness within maternity services of access to patient information in alternative languages.
- Ensure all patients' referral-to-treatment times do not exceed national targets and that services are delivered in a way that focuses on patients' holistic needs and does not mean patients experience long delays in receiving their first outpatient appointment.
- Ensure all outpatient departments have sufficient facilities for disabled people, such as accessible toilets.
- Ensure staff promote the confidentiality of patients by ensuring conversations about patients cannot be overheard by other patients.
- Ensure that the temperatures of fridges used for the storage of medication and equipment are checked daily.
- Ensure patients' privacy and dignity are fully respected when patients are waiting for tests in public areas such as waiting rooms.

Outstanding practice and areas for improvement

- Review staffing levels for the provision of services within the specialist palliative care team

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Requirement notices

Too many patients arriving at the emergency department by ambulance were cared for in the corridor because there were insufficient available cubicles. This impacted on their safety, privacy and dignity.

Patients with mental health needs attending the emergency department out of hours waited too long for assessment and support from appropriately qualified mental health practitioners.

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

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse **Regulation 11 The Health and Social Care Act 2008 (Regulated Activities)** **Regulations 2010 Safeguarding people who use services from abuse.** 1. The provider did not have suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of: 1. Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs; 2. Responding appropriately to any allegation of abuse. **[Now Regulation 13 including Regulation 13(1), 13(2), and 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]** **Children's safeguarding assessments were not consistently carried out.** **There was no safety net to ensure all appropriate child safeguarding referrals were made.** **Not all senior medical staff in the emergency department were trained in safeguarding level 3.**
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **Regulation 12 The Health and Social Care Act 2008 (Regulated Activities)** **Regulations 2010 Cleanliness and infection control.** **[Now Regulation 12 including Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]** **The provider had not, so far as reasonably practicable, ensured that ensure service users were protected against identifiable risks of acquiring a** **healthcare-associated infection.**

This section is primarily information for the provider

Requirement notices

Appropriate standards of cleanliness and hygiene in relation to equipment and materials used in the treatment of service users were not maintained.

Infection control procedures were not consistently applied in all ward areas.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Management of medicines. [Now Regulation 12(1) including Regulation 12(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] The provider did not protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, holding, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purpose of the regulated activity. Ophthalmology outpatient department nurses were using "patient protocols" and associated guidelines to write a patient specific direction from which the healthcare assistants were administering eye drops

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Regulation 15 (1) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Safety and suitability of premises

This section is primarily information for the provider

Requirement notices

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

1. Suitable design and layout.

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

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 20 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records. 1. The provider had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of: 1. an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. [Now Regulation 17 including Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] Documentation relating to patients' mental capacity was not obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records. Explanations for the reason for the decision to withhold resuscitation were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or reasons why decisions to withhold resuscitation were not discussed, were not documented.

This section is primarily information for the provider

Requirement notices

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

1. kept securely and can be located promptly when required

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

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

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing. [Now Regulation 18 including Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.] The provider had not taken appropriate steps to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed for the purposes of carrying on the regulated activity. There were not always sufficient numbers of suitably qualified, skilled and experienced staff in the emergency department. Safe levels of staffing and a safe skill mix had not been defined in relation to caring for patients in the emergency department corridor.