Care Quality Commission

Gloucestershire Hospitals NHS Foundation Trust

Cheltenham General Hospital

Quality Report

Cheltenham General Hospital
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Date of inspection visit: 24-27 January 2017, 6 February 2017
Date of publication: 05/07/2017

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

Urgent and emergency services	Requires improvement
Medical care (including older people's care)	Requires improvement
Surgery	
End of life care	Good
Outpatients and diagnostic imaging	

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 (midwife led) 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 carried out an announced inspection 24-27 January 2017 and an unannounced inspection at on 6 February 2017. This was a focused inspection to follow-up on concerns from a previous inspection. As such, not all domains were inspected in all core services.

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

• End of life care

• Outpatients and diagnostic imaging

We did not inspect the critical care services (previously rated outstanding) or maternity services (previously rated as good).

As we did not inspect and rate all services, we did not rate Cheltenham General Hospital following this inspection.

Safe

We rated the safe domain as requires improvement in urgent and emergency services, medical care and surgery. We rated it as good in, outpatients and diagnostic imaging and end of life services.

- We had concerns about patient safety, particularly when the emergency department was crowded, which was a regular and frequent occurrence. Lack of patient flow within the hospital and in the wider community created a bottle neck in the department, creating pressures in terms of space and staff capacity. This in turn, increased the risk that patients may not be promptly assessed, diagnosed and treated.
- Crowding in the emergency department meant that ambulance crews were frequently delayed in handing over their patients. Patients were not always assessed quickly on their arrival in the emergency department.
- There was no designated room for mental health practitioners to conduct mental health assessments within the emergency department. Patients would be assessed in one of the review rooms, which did not meet the safety standards recommended by the Royal College of Psychiatrists.
- Compliance with mandatory training was variable.
- Within the medical division there was not a clear overview of Mortality and Morbidity (M&M) meetings held in line with the trust's M&M meeting schedule. Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes. Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- Some areas were not fit for purpose and the fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in line with the trust's policy in all areas.

Summary of findings

- There were new machines for checking of patients' blood sugar however, not all staff had had training so the old machines were also still in use. Staff did not always calibrate these daily in line with manufacturer's guidance.
- Staff did not monitor fridge temperatures consistently or take actions where these fell out of normal range, which meant medicines were not always stored correctly. Staff did not always comply with the trust policy and best practice when receiving controlled drugs from pharmacy.
- Records were not stored safely to ensure patient confidentiality was maintained.
- Some wards scored low for compliance with harm free care and it was not obvious what actions were taken to improve practice.
- Staff did not always assess risks to patients or follow up identified risks with mitigating care interventions.
- Nursing staffing levels in wards, departments and theatres were at times below establishment and wards relied on bank and agency to cover shifts every day.
- The trust did not assess the acuity of patients daily to ensure safe staffing levels were in place on each shift and particularly at night. This was a concern in the coronary care unit.
- In the time frame since our last inspection, the number of surgical site infection rates for replacement hips had increased. However this had improved at this inspection.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again. Not all staff within these specialities were aware of the never events and the learning from these.
- Kemerton and Chedworth Suite was at times being used as an inpatient ward but domestic cover had not always been set up for weekends to provide cleaning and drinks to patients when the staff were busy.
- The completion of six do not attempt cardio pulmonary resuscitation (DNACPR) forms we reviewed were of variable quality.
- There were no centrally held training records for syringe driver training or competency for ward staff.
- There was a trust major incident and business continuity plan. However, the chaplaincy service, mortuary staff, bereavement officers and in-patient and community palliative care teams had not been involved in the major incident plan practice exercises.
- A number of patient treatment rooms in ophthalmology had carpet flooring and contained visibly dusty equipment, and the trust had not met its infection prevention and control training target.
- The phlebotomy clinic environment was small and did not allow staff to respond to patients effectively if they became unwell.
- Staff did not always have access to the most up to date policies and procedures within the outpatients department, and there were several versions one Patient Group Directive (PGD) in circulation in ophthalmology

However:

- There was an openness and transparency about incident reporting and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- The endoscopy unit held join advisory group (JAG) accreditation and had procedures in place in line with the national safety standards for invasive procedures. Equipment was decontaminated and sterilised in line with best practice.
- There were hourly board rounds undertaken by senior clinicians in the emergency department. This provided an overview of the department's activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams. Patient safety checklists had been introduced, which provided a series of time-sequenced prompts to ensure assessments, care and treatments took place promptly and with the required frequency. There was a well-structured medical staff handover where patients' management plans and any safety concerns were discussed.
- Within the end of life service, potential risks to patients were assessed by ward staff. Identified patient safety risks were monitored and mitigating actions put in place.

Summary of findings

Effective

We rated the effective domain as good in urgent and emergency services, surgery, end of life. We rated it as requires improvement in medical care.

- People's care and treatment was planned and delivered in line with current evidence-based guidance and standards. There was a range of recognised protocols and pathways. Performance in national audits was mostly in line with other trusts nationally.
- Nursing and medical staff received regular teaching and clinical supervision within the emergency department. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Staff demonstrated knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- Patients were having their pain effectively managed.
- There was good culture of multidisciplinary working across all staff groups to make sure patients care was coordinated
- Staff understood that end of life care could cover an extended period for example in the last year of life or patients.
- End of life care was delivered with the principles of the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's
- There was a yearly programme of end of life care education for some medical staff which covered symptom management, levels of care, diagnosing dying, resuscitation and communication skills. There was also some evidence of a programme of non-medical staff education for nursing and allied health professionals for example , covering resuscitation, syringe driver training, quarterly end of life study days and symptom management.
- Staff were supported with revalidation practices and there was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills.
- There was an effective framework for 'board round' and ward rounds and included input from staff from the multidisciplinary healthcare teams.
- There were effective processes in place to admit patients directly to Lillybrook ward when neutropenic sepsis was suspected.

However,

- The trust was not meeting the standard which requires the percentage of patients re-attending (unplanned) the department within seven days to be less than 5%.
- The trust had been identified as a 'mortality outlier' in to relation reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions had implemented had made improvements and these were ongoing at the time of our inspection.
- The emergency theatre was only manned on site for 20 hours each day. The remaining four hours were covered by 'on call' staff, which potentially placed patients at risk.
- The trust had introduced a new computer system prior to our inspection. This was causing issues for staff resulting in work arounds to prevent any risks to patients.
- Not all staff received annual appraisals.
- Theatre utilisation figures were low.
- Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records. Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation attempts had been made were not always documented.
- There was no organisational oversight of staff competency with regards to syringe driver training as records were not held centrally.

Summary of findings

- There was not a seven day face to face service provided by the in-patient end of life care team. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- Whilst in some cases the possibility of dying had been recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, not all appropriate patients experienced this.
- The trust had evidence-based care pathways but these were not always reviewed and updated in a timely manner.
- The medical service did not consistently review the effectiveness of care and treatment through national audits.
- Information was not always accessible to staff including information about care and treatment pathways.
- Staff did not always put actions in place when patients were at risk of malnutrition and hydration.

Caring

We rated the caring domain as good in all the services this domain was inspected (urgent and emergency services, medical care and end of life services).

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. Medical and nursing staff explained care and treatment in a sensitive and unhurried manner.
- Staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and respectful of cultural and religious differences in end of life care.
- Emotional support for patients and relatives was available through the in-patient and community end of life care team, through clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services

However:

- Information about patients was not always kept confidential.
- The results from a patient-led assessment of the care environment demonstrated that privacy for patients was not always provided.

Responsive

We rated the responsive domain as requires improvement in urgent and emergency services, medicine, surgery and outpatients and diagnostic imaging. We rated it as good in end of life services.

- The trust was not consistently meeting the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department.
- Some patients spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.
- Crowding meant that patients sometimes queued in the corridor, where they were afforded little comfort or privacy.
- Patients with mental health needs were not always promptly assessed or supported, particularly at night time when there was no mental health liaison service. There was a lack of an appropriate welcoming space for patients with mental health needs.
- The delivery of cardiology services did not meet the needs of the local population resulting in transfers out of the area.
- There were delays to discharges, which meant patient flow through the hospital was compromised.
- Due to pressure for beds and the demand on services, some patients had to use facilities and premises that were not always appropriate for inpatients.

Summary of findings

- Elective operations were being cancelled due to the pressure on the beds within the trust and medical patients were being cared for on surgical wards to meet the demand.
- Not all patients had their operations re-booked within the 28-day timescale.
- Six patients had been waiting over 52 weeks for treatment, which is not acceptable.
- The average length of stay for both elective and non-elective (emergency) patients was above (worse) than the England average There was a waiting list for patients requiring endoscopic procedure.
- The hospital was not meeting the 62 day target for cancer patients, and the trust was not meeting referral to treatment target in all specialities
- The environment did not meet the needs of patients with dementia.
- The hospital was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- Complaints were not responded to in a timely manner.
- Patients were experiencing delays in diagnosis and treatment because the diagnostic imaging department had a reporting backlog of 19,500 films, and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety, diagnosis and ongoing treatment.
- Implementation of new computer systems had impacted on waiting lists as some specialties could not see their live waiting lists.
- Patients were not able to easily access the top floor clinics in outpatients due to the lift being out of order.
- There were no designated beds for people receiving care at end of life. Side rooms were used when available but could not be guaranteed.
- The percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not all known for all wards or hospital sites.
- The trust did not have systems in place to identify all patients in the hospital who were approaching end of life.

However:

- The emergency and urgent care service had a number of admission avoidance initiatives in place to improve patient flow. These include the integrated assessment team who proactively identified and assessed appropriate patients who may be able to be supported in the community to avoid hospital admission.
- Though not managed quickly enough, complaints were used to drive improvement.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services was better than the England overall performance. For surgical services between January 2016 and November 2016 it had been about the same as the England overall performance.
- The oncology service provided a 24-hour helpline and facilitated direct admissions when sepsis was suspected in patients with neutropenia.
- Staff in theatres and recovery had guidance in place to help reduce the anxiety of patients living with dementia when they using their services.
- The hospital had introduced a new waiting list validation process to discharge some patients back to primary medical care facilities.
- Visually impaired patients were able to access services in ophthalmology through the use of colour coded signs, which made navigation of the department easier.

Summary of findings

- The oncology department provided an information presentation for all newly diagnosed patients which included opportunities to ask questions on a one to one basis.
- The specialist palliative care team responded promptly to referrals, usually within one working day.

Well-led

We rated the well-led domain as good in urgent and emergency services, and end of life and requires improvement in medical care. We did not inspect this domain in surgery or outpatients and diagnostic imaging.

- There was a strong, cohesive and well informed leadership team within the urgent and emergency care service, who were highly visible and respected. There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the department was under pressure. Staff felt respected, valued and supported. Morale was mostly positive, although to an extent, undermined by workload pressures. There was a detailed improvement plan in place with clear milestones and accountability for actions.
- The emergency department produced high quality information which analysed demand capacity and patient flow, and which was used to inform the improvement plan.
- There were robust governance arrangements in place within the urgent and emergency care service. Clinical audit was well managed and used to drive service improvement. Risks were understood, regularly discussed and actions taken to mitigate them. Service improvement was everybody's responsibility. Staff were encouraged and supported to undertake service improvement projects.
- The trust had a clear vision and strategy to deliver care at end of life linked to national best practice including Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's. The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- Services within specialist palliative and end of life care had been continuously improved and sustainability supported since the last inspection March 2015.
- Staff felt supported by managers and senior management felt assured by the new executive team.

However;

- The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team but it did not appear that the risks relating to staff wellbeing, resilience and sustainability, had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- There was a limited approach to obtaining the views of people who used the service.
- Workload pressures prevented opportunities for staff reflection or meaningful staff engagement and involvement in shaping the emergency and urgent care service.
- There was no risk register specific to end of life care for the trust so there was no easy trust wide oversight of risk relating to the service.
- There was a program of internal and national audits for end of life care, which were on time. However most local audit activity had not yet benefited from a thorough analysis of the data produced.
- There was a lack of overview and governance around mortality and morbidity (M&M) meetings within the medical care.
- There was a lack of understanding of the risk to safe patient care, the acuity of patients on daily basis have. Risk were not always aligned with the risk registers

Summary of findings

We saw several areas of outstanding practice including:

- Direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- The expansion of the 'MAD' multi-disciplinary clinics in urology allowed more patients to access the one stop services and receive same day tests and results for the majority of cases.
- A new initiative had been developed in the oncology outpatient department where nurses were trained to give a group presentation to new patients. The presentation covered information such as car parking, dietary tips and financial advice. During the session, one to one sessions were also provided with specialist nurses.

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

Importantly, the trust must:

- Ensure that all information related to patients' mental capacity and consent for 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) is available in patient records.
- Ensure trust staff comply with all the requirements of the Mental Capacity Act (2005).
- When using Kemerton and Chedworth Suite for inpatients, provision must be made for the cleaning of the units at weekends and to provide patients with clean water jugs and drinks.
- Review processes to monitor the acuity of patients to ensure safe staffing levels.
- Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health (COSSH).
- Ensure machines used for near patient testing of patient's blood sugar, are calibrated daily and this is recorded or ensure all staff are trained in how to use the new machine so the old machines can be removed.
- Ensure effective cleaning of ward areas and equipment.
- Review the governance and effectiveness of care and treatment through participation in national audits.
- Ensure staffing levels meet the acuity of patients in the coronary care unit.
- Ensure patient records are kept securely at all times.
- Ensure steps are taken to reduce the current typing backlog in some specialities
- Ensure specialities have oversight of all of their waiting lists.
- Ensure that all staff are up-to-date with mandatory training and receive yearly appraisals in line with trust policy
- Ensure that patients arriving in the emergency department receive a prompt face-to-face assessment by a suitably qualified clinician.
- Ensure that a suitable space is identified for the assessment and observation of patients presenting at the emergency department with mental health problems.

In addition the trust should:

- Ensure all complaints are handled within trust policy timescales
- Ensure all risk identified relating to the provision of end of life care is included on a risk register.
- Ensure the training needs analysis for general staff on wards related to end of life care is completed by the trust end of life care strategic group.
- Consider involving specialist palliative care team and support teams in major incident plan practices or exercises.
- Review the signage and consider if the system of using 'white rose' symbols to assist location of trust mortuaries is effective
- Ensure staff in specialist palliative care team are able to use the results of the safety thermometer information in relation to patients receiving end of life care.
- Ensure all staff within the surgical specialities is aware of Never Events and the learning needed to prevent a reoccurrence.

Summary of findings

- Continue to make improvements with the reduction of surgical site infection rates.
- Consider a system to recognise and respond to blank boxes on prescription charts to make sure patients receive medicines as prescribed.
- Ensure emergency trolleys should be checked in line with trust policy and best practice guidance.
- Review the pre admission clinic area including appropriate seating.
- Provide resuscitation equipment for the pre admission unit to ensure if a patient collapsed, they receive the correct care in a timely manner.
- Review the equipment in the pre-admission unit to ensure it meets the needs of the service.
- Ensure the safe management of medicines at all times and including the checking and signed for controlled drugs administration. Ensure all patient group directions (PGDs) are reviewed and in date. Review processes to recognise and respond to blank boxes on prescription charts to make sure patients receive medicines as prescribed.
- Review the lack of 24-hour emergency theatre to ensure no patients will be put at risk.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.
- Ensure oversight of mortality and morbidity (M&M) meetings across all services.
- Ensure staff can decontaminate hands on entering and leaving clinical areas where care is delivered.
- Ensure staff follow best practice when patients are admitted with potentially transmittable viruses such as diarrhoea and vomiting.
- Ensure replacement of equipment to ensure safe diagnosis of medical conditions.
- Ensure medicines are stored, used and disposed of in line with manufacturers specifications and trust policy.
- Ensure fire doors are secured in line with fire risk assessments.
- Ensure treatment pathways are reviewed and update to ensure best evidence-based treatment.
- Ensure effective monitoring of clinical improvement and audits, including compliance with accurate and timely NEWS assessments
- Review processes to ensure compliance with the accessible information standards.
- Continue to work in collaboration with partners and stakeholders in its catchment area to improve patient flow within the whole system, thereby taking pressure off the emergency department, reducing crowding and the length of time that patients spend in the department.
- Consider ways to ensure the emergency department is supported by the wider hospital and that there is more engagement from specialties in addressing the risks associated with patient flow.
- Ensure steps are taken to reduce the current typing backlog in some specialities
- Ensure effective cleaning systems are in place in clinical areas of both the environment and equipment.
- Ensure specialities have oversight of all of their waiting lists.
- Ensure patient records are stored securely at all times.
- Take steps to ensure all patients' referral to treatment times do not exceed national targets including cancer wait targets.
- Continue to reduce the current reporting backlog.
- Take action to monitor and reduce the numbers of temporary notes in use.
- Ensure reporting of plain film x-rays for the accident and emergency department meet the three day turnaround.
- Ensure flooring in treatment rooms conforms to infection prevention and control standards.
- Review the phlebotomy clinic environment so it is fit for purpose and accessible to all patients.
- Ensure patient privacy and dignity is respected at all times when giving care or treatment.
- Ensure steps are taken to allow patients with limited mobility to access all services on an equal basis to others by fixing lifts.

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 	We have rated this service as requires improvement overall because:

- The trust was not consistently meeting the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department. A significant number of four hour breaches were attributed to a shortage of inpatient beds. The trust was not meeting the standard which requires that patients are reviewed by a doctor within one hour of arrival.
- Patients were not consistently assessed promptly on arrival and in some cases a face-to-face assessment did not take place for some time. This meant there was a risk that seriously unwell or deteriorating patients may not be identified and managed promptly.
- Some patients waited too long in the emergency department after the decision had been made to admit them to an inpatient bed. Patients regularly queued in the corridors in the emergency department and, despite the efforts of staff, patients' comfort and dignity could not be maintained in the corridor.
- Patients who attended the emergency department with mental health needs did not always access prompt assessment and support from mental health practitioners, particularly if they attended out of hours. There was not a designated mental health assessment room as recommended by the Royal College of Psychiatrists.
- Compliance with mandatory training was variable so we could not be assured that all staff were familiar with safe systems, processes and practices.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team but it did not appear that the risks relating

to staff wellbeing, resilience and sustainability had been widely shared or escalated within the organisation and they were not included on the department's risk register.

- The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.

However,

- The emergency department was taking steps to mitigate the risks associated with crowding. Hourly board rounds conducted by senior clinicians provided an overview of activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams.
- A patient safety checklist had been introduced, which provided a series of time-sequenced prompts for staff to undertake risk assessments, observations, tests and treatments, although audits showed that the use of this documentation was yet to be embedded in practice and was not consistently completed.
- There were few serious incidents reported in urgent and emergency care. We saw good evidence that when incidents occurred, lessons were learned and improvements were made. There was openness and transparency about safety. Staff were familiar with their responsibilities under the Duty of Candour regulation.
- There were effective processes in place for the identification and management of adults and children at risk of abuse and staff were familiar with these.
- There was a range of recognised treatment protocols and care pathways. Compliance with pathways and standards was monitored through

Summary of findings

participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.

- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services such as the integrated discharge team.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enable staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.
- Complaints were listened to and acted upon. There was evidence that changes and improvements had been made in response to complaints.
- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.

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- Patients and their families were involved as partners in their care. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- There was a strong, cohesive and well informed management team who were highly visible and respected within the department.
- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, which included safety, quality and patient experience. Risks were understood, regularly discussed and actions taken to mitigate them.
- The emergency department had developed an improvement plan with clear milestones and accountability for actions.
- Staff morale was mainly positive, although this had been somewhat overshadowed by crowding and the pressures this placed on staff. Staff nevertheless felt valued and supported.
- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the department was under pressure.
- There was a strong focus on learning and improvement. Clinical audit was well managed and used to drive improvement, mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient experience.

Medical care (including older people's care)

Requires improvement

We rated this service as requires improvement because:

- The trust did not assess the acuity of patients daily to ensure safe staffing levels were in place on each shift, particularly at night. This was of concern in the coronary care unit.
- The service did not consistenly participate in and review the effectiveness of treatment through national audits.
- There were insufficient infection control and prevention facilities when entering and leaving some areas in wards and the cleanliness of equipment, such as commodes, was not always assured.

Summary of findings

- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- Some areas were not fit for purpose and the fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in line with the trust's policy in all areas.
- There were new machines for checking of patients' blood sugar however, not all staff had had training so the old machines were also still in use. Staff did not always calibrate these daily in line with manufacturer's guidance.
- Fridge temperatures were not monitored consistently and medicines were not always stored correctly. Staff were unsure of when to dispose of some medicines in line with manufacturer's recommendations.
- Staff did not always comply with the trust policy and best practice when receiving controlled drugs from pharmacy.
- Records were not stored safely to ensure patient confidentiality was maintained.
- Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day.
- The delivery of cardiology services did not meet the needs of the local population.
- There were delays to discharges, which meant patient flow through the hospital was compromised.
- The service was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- There was not a systematic approach to mortality and morbidity (M&M) meetings. This meant there was a lack of overview and governance around mortality and morbidity (M&M) meetings.
- There was a limited approach to obtaining the views of patients and their relatives.
- The service had only made limited changes to improve treatment and care since our last inspection in 2015.

Summary of findings

- Risks on the risk register were not always aligned with risks in the service.

However:

- Staff understood their responsibility to report incidents and there was evidence of learning from incidents across the organisation.
- Staff were aware of their responsibilities for identifying and reporting safeguarding issues.
- There were safe processes to review patients and ensure care and treatment plans were reviewed.
- Ward staff in all areas we visited were seen to wear the correct uniform and use personal protective equipment, gloves and aprons as needed.
- Patients were positive about the way they were treated and cared for in the medical wards.
- We observed staff treated patients with kindness, dignity, respect and compassion.
- There was a dedicated helpline for oncology and haematology patients. This enabled patients to be assessed and, if required (for example when neutropenic sepsis was suspected), admitted directly to Lillybrook ward without the need to go through the emergency department.
- There was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills. Nurses were supported with revalidation processes.
- The endoscopy unit had safe processes in place to ensure staff decontaminated and sterilised equipment in line with best practice. The endoscopy unit held join advisory group (JAG) accreditation and had procedures in place in line with the national safety standards for invasive procedures.
- There was an effective framework for 'board round' and ward rounds which included input from staff from the multidisciplinary healthcare team.
- Processes were in place to ensure consultants reviewed patients seven days a week. .
- Staff were aware of mental capacity assessment and of deprivation of liberty safeguards applications.

Summary of findings

- The trust's referral to treatment time (RTT) for admitted pathways for medical services had been better than the England overall performance.
- Though information leaflets were not readily available for patients whose first language was not English, there was access to translation services Staff knew how to access this if needed.
- Staff felt supported by managers and senior management felt assured by the new executive team.

Surgery

We did not rate this service as we did not inspect all domains. However, we found:

- Since our inspection in March 2015, the number of surgical site infection rates had increased for replacement hips. However this had improved at this inspection but for long bone reduction the number of surgical site infections was above the national average.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again. Not all staff within these specialities were aware of these never events and the learning from them.
- There were periods of understaffing on the surgical wards and operating theatres, where the trust's planned staffing numbers of qualified nurses were not met.
- Mandatory training for all staff was not meeting the trust's target.
- The surgical division was not meeting the trust's target for staff appraisals.
- Due to pressure for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients and staff were not aware of how to set up support services.
- The trust had introduced a new computer system prior to our inspection that was causing some issues for staff resulting in work arounds to prevent any risks to patients.

However:

Summary of findings

- The service encouraged openness and transparency from staff with incident reporting, and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- The trust had been identified as a 'mortality outlier' in to relation Reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions they had implemented had made improvements and these were ongoing at the time of our inspection. for example, in the 2016 hip fracture audit which had shown an improvement on 2015 audit
- Training in safeguarding of adults and children had met the trust target for completion.

End of life care

Good

We rated this service as Good because:

- End of life care provided at Cheltenham General Hospital was safe, effective caring, responsive and well led because:
- The processes in place to keep people safe for end of life care were good. Staff in the specialist palliative care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong.
- Patient's records demonstrated that nutrition and hydration needs were assessed and appropriate actions were documented as followed in patients' individual care plans.
- Records documented discussions with relatives around what to expect with the dying process.
- Risks to patient's receiving care at end of life were assessed by ward staff with appropriate assessments recorded in medical records for example the prevention and management of pressure ulcers and falls.
- Staff we spoke with on the wards understood that end of life care could cover an extended period for example in the last year of life and also applied to patients with non-cancer diagnoses such as dementia. Staff, teams and services worked together to deliver effective care and treatment.

Summary of findings

- Staff we observed on wards delivering end of life care to patients were compliant with key trust policies such as infection control.
- Arrangements in place for managing medicines kept patients safe. Medicines to relieve pain and other symptoms 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.
- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The staffing levels and skill mix of the nurse and medical personnel in the specialist palliative care team were planned and reviewed and supported safe practice. We saw evidence of a yearly education programme of end of life care for medical, nursing and allied health professionals. This included: resuscitation, syringe driver training, quarterly end of life study days and symptom management.
- The specialist palliative care team responded promptly to referrals, usually within one working day.
- Patients were treated with kindness, dignity, respect and compassion. Staff took the time to interact with people who received end of life care and those close to them in a respectful and considerate manner.
- We saw many written compliments about how caring staff were in the inpatient specialist palliative care team. We saw that patients' and those people close to them, were involved as partners in their care.
- The specialist palliative care team and wards staff understood the impact a patients' care, treatment or condition had on their wellbeing and on those people close to them.
- Emotional support for patients and relatives was available through the in-patient and community specialist palliative care team, the chaplaincy team and bereavement services. Staff had access to support through their own teams when needed.

Summary of findings

- Services were delivered and additional services planned in order to effectively meet patient's needs. Plans and actions included audit to inform future planning so that the end of life team could inform better decision making with patients they cared for.
- There was a clear vision and strategy to deliver care at end of life. The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- Leadership encouraged openness and transparency and promoted good quality care. There were leads on the wards who supported the development and delivery of high quality end of life care.
- Services within specialist palliative and end of life care had been continuously improved and sustainability supported since the last inspection March 2015.

However:

- Documenting 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decisions had improved since the last inspection however concerns regarding DNACPR remained. For example not all DNACPR having relevant clinical information and not all patients or those close to them being recorded as involved in discussions about resuscitation. These concerns were not identified as a risk and did not feature on a risk register
- There were no centrally held training records for syringe driver training or competency for ward staff.
- There was not a full understanding of performance for all aspects of end of life care. For example the percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not known for all wards or hospital sites.
- There was no risk register specific to end of life care for the trust so oversight of all end of life risk was not easy.

Summary of findings

- When we reviewed maintenance records some provided were out of date. The trust told us they were clear that equipment listed was not in use. We saw email communication from directors supporting this.
- There was not a seven day face to face service provided by the specialist palliative care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals to access.
- Some of the 'white rose' symbols used to locate the mortuary at the hospital were not easy to follow. Signs were not always at eye level for someone walking or in a wheelchair and there were long gaps in signage that led to confusion. Mortuary and bereavement officers told us relatives had commented they were useful. Some relatives had reported they appreciated these signs. However bereavement office staff accompanied relatives when they knew people were attending the mortuary.

Outpatients and diagnostic imaging

We did not rate this service as we did not inspect all domains. However, we found:

- There were good infection control measures in place to help keep people safe, including hand hygiene practices, and the outpatient and diagnostic imaging departments had 100% compliance.
- Patients who were vulnerable were protected from avoidable harm through comprehensive safeguarding procedures, and staff showed good understanding of these procedures and shared learning from safeguarding incidents.
- Staff were given the right skills and training to do their jobs, and in ophthalmology a competency based training package had been developed for healthcare assistants.
- Patients had access to specialist services, and the urology department had developed a dedicated consent form for cystoscopies and was expanding its one stop clinic service.

Summary of findings

- A new waiting list validation process had allowed some patients to be discharged back to primary medical care facilities for their ongoing care and follow up treatment.
- Visually impaired patients were able to access services on an equal basis to others in ophthalmology through the use of colour coded signs, which made navigation of the department easier.
- The oncology department provided an information presentation for all newly diagnosed patients which included opportunities to ask questions on a one to one basis.

However;

- The service did not have sufficient arrangements to keep clinical and patient areas clean. Some treatment rooms in ophthalmology had carpet flooring and contained visibly dusty equipment, and the trust had not met its infection prevention and control training target.
- The environment in the phlebotomy clinic was small and did not allow staff to respond to patients effectively if they became unwell..
- The trust did not make sure staff had access to the most up to date policies and guidance, and had several versions of one Patient Group Directive (PGD) in circulation in ophthalmology.
- The hospital was not meeting the 62 day waiting list target for cancer patients, and the trust was not meeting referral to treatment target in all specialities.
- Patients were experiencing delays in diagnosis and treatment because the diagnostic imaging department had a reporting backlog of 19,500 films, and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety, diagnosis and ongoing treatment.
- Implementation of new IT systems had impacted on waiting lists as some specialties could not see their live waiting lists.
- Patients were not able to easily access the top floor clinics in outpatients due to the lift being out of order.

Cheltenham General Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; End of life care; Outpatients & 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.

The health of people in Gloucestershire is generally better than the England average. Deprivation is lower than average, however about 13.8% (14,600) of children live in poverty. Life expectancy for both men and women is higher than the England average. Life expectancy is 7.8 years lower for men and 6.3 years lower for women in the most deprived areas of Gloucestershire than in the least deprived areas.

In the latest financial year, 2015/16, the trust had an income of £498.9 million, and costs of £494.3 million, meaning it had a surplus of £4.6 million for the year. At the time of the inspection the trust predicted it would have a deficit of £18.7 million in 2016/17.

Activity and patient throughput. In 2015/16 the trust as a whole had:

• 127,369 A&E first attendances

• 114,328 Inpatient spells (51,932 non-elective, 62,396 elective)

• 451,771 Outpatient attendances

• 6,388 births

• 2,067 referrals to the specialist palliative care team

This was a focused inspection to follow-up on concerns from a previous inspection. As such, not all domains were inspected in all core services.

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
- End of life care
- Outpatients and diagnostic imaging

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Anthony Berendt, Medical Director, Oxford University Hospitals NHS Foundation Trust

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

The team included CQC inspectors and a variety of specialists: directors of nursing and governance, consultants and medical staff from medicine, surgery, emergency services, a junior doctor; senior nurses in medicine, surgery, theatres, care of the elderly and palliative care. The team also included one expert 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 clinical commissioning group, NHS Improvement, the local council, Gloucestershire Healthwatch, mental health and community partner organisations, the General Medical Council, the Nursing and Midwifery Council and the royal colleges.

People who used the services were able to shared their experiences by email and telephone and on our website. We also collected feedback from patients and relatives on comment cards during the inspection.

We carried out an announced inspection 24-27 January 2017 and an unannounced inspection at Cheltenham General Hospital on 6 February 2017. We held focus groups and drop-in sessions with a range of staff 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.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Facts and data about 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.

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Detailed findings

Between Q1 2015/16 and Q2 2016/17, the trust's bed occupancy has been consistently higher than the England average by 2 to 8%. This was 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.

The executive team had recently undergone a period of significant change having been a previously stable and longstanding board. The previous chief executive retired in April 2016 having been chief executive since 1 May 2008. The new chief executive took up their role in June 2016. A new chairman joined the trust in November 2016. The finance director and two non-executive directors stood down in September 2016. The two non-executive directors had been replaced at the time of the inspection,. There was an interim chief operating officer and an interim finance director in post

CQC inspection history

Gloucestershire Hospitals NHS Foundation Trust has had a number of inspections since first registering with CQC. The last inspection occurred in March 2015 and was a full announced comprehensive inspection. At that inspection, Cheltenham general Hospital was rated as requires improvement.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	N/A	Requires improvement	N/A	N/A
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	N/A	Requires improvement	N/A	N/A
Overall	Requires improvement	N/A	N/A	N/A	N/A	N/A

Urgent and emergency services

Safe	Requires improvement
Effective	Good
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 (CGH) by the unscheduled care service, which forms part of the medical division. An emergency department (ED), 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. Critically ill children or children who need to be admitted are taken to GRH where paediatric services are provided.

Emergency and urgent services in Gloucestershire were reconfigured in July 2013 when night time services at CGH's ED were reduced. Self-presenting (walk in) patients continue to be seen in the ED 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 Gloucester Royal Hospital (GRH) where emergency medicine doctors are available 24 hours a day.

ED patients receive care and treatment in two main areas; minors and majors. Self-presenting patients with minor illness or injury 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 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 by a dedicated ambulance entrance and the resuscitation room is located just inside this entrance.

We conducted an announced visit during a weekday and conducted a further unannounced visit during the evening. We spoke with six patients and relatives in ED and reviewed 33 comments cards completed by people who had attended the department in the weeks leading up to our inspection. We spoke with staff, including nurses, doctors, managers, support staff and ambulance staff. We observed care and treatment and looked at care records. Prior to and following our inspection, we reviewed performance information about the trust and information from the trust.

Emergency and urgent services provided by the trust are located on two hospital sites, the other being Gloucester Royal Hospital (GRH). Services at GRH 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 contained in the two reports.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Urgent and emergency services

Summary of findings

We have rated this service as requires improvement overall because:

- The trust was not consistently meeting the national standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department. A significant number of four hour breaches were attributed to a shortage of inpatient beds. The trust was not meeting the standard which requires that patients are reviewed by a doctor within one hour of arrival.
- Patients were not consistently assessed promptly on arrival and in some cases a face-to-face assessment did not take place for some time. This meant there was a risk that seriously unwell or deteriorating patients may not be identified and managed promptly.
- Some patients waited too long in the emergency department after the decision had been made to admit them to an inpatient bed. Patients regularly queued in the corridors in the emergency department and, despite the efforts of staff, patients' comfort and dignity could not be maintained in the corridor.
- Patients who attended the emergency department with mental health needs did not always access prompt assessment and support from mental health practitioners, particularly if they attended out of hours. There was not a designated mental health assessment room as recommended by the Royal College of Psychiatrists.
- Compliance with mandatory training was variable so we could not be assured that all staff were familiar with safe systems, processes and practices.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team but it did not appear that the risks relating to staff wellbeing, resilience and sustainability had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.

However,

- The emergency department was taking steps to mitigate the risks associated with crowding. Hourly board rounds conducted by senior clinicians provided an overview of activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams.
- A patient safety checklist had been introduced, which provided a series of time-sequenced prompts for staff to undertake risk assessments, observations, tests and treatments, although audits showed that the use of this documentation was yet to be embedded in practice and was not consistently completed.
- There were few serious incidents reported in urgent and emergency care. We saw good evidence that when incidents occurred, lessons were learned and improvements were made. There was openness and transparency about safety. Staff were familiar with their responsibilities under the Duty of Candour regulation.
- There were effective processes in place for the identification and management of adults and children at risk of abuse and staff were familiar with these.
- There was a range of recognised treatment protocols and care pathways. Compliance with pathways and standards was monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.

Urgent and emergency services

- Care was delivered in a coordinated way with support from specialist teams and services such as the integrated discharge team.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enable staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.
- Complaints were listened to and acted upon. There was evidence that changes and improvements had been made in response to complaints.
- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- There was a strong, cohesive and well informed management team who were highly visible and respected.
- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, which included safety, quality and patient experience. Risks were understood, regularly discussed and actions taken to mitigate them.
- The emergency department had developed an improvement plan with clear milestones and accountability for actions.
- Staff morale was mainly positive, although this had been somewhat overshadowed by crowding and the pressures this placed on staff. Staff nevertheless felt valued and supported.
- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the department was under pressure.
- There was a strong focus on learning and improvement. Clinical audit was well managed and used to drive improvement, mistakes were openly discussed and learning acted upon. Staff at all levels were encouraged to play their part in improving patient experience.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We have rated this domain as requires improvement because:

- We had concerns about patient safety, particularly when the department was crowded, which was a regular and frequent occurrence. Capacity was compromised because ED attendances were increasing, both in numbers and in terms of patient acuity. Lack of patient flow within the hospital and in the wider community created a bottle neck in the ED, creating pressures in terms of space and staff capacity. This in turn, increased the risk that patients may not be promptly assessed, diagnosed and treated.
- Crowding in the emergency department meant that ambulance crews were frequently delayed in handing over their patients.
- Patients were not always assessed quickly on their arrival in the emergency department. Initial assessment (triage) often consisted of a verbal handover from ambulance staff to the nurse coordinator without a face to face assessment of the patient.
- There was no designated room for mental health practitioners to conduct mental health assessments. Staff told us that patients would be assessed in one of the review rooms, which did not meet the safety standards recommended by the Royal College of Psychiatrists.
- Compliance with mandatory training was variable. We could not be assured that staff were up to date in their knowledge of safe systems.

However,

- There was openness and transparency in relation to safety. There were few serious incidents but when these occurred, lessons were learned and well disseminated throughout the department.
- There were hourly board rounds undertaken by senior clinicians in the department. This provided an overview of the department's activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams.
- Record keeping was generally good. Patient safety checklists had been introduced, which provided a series of time-sequenced prompts to ensure assessments, care and treatments took place promptly and with the required frequency. However, audits showed that use of this checklist was not fully embedded in practice.
- There was a well-structured medical staff handover where patients' management plans and any safety concerns were discussed.

Incidents

- The trust reported no never events in urgent and emergency care between December 2015 and November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.
- In the same reporting period, seven serious incidents were reported, investigated and actions put in place to reduce the risk of reoccurrence. These were as follows:

- December 2015: Delay to act on symptoms of severe sepsis – a root cause analysis (RCA) took place, the case was discussed at a mortality and morbidity (M&M) meeting, and learning was disseminated through ongoing education. All actions on the action plan were complete.
- February 2016: transfusion of blood intended for another patient. A root cause analysis was undertaken and actions arising, including staff training and segregation and labelling of blood were completed.
- March 2016: Failure to recognise a seriously ill patient. Delayed clinical review (2 hours, 35 minutes) and inappropriate transfer of a ventilated patient. A root cause analysis took place and actions arising from this were completed, including simulation training.
- May 2016: Sudden deterioration of patient. Patient observations were not recorded for a period of 4 hours. A root cause analysis was undertaken. Actions arising, including ongoing promotion of safety checklist and hourly board rounds were completed.
- July 2016: Prescribing error leading to acute kidney injury. A root cause analysis was conducted and actions, including personal learning and reflection and email safety briefing were completed.

- August 2016: Delayed ambulance response, delayed diagnosis in ED of a subdural haemorrhage. A joint root cause analysis was conducted with the ambulance service. An action plan was due to be completed in February 2017.
- November 2016: failure to escalate a deteriorating patient. This incident was under investigation at the time of our inspection.

- There was a strong safety culture in the ED where safety issues were regularly discussed. The department had a designated clinical governance lead who led regular reviews of incidents. Incidents were discussed at bi-monthly meetings and learning was disseminated in a number of ways:

- Message of the week: posters were displayed around the department to draw staff's attention to learning. Topics had included: making reasonable adjustments for people with learning disabilities, mental health, dementia or any condition where communication was impaired, referral of apprpriate patients to the falls team, pain asessment, safeduarding children screening and sepsis treatment.
- Safety newletters were issued every two months.
- Mortality and Morbidity (M&M) meetings were held every month 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, discussed at handover meetings and disseminated within the division via the 'Share Point' internet page. Mortality and morbidity trends were also reported in monthly emergency pathway performance reports.
- Quarterly missed radiology newsletters, combined with teaching and the development of new pathways involving trauma and orthopaedics, had led to a decrease in missed abnormal radiology over time.
- 'Theme of the fortnight' - learning was disseminated to trainee doctors, in addition to 'learning bites' at each early/late shift handover.

Duty of candour

- Staff were familiar with their responsibilities under the Duty of Candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is a regulation which was introduced in November 2014. This Regulation requires the provider to notify the relevant person that an incident causing moderate or serious harm has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Consultants provided examples of where duty of candour had been applied. We saw that patients and their families had been contacted and kept informed during the investigation of serious incidents

Safety Thermometer

- The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month.
- Data from the Patient Safety Thermometer showed that the trust reported no pressure ulcers, two falls with harm and no catheter urinary tract infections in urgent and emergency care between January 2016 and January 2017.

Cleanliness, infection control and hygiene

- The department was visibly clean and tidy. We saw cleaning in progress.
- Staff observed the 'bare below the elbow' policy. The department was equipped with adequate hand washing facilities. Staff wore protective clothing such as gloves and aprons.
- 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. Compliance in the period April to October 2016 was mainly good but audits were taking place regularly.

- Cannula insertion: compliance ranged from 60% to 100% (average 86%). Results were reported for six out of seven months.
- Urinary catheter insertion was 100% compliant for six out of seven months, with no results reported for one month.
- Hand hygiene compliance was 100% compliant but results were only recorded for three out of six months.

- Compliance with the 'bare below the elbow' policy was 100% compliant but results were only reported for three out of seven months.
- There were two assessment/treatment rooms in majors where infected patients could be isolated and barrier nursed to prevent the spread of infection.

Environment and equipment

- The emergency department was generally laid out and equipped to protect people from avoidable harm. However, at busy times, crowding was an issue. During our unannounced visit on 8 February 2017 the department ran out of patient trolleys. The staff had to identify one patient who could sit in a chair in the event that another patient arrived who required a trolley.
- Patients were not always given access to call bells so that they could summon help from staff.
- We had previously raised concerns about poor lines of sight in both the main waiting area, which meant that waiting patients were not adequately observed. This meant that a deteriorating patient or inappropriate behaviour may go unnoticed. This remained unchanged.
- There was a children's waiting area accessed via the main waiting area. Although there was a sign on the door to prevent people using this as a thoroughfare, there was nothing to stop people entering this area as it was not secured. Children in the waiting area could not be observed by staff but there was an emergency call button which could be used to summon attention. We heard staff telling parents to use the button if they were concerned. Staff told us the alarm was tested every day.
- We checked a range of equipment, including resuscitation equipment, in the ED. Resuscitation trolleys were all in order and appropriately stocked. Regular checks were documented.
- The resuscitation area was well organised and equipment was well laid out and easily accessible. Staff told us this was maintained by intensive care staff. There were protocols for paediatric resuscitation displayed. We checked consumable equipment, which was clean and in date.
- There were appropriate arrangements for the segregation, storage and disposal of waste and we saw staff comply with these safe systems.
- However, we noted that the paediatric treatment room had no oxygen or suction equipment. Staff described difficulties in transferring children to the resuscitation area in an emergency because there was only a couch, which could not be moved as it was not on wheels.

Medicines (includes medical gases and contrast media)

- Medicines were appropriately stored in locked cupboards or fridges. There was evidence that fridge temperatures were regularly checked. Temperatures were within the correct range at the time of our inspection.
- Controlled drugs were stored appropriately and suitable records were kept. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.
- Patient Group Directions (PGDs) were in place and were up-to-date. PGDs are agreements which allow some registered and appropriately trained nurses to supply or administer certain medicines to a pre-defined group of patients without them having to see a doctor.
- Patients' allergy status was consistently recorded on medicine administration charts. This reduced the risk of patients receiving inappropriate medicines which may have a harmful effect.

Records

- Patients' records in the emergency department were in paper format and were scanned on to the hospital's electronic system when patients were discharged or transferred to a ward.
- During our visit the computer system failed. The staff immediately switched to a paper-based system and whiteboards. This was an efficient response to what was, we were told, a relatively frequent occurrence.
- Patients' records were appropriately stored to enable easy access for staff, whilst not being easily accessible for people who were not authorised to view them.
- We looked at a small sample (six) of patients' records and found they were generally well completed. Patients' observations (vital signs) and early warning scores were completed consistently (see assessing and responding to patient risk below). A newly introduced safety checklist, which was required for all patients in the majors' area, was also consistently completed.
- There were monthly audits of records relating to the recording of observations of vital signs and National

Early Warning Scores (NEWS). NEWS is a recognised early warning score tool to assess patients' risk and their need for physical observations. The trust told us that no other routine audits of record keeping took place, although documentation checks would form part of other clinical audits.

Safeguarding

- There were processes in place for the identification and management of adults and children at risk of abuse (including domestic violence). Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were identifiers visible on patients' records where patients were known to the service due to previous safeguarding concerns. Staff could then access management plans to support patient' ongoing care and treatment.
- The department was meeting most of the Safeguarding Children's Standards produced by the College of Emergency Medicine's Clinical Effectiveness Committee:
- Training records showed that in October 2016, 82.9% of medical staff had completed level 2 safeguarding training for adults and children. Nursing staff performed better, with 96.5% completing level 2 safeguarding adults training and 90.1% completing level 2 safeguarding children training.
- The trust told us that all consultants and middle grade doctors had received level 3 child protection training.
- 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 ED doctor during their ED attendance.
- At our last inspection we were concerned that there was no 'safety net' to ensure that child safeguarding referral rates were appropriate. There was a health visitor liaison team who attended the ED every few days to check referrals but they did not check all child attendances to see if any had been missed. In response to our findings the department strengthened processes to include a review of all child attendances by a children's safeguarding nurse and completion of any missed paediatric liaison forms. In addition, they checked adult attendances relating to overdoses, deliberate self-harm, drug or alcohol abuse and domestic abuse to see if they had any children and if so, ensure that paediatric liaison forms were completed and necessary authorities informed.

Mandatory training

- Staff were required to complete mandatory training, including refresher training, in 12 essential subjects. The trust's target for completion of mandatory training was 90%. The compliance rate for medical staff was between 57.1% and 80%; therefore significantly below the trust target. For nursing staff the target was met for nine out of 12 subjects, with the remaining three (manual handling practical, conflict resolution and basic adult resuscitation) ranging between 69% and 79%.

Assessing and responding to patient risk

- Patients were not always assessed promptly on arrival in the emergency department.
- The trust monitored ambulance turnaround times in the emergency department. Performance at CGH showed an upward (worsening) trend between January 2016 and December 2016. In December 2016, 618 journeys had a turnaround time of 30 to 60 minutes and 74 had a turnaround time of 60 minutes or more.
- The trust used a nationally recognised triage system (Manchester) in ED for the initial assessment of all patients. Guidance issued by the College of Emergency Medicine (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 which should occur 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.

- Trust-wide, the median time from arrival to initial assessment (emergency ambulance cases only) was worse than the England average for the 12 months from December 2015 to November 2016. In November 2016 the median time to initial assessment was 12 minutes, compared with the England average of seven minutes. During the week of our inspection performance against the 15 minute standard for patients brought by ambulance to CGH ranged from 48.6% to 64%.
- Patients arriving by ambulance were triaged by the majors' nurse coordinator. We observed in most cases there was no face-to-face assessment of patients and the triage consisted of a handover from ambulance staff, who were then directed to transfer the patient to a clinical area or to the corridor. During our visit we observed a verbal handover of a patient who had a significant head injury. The coordinator did not see the patient, who was in the corridor. The ambulance crew was directed to the minors' area of the department. An hour later the patient had to be transferred to majors, which had several empty cubicles when the patient had initially arrived.
- The emergency department used the national early warning score (NEWS) tool to identify seriously ill and/or deteriorating patients. NEWS scores are calculated by measuring and grading vital signs such as blood pressure respiratory rate and temperature. A high score may indicate the need for more frequent observations or immediate intervention. All patients in the majors' area were supposed to have their vital signs measured and a NEWS score calculated on an hourly basis. We looked at a sample of six patients' records. Patients' observations were completed with the required frequency and early warning scores were correctly calculated.
- Compliance with the use of the early warning score tool was monitored monthly. Results ranged from 70% to 100% (an average of 90%) in the period January to November 2016. The monthly audit also tested whether appropriate actions were taken in response to early warning signs. Performance ranged from 90% to 100% (an average of 98%).
- The trust had introduced an emergency department patient safety checklist (known as SHINE) in March 2016. The documentation prompted staff to undertake observations, tests and treatments in a time based sequence. Compliance with this new system was being monitored via monthly audits. Whilst this was improving over time, use of the system was not well embedded. Performance ranged from 35% to 43% in the period September to November 2016.
- Self-presenting patients were assessed on arrival by a triage nurse, following their registration at the reception desk. The trust monitored the time that patients waited for their initial assessment. During the week of our inspection, performance against the 15 minute standard for self-presenting patients ranged from 61.3% to 79%.
- 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 and staff confirmed they had received no training to recognise red flags, although they named a few of these, including severe abdominal pain, chest pain and severe bleeding. They told us they summoned help either in person or by phone. The RCEM Triage Position Statement states: "Some elements of the triage process, such as initial recognition of urgency, may be undertaken by an unregistered health worker, e.g. reception staff using clearly defined "red flags" which identify urgency. For this reason non-registered health care workers in emergency settings should have basic training in red flag presentations and how to call for immediate assistance…"
- There was insufficient observation and monitoring of patients in the waiting room. Some of the waiting room was not within the receptionists' line of sight and we observed that the triage nurse did always enter the waiting room when calling patients in for assessment. Children were not supervised as recommended Health Building Note (HBN) 15-01 which states "the waiting area should be provided to maintain observation by staff.." There was however, a bell which could be used to summon staff and we heard staff inform parents of this.
- There was an hourly 'safety board round' conducted by the majors coordinator and the consultant (or middle grade doctor) in charge. This was an opportunity to identify any safety concerns and update the escalation status of the department. The escalation status (defined in the department's escalation policy) describes the department's ability to provide safe, timely and efficient care to patients. Factors affecting this ability included surges in activity, insufficient staff and a lack of patient

flow within the hospital. There was a guide for shift leaders for managing escalation, which outlined the processes, including communication to alert the site management team of the department's status.

- The emergency department measured performance against the standard which required applicable patients to be screened for sepsis on arrival. Sepsis is a life-threatening condition that arises when the body's response to infection injures its own tissues and organs. In the period July 2016 to November 2016 performance was between 96% and 98%. The department also measured the time that patients were treated with antibiotics. The RCEM standard is that 50% of patients should receive antibiotics within one hour and 100% within four hours. Between July and November 2016 compliance ranged from 41% to 62%.
- There was a sepsis screening tool and care pathway in use and the safety checklist included a prompt to ensure that staff considered sepsis. Staff told us that ambulance crews pre alerted ED staff when an incoming patient was suspected to have sepsis. The patient would be taken directly to the resuscitation area on arrival where the screening tool would be activated. Where no pre-alert took place or where the patient self-presented, the first opportunity to identify possible sepsis was at triage. The safety checklist which staff were required to complete for all majors patients contained a prompt to remind staff to consider sepsis. The sepsis screening tool prompted staff to consider sepsis if the patient early warning score was 3 or more. During our unannounced visit we saw an excellent response to a pre-alert from the ambulance service. The information was calmly recorded by a nurse who immediately discussed the incoming patient with the consultant and nurse in charge. There were no cubicles immediately available but the staff worked to together to identify and transfer another patient to another part of the department to make room for the incoming patient.
- Patients with mental health problems were risk assessed and prioritised using a mental health assessment pro forma. In the RCEM Mental Health in the ED audit 2014-15 the ED had not met the fundamental standard which requires that a risk assessment is taken and recorded in the patient's clinical record. The ED scored 80% against the RCEM standard of 100%. Actions taken to improve this included the provision of training in the use of the documentation at medical staff induction. The department was also training emergency nurse practitioners to undertake risk assessments. There were plans to re-audit this in July 2017. There was information displayed in the emergency department on a notice board headed 'Mental Health in ED'. This included guidance for staff to meet the needs of patients in mental health crisis, how to conduct risk assessment and protocols for admission.
- Crowding in ED was a serious and ongoing risk, which was identified on the department's and the trust's risk register. There was a trust Escalation and Patient Flow Policy, within which there was an Emergency department escalation policy, including a guide for shift leaders; Maintaining safety in the emergency department. Shift leaders completed hourly board rounds where they allocated scores against defined trigger points, including the number of patients in the department, space available in majors and resuscitation and the number of ambulances queuing.
- There was a system in place to ensure that significant radiological pathology was not missed. All radiology reports were reviewed by a consultant the next working day and patients were notified if anything had been missed and asked to re-attend the department. Funding had been secured for a project, led by an ED consultant, to work with radiology to monitor and learn from missed pathology. Learning was disseminated via teaching sessions, in addition to bi-monthly newsletters.

Nursing staffing

- The emergency department was consistently staffed to planned levels of nursing staff.
- Staffing levels and skill mix had been set in accordance with NICE guidance, with nurse to patient ratios of one to three or one to four. These levels had been provided consistently in the three weeks leading to our inspection.
- At November 2016, the ED reported a vacancy rate of 11.2% at CGH. Bank and agency staff were employed to cover any shortfalls in the rota. An orientation checklist was completed by temporary staff before they began work to ensure familiarisation with the department and its policies and procedures.
- There was not a dedicated paediatric trained workforce in ED; however the department was taking steps to upskill adult-trained nurses, in order to meet the standards set out in the RCPCH Standards for Children and Young People in Emergency Care Settings (2012). This guidance identifies that there should always be a

registered children's nurse on duty in ED or trusts should be working towards this. The guidance recognises that this is often not achievable but states that "nursing staff caring for sick children require competence in emergency nursing, including organisational and clinical skills, and in the care of children." Nursing staff should be trained to at least Paediatric Intermediate Life Support (PILS) or Paediatric Life Support (PLS) level.

- The ED risk register highlighted the risk of "inappropriate care of children by adult-qualified nurses". This was graded as a moderate risk. Actions to mitigate the risk included the development of a rolling programme on paediatric illness and it was recorded that "all registered nurses in ED undergo detailed induction, ongoing training and paediatric resuscitation training to mitigate any risk. The department employed one registered children's nurse. All nurses received a half day's training (a general introduction to paediatrics) as part of their induction. Training records showed that approximately 30% of adult trained nurses had completed an acutely unwell/injured child course, with a further 7% due to start or complete the course in 2017. Approximately 63% had completed PLS or advanced paediatric life support training.

Medical staffing

- There was senior medical presence in the emergency department from 8am to 10pm, seven days a week, although patients were not brought to the department after 8pm. After 10pm the department was nurse-led. There was medical presence within the hospital and doctors could be called upon to support ED nursing staff. There was also an ED consultant on call.
- An out of hours GP (provided by a third party) was available from 6.30pm to 8am in the adjacent fracture clinic, although staff told us that cover was variable.
- Every evening there was a 'step down' process as the department transitioned from being an emergency department to a minor injuries unit. The ED consultant, middle grade doctor and nurse coordinator discussed all remaining majors patients with the hospital's medical registrar and agreed a plan for each. We were told that most patients would be allocated a bed but some would remain in the ED. Nursing staff told us that sometimes they felt vulnerable when majors' patients remained in the department after 10pm as the inpatient doctors were not always able to respond quickly.
- We observed a well organised, smooth step down process during our unannounced inspection. Planning began at 7.30 pm when the nurses in charge of each area identified patients who were likely to require admission. These patients were discussed with the ED consultant who calculated whether these patients could be assessed and diagnosed and, if necessary, referred to inpatient teams before 10pm. If this were not possible, then they would refer relevant patients based on the history provided by ambulance crews and their observations. This was not necessary during our inspection.
- There were structured handovers between medical staff at the beginning of each shift.
- All consultants and registrars were trained in advanced paediatric life support. Junior doctors received training on induction which covered safeguarding and the sick child. There were also written guidelines on paediatric care.
- There were two ED consultants dedicated to paediatrics. One was responsible for developing protocols and audit, while the other took the lead on children's' safeguarding matters. They had regular meetings with paediatrics and attended the paediatric risk meeting.

Other Staffing

- At our last inspection staff raised concerns about the level of portering support provided to the ED. There was usually one porter allocated to the department, which at times was inadequate and nurses were required to undertake patient transfers. The matron told us that a bid had been submitted to increase this support but it had been turned down for financial reasons. During our unannounced visit we saw that nursing and portering staff were having difficulty transferring patients to the wards because three available beds had been identified at the same time. We observed a nurse and a porter took 25 minutes to transfer a patient to the far end of the hospital. This delayed the transfer of other patients out of the department.

Major incident awareness and training

- There was a major incident plan, including actions cards, which had been recently reviewed and were up-to-date. There was a training DVD available on the department's intranet: Initial Operational Response, produced by the Home Office with advice and guidance

on the managing incidents where patients were contaminated with hazardous materials (HAZMAT) or a chemical, biological, radiological or nuclear (CBRN) incident.

- Staff in the emergency department told us they felt safe. All staff carried personal alarms, which, when activated, sounded throughout the department. Staff were provided with conflict resolution training; however only 74.3% of medical staff and 79.6% of nursing staff had completed this.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We have rated this domain as good because:

- People's care and treatment was planned and delivered in line with current evidence-based guidance and standards.
- There was a range of recognised protocols and pathways. Compliance with pathways and standards was monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance, for example in the treatment of sepsis.
- Nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated way with support from specialist teams and services. Specialist teams, such as the integrated discharge team, worked closely and collaboratively with the emergency department.
- Staff demonstrated knowledge and understanding of their responsibilities in relation to the Mental Capacity Act 2005 and consent.
- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.

However,

- The trust was not meeting the standard which requires the percentage of patients re-attending (unplanned) the department within seven days to be less than 5%.

Evidence-based care and treatment

- Care and treatment was delivered using recognised clinical guidelines, for example, National Institute for Health and Care Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) Clinical Standards for Emergency Departments. There were clear pathways, supported by proformas for the management of conditions such as stroke and sepsis. We saw evidence in patients' records that staff were familiar with these pathways and that they were followed.
- Compliance with pathways and standards was audited on a regular basis and education took place to continuously improve knowledge of and compliance with good practice.

Pain relief

- When we inspected the emergency department in March 2015 we found that patients did not consistently receive prompt pain relief. The department had performed poorly in relation to pain management in the Royal College of Emergency Medicine audits in relation to renal colic (2012) and fractured neck of femur (2012-13).
- An internal re-audit of the management of fractured neck of femur was undertaken in 2016 (on both hospital sites and the emergency departments continued to score poorly in relation to the assessment and management of pain. The audit found that pain assessments were not consistently recorded at triage and many patients were not reviewed by a doctor within one hour, which delayed pain management. It was concluded that workload was a major contributing factor.
- The department had delivered teaching sessions to medical and nursing staff to raise awareness and improve performance.
- The new safety checklist contained hourly prompts to assess and reassess pain. We checked a sample of six patients' records during our visit and saw that pain assessments had been completed at regular intervals.

Nutrition and hydration

- The patient safety checklist prompted staff to offer patients food and drink at appropriate intervals. In the small sample of patients' records we checked, there was evidence that patients had been offered refreshments.

Patient outcomes

- Information about patient outcomes was routinely collected and monitored. The trust participated in national RCEM audits and internal audits so they could benchmark their practice and performance against best practice against other emergency departments. There was a designated consultant audit lead for the department, who oversaw the audit programme and the completion of action plans. The trust performed in line with other trusts nationally overall.
- In the 2015/16 RCEM audit for Venous Thromboembolism Risk in Lower Limb Immobilisation in Plaster Cast, Cheltenham General Hospital performed:
- In the upper quartile for the measure 'If a need for thromboprophylaxis is indicated, there should be written evidence of the patient receiving or being referred for treatment'.
- Between the upper and lower quartiles for the measure 'Evidence that a patient information leaflet outlining the risk and need to seek medical attention if they develop symptoms for VTE has been given to all patients with temporary lower limb immobilisation'. An action plan was developed in response to the audit findings. Actions included, teaching to medical staff and emergency nurse practitioners, the introduction of a plaster pack which would serve as an aide memoire and personal feedback to ENPs.
- In the 2015/16 Procedural Sedation in Adults audit Cheltenham General Hospital was in the upper quartile compared to other hospitals for five of the seven measures. The remaining two measures were between the upper and lower quartiles.
- The trust was not meeting the standard which requires the percentage of patients re-attending (unplanned) the department within seven days to be less than 5%. Performance between October 2015 and September 2016 was between 7 and 8%; this was however, generally better than the England average.

Competent staff

- There was a programme of ED 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. The matron told us that all nursing staff received seven to eight days training per year.
- Junior medical staff told us they were well supported and had access to regular training, including regular 'learning bites' at daily handover meetings. There was protected one to one time (one hour) each month with consultants, where the subject was nominated by the junior doctor. They told us the trust was a popular place to come for a good training experience. One doctor told us "I can always ask a consultant for support, however busy they are."
- Appraisal rates for the unscheduled care division trust-wide were as follows:
- Healthcare Assistant staff: 83%
- Other, including administrative and clerical staff: 87%
- Medical staff: 83%
- Nursing staff: 77%
- The General Medical Council (GMC) reported in their 2016 regional review that doctors in training had commented favourably about the willingness of ED consultants on the floor to teach. They also commented positively about multidisciplinary teaching, with educational sessions provided by mental health professionals and physiotherapists and opportunities for simulation training. In the 2016 GMC survey there was positive overall satisfaction fed back by foundation year 1 doctors. Foundation year 2 doctors and core trainee doctors expressed some concerns about clinical supervision, particularly at night, handover and workload.
- There was a communication box in the department with a range of staff resources; information on study days, professional articles, safety newsletters and best practice information.

Multidisciplinary working

- Staff, teams and services mostly worked well together to deliver effective care and treatment. There was a good relationship with the mental health trust and regular multidisciplinary meetings with the ED, mental health trust and the police to discuss regular attenders.

- During our unannounced visit we saw good communication between the emergency department and the diagnostic imaging department.
- However, some nursing staff had told us that had told us that they did not always feel well supported by the inpatient teams after the emergency department doctors had gone off duty. They said that they sometimes felt vulnerable because doctors on the wards may not be able to respond quickly.
- At our last inspection we were told that a performance measure had recently been implemented whereby specialties were required to accept admissions from ED within 30 minutes of the decision to admit. This was monitored by daily analysis of breaches. At our most recent inspection we were told that although delays in specialist review were still monitored and reported on in weekly breach meetings and at the monthly emergency care board, internal professional standards had only recently been published. It was reported in the December 2016 emergency care pathway report that the implementation of internal professional standards for all specialties, which was an action of one of the emergency care board's work streams, was "not on track to deliver". It was reported that the work stream had managed to agree seven of the 'top ten' standards with key stakeholders. The report went onto say, "there remains some concern among the clinical body regarding some of the wording of the standards but the chief executive has asked the work stream to simply define the standards we are aspiring to achieve in order to establish the improvement actions required to deliver them".
- During our visit we saw the (inpatient) medical registrar in the emergency department proactively identifying patients who could be fast-tracked for admission.

Seven-day services

- There was senior medical staff presence in the ED seven days a week.
- Pharmacy services were available Monday to Friday only, although there was a pharmacist on call out of hours. Senior staff in the emergency department were unhappy about the lack of service over the weekend.
- Radiology was available seven days a week.
- Mental health liaison was available seven days a week; however support for children and young people was reduced at weekends. Specialist support for patients presenting with drug or alcohol misuse was not available at weekends.

Access to information

- Information needed to deliver effective care and treatment was available to staff involved in patients' ongoing care when they were discharged or transferred to another service.
- Patients admitted to inpatient wards from the emergency department had their records scanned onto the hospital's electronic system before they were transferred to the ward. For those patients who were discharged from the emergency department, an electronic discharge summary was generated and sent to the patient's GP.
- 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 EDs 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 new patient record system had been introduced in December 2016. Staff described numerous difficulties with this system, which were time consuming and distracting.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for their verbal consent prior to care and treatment being delivered. Doctors and nurses explained things to patients simply, checking their understanding and asked permission to undertake examinations or perform tests.
- The trust reported that at 31st October 2016 Mental Capacity Act (MCA) awareness training had been completed by 86.7% of all staff within Urgent and Emergency Care.
- Deprivation of Liberty Awareness (DoLs) training had also been completed by 86.7% of all staff within Urgent and Emergency Care. However, the completion rate for both modules fell below the trust target of 90%.

Urgent and emergency services

Are urgent and emergency services caring?

Good

We rated this service as good because:

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.

Compassionate care

- We observed staff interacting with patients and their relatives in a respectful and considerate manner. We observed staff greeting patients and their relatives and introducing themselves by name and role. Staff wore name badges and there was a poster displayed to help patient identify staff roles by the colour of their uniform.
- Patients and relatives we spoke with told us staff were caring, compassionate, friendly and engaging. We saw staff providing reassurance to patients when they were anxious or confused.
- Patients' privacy and dignity were respected where possible. However at times this was challenging due to crowding. Patients sometimes queued in the corridor because there were no cubicles available. Staff tried to keep a side room free so that patients requiring clinical tests, private conversations or toileting were given some privacy.
- The trust used the friends and family test to capture patient feedback. Response rates had increased significantly since the introduction of a new digital methodology and in September 2016 was 27.5%. However, the percentage of respondents who would recommend the service started to decline in September 2016. In December 2016, 78% of responses were positive, compared with 86% nationally.
- We spoke with approximately six patients/relatives and reviewed 33 comments cards from people who had attended the emergency department in the weeks leading up to our inspection. All of the feedback was positive. Comments included:

- "Caring staff, I was treated with dignity and respect."
- "Really good care. Lots of great advice and reassurance."
- "Fantastic care. Vey empathetic, caring staff."
- "We were treated with fabulous care and kindness. My family, who came with me, were also treated very well."
- "Really lovely,
- "All staff I encountered were kind, caring and respectful."
- "The service I have received has been excellent. The staff have been caring and nothing was too much trouble"
- "X was very reassuring and friendly. She was very maternal which was nice because I was here without my mum. Thanks for looking after me."
- "Polite and helpful reception staff."

Understanding and involvement of patients and those close to them

- We witnessed doctors explaining treatment plans to patients and their relatives. They took time to check their understanding and asked them if they had any questions. Relatives told us they felt they had been involved in the decision-making process about the treatment of their family members.
- A patient told us "all of the staff answered all of my questions clearly."

Emotional support

- We observed an appropriately sensitive and sympathetic discussion with a relative about the treatment plan for their family member who was terminally ill.

Urgent and emergency services

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

Requires improvement

We have rated this service as requires improvement because:

- The trust was not consistently meeting the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department.
- Some patients spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.
- Crowding meant that patients sometimes queued in the corridor, where they were afforded little comfort or privacy.
- Patients with mental health needs were not always promptly assessed or supported, particularly at night time when there was no mental health liaison service. There was a lack of an appropriate welcoming space for patients with mental health needs.

However:

- The service had a number of admission avoidance initiatives in place to improve patient flow. These include the integrated assessment team who proactively identified and assessed appropriate patients who may be able to be supported in the community to avoid hospital admission.
- We saw evidence that complaints were used to drive improvement.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enable staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.

Service planning and delivery to meet the needs of local people

- The trust was working closely with commissioners to identify system-wide strategies to improve patient flow.
- Facilities and premises were adequate but with some limitations. There was limited parking close to the emergency department, although there was drop off area. The waiting room was small; staff said there was sometime inadequate seating. The room was gloomy and unwelcoming. One patient complained about the hard seating which was uncomfortable during their long wait.
- The department was frequently crowded. Patients queued in the corridor, some on arrival in the department, and waiting to be seen, some while waiting to be transferred to a ward. The trust monitored and reported on corridor usage in their weekly breach reports. In the week of our inspection corridor usage ranged between three and thirteen patients per day.
- There was not a separate room which could be used to undertake mental health assessments or a quiet space where people with mental health needs could wait. This did not comply with standards for liaison psychiatry services, developed by the psychiatric liaison accreditation network (PLAN). Staff told us they used side rooms when these were available.
- The trust was working collaboratively with the local A&E delivery board and engaging 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 ED.
- All health and social care partners, including the local care trust and the ambulance service, the council and the Clinical Commissioning Group, 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.

Meeting people's individual needs

- The service took account of the individual needs of patients but was not always able to provide a responsive service to patients with mental health needs.
- The department was accessible for people with limited mobility and people who used a wheelchair. There were wheelchairs available in the department and staff could access wheelchairs and trolleys which could accommodate bariatric patients.
- The waiting room was small and this presented a problem in terms of maintaining confidentiality at the reception desk. The department had not taken any steps to address this. Staff told us that they were understanding if people did not wish to share their personal details and simply recorded the presentation as 'personal'.
- There was poster at the reception desk which described the pathway through the department. We felt that this could be better publicised by displaying the information more prominently in the waiting area. Waiting times were displayed on a television screen but patients and staff agreed that the information was not helpful.
- There was no hearing loop provided for people who were hard of hearing and used a hearing aid.
- Reception staff had some translation aids available for people whose first language was not English. Staff told us that a telephone interpreter service could be provided.
- There were vending machines in the waiting area that patients and visitors could access food and drink. There was a television in the main waiting area, and some reading material had been provided.
- There were male and female toilets and nappy changing facilities were available in the children's area. There was not a designated area for breast feeding mothers but staff told us they would find a private space if required.
- There was a small separate waiting area for children, which was not overlooked by the adults' waiting area. It was suitably furnished, decorated and equipped with toys.
- There was a mental health liaison team (MHLT), which supported the emergency department and the Acute Care Unit from 8am to 10pm seven days a week. The team, who were employed by the local mental health trust, aimed to respond verbally to all crisis and urgent referrals for mental health advice or assessment and provide assessment within two hours. Between June and October 2016 the service received 120 urgent referrals, of which 55% were seen within two hours. Most non urgent referrals were seen within 24 hours. Data provided by the service was not split by site, but staff complained that they believed the service was less responsive on the Cheltenham Hospital site because the liaison staff based themselves at Gloucester Royal Hospital. They said that they refused to travel to Cheltenham General Hospital after 8pm so this was effectively when the service stopped.
- Out of hours, staff could contact the crisis home treatment service provided by the local mental health trust or the on call psychiatrist. Staff told us that this service was not responsive as there were limited resources and priority was given to people in the community, as opposed to patients who were regarded as being in a 'place of safety'.
- The trust had a policy that patients with mental health illness would not be admitted to an inpatient bed overnight, awaiting psychiatric assessment, unless they had a physical illness or injury. Concerns had been raised about this policy by an ED consultant at the ED governance meeting in November 2016. It was reported that there had been a number of incidents where high risk patients had absconded from the ED because the department did not have the appropriate staffing to supervise these patients. The ED management team told us the provision of MHLT support was to be extended to cover the 24 hour period from February 2017.
- In April 2015 the local mental health trust appointed a high intensity case worker to identify strategies to more effectively manage people with mental health issues who frequently attended the emergency departments in Gloucestershire. One of the objectives was to produce multi-agency management plans to support frequent attenders. Data produced in June 2016 showed an overall reduction in both attendances and admissions where high intensity users were proactively case managed. The patient records system identified patients with management plans in place (by use of an icon) so that staff could refer to their history and seek guidance on how to best manage each presentation. We were told that patients were able to provide input into these plans; however, when we reviewed a sample of these plans there was no evidence of any patient input.
- There was a specialist alcohol liaison service which supported the ED from Monday to Friday from 9am to 5pm. Patients attending ED who were identified as having harmful and dependent drinking behaviours

were offered assessment, brief intervention and signposting to relevant services. ED staff assessed patients and, where appropriate, provided them with a leaflet and an appointment to see the alcohol liaison worker at the next available clinic slot or within 48 hours. People attending ED on Friday or Saturday would be given an appointment for the following Monday. It was noted in a report to the psychiatric liaison meeting in November 2016 that lack of service provision at weekend created a referral backlog and compensatory pressures on workflow during the early part of the week.

- There was guidance available for ED staff to assist them to identify and manage patients with a learning disability. There was a team of learning disability liaison nurses who could be called upon to support staff. Staff received awareness training as part of their induction. This included meeting the trust's learning difficulties team, who described what their role was, how to contact them and what they could offer patients. Support included the production of individual support plans for patients with a learning disability. These were produced in an easy read format and included patient's likes and dislikes and preferences for care.
- Staff received dementia awareness training as part of their induction. They used purple butterfly stickers on patients' records and purple wrist bands to identify patients with cognitive impairment. The department provided 'twiddlemitts' for patients who were restless or anxious. Twiddlemitts are knitted mittens with items of varying texture attached inside and out. They are knitted by volunteers using bright coloured wool and lots of attachments. They provide simple stimulation for people with dementia and other memory conditions. They minimise agitation, increase flexibility of the fingers and soothe fidgety hands.
- The department had appointed a dementia champion who was a source of advice and support.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- 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 not consistently meeting key national performance standards for emergency departments:
- The trust was not consistently meeting the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. The trust did not meet the standard between January and December 2016 and performance was worse than the England average, which was also below the standard. However, performance at CGH was better and ranged from 88% to 89% in the same period. During the week of our inspection, performance was 94.4%.
- The trust also failed to meet the standard recommended by the Royal College of Emergency Medicine (RCEM) in relation to the time from arrival to treatment (one hour) in 10 out of 12 months in the period December 2015 to January 2016. In November 2016 the trust-wide median time to treatment was 60 minutes, compared with a national average of 59 minutes. At CGH the median wait was lower (better), ranging from 59 minutes to 79 minutes in the same period.
- 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. Between January December 2016, the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was generally better than the England average. The trust's performance had improved over time and in December 2016 trust performance was 12%, compared to an England average of 17%. Over the same reporting period, four patients waited more than 12 hours from the decision to admit until being admitted.
- In the week of our inspection (week commencing 23 January 2017), seven patients were in the emergency department at CGH for longer than six hours and one patient spent longer than 10 hours in the department.
- 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) should be less than 5% (recognised by the Department of Health as being an indicator that patients are dissatisfied with the length of time they

have to wait). Between December 2015 and November 2016 the trust's monthly median percentage of patients leaving the trust's urgent and emergency care services before being seen for treatment was better than the England average. The trust's performance was consistently between 1.2% and 2.3%. In December 2016, the trust's performance was 1.6% compared to the England average of 3%.

- The emergency department operated a clinical model (known as UTOPIA), whereby all emergency admissions, including those patients referred by their GP, attend the ED. The principal driver for this was to ensure the earliest possible review of all patients by a senior decision-maker who was capable of assessment and instigation of initial management plans. It also enabled some patients, who would otherwise have been admitted, to be assessed and discharged. There was recognition that the increasing numbers and acuity of patients, and poor patient flow within the hospital, leading to crowding and associated risks, made this model unsustainable, given the current resourcing and capacity of the emergency department. Detailed diagnostic work was underway both within the emergency department and within the wider system to develop a model which was affordable and sustainable.
- There was detailed monitoring of breaches hour by hour in the emergency department and the site management team. There was a weekly breach meeting chaired by the chief operating officer and monthly performance was reported to the emergency care board against a monthly trajectory agreed with NHS Improvement (NHSI). It was reported in the emergency pathway report that the NHSI recovery trajectory was met in quarter 2 (July to September) but performance in October and November were below trajectory. The report highlighted the multiple challenges in maintaining progress:

- The trust's emergency departments had seen a 4.9% increase in attendance in the 12 months to November 2016
- There was a significant shortage of junior and middle grade medical staff in the emergency departments
- High bed occupancy levels, average length of stay, medically fit for discharge patients and delayed transfers of care. The report stated "Occupancy levels at Gloucestershire Hospitals have historically run at more than 95% for many years. The Trust considers this unacceptable and recognises the impact on the potential quality of care and the impact on staff. The trust recognises a significant piece of work is required to sustainably reduce occupancy rates to acceptable levels of 92.5% and elements towards achieving a reduced occupancy sit across a number of work streams within the programme…"

- The trust's risk register recorded "Delayed discharge of patients who are on the medically fit list above the agreed 40 limit leading to detrimental effects on capacity and flow of patients through the hospital from ED to ward".
- Analysis of the main contributing factors to four hour breaches in November 2016 showed that bed availability was by far the biggest single cause of breaches (35.9%). The second biggest cause was 'awaiting assessment' (20.57%) and the third biggest cause was 'others' (this includes waiting for diagnostics, porters, transport and specialists).

- The trust recognised that crowding in the ED presented a risk to patient safety, patient experience and performance against key waiting time targets. There was a trust Patient Flow and Escalation Policy (September 2016) which set out steps to mitigate these risks by ensuring that patient flow throughout the two hospitals was managed.
- There were regular capacity and flow meetings throughout the day an attended by a representative from the ED. The site management team maintained an organisational overview of capacity and issues affecting flow, and liaised closely with the ED coordinator.
- The escalation policy described and rated the escalation of each hospital, ranging from green (low risk) to black (very high risk). The escalation level was triggered by bed capacity or ED capacity (numbers and breaches) and was reviewed regularly. In the ED, escalation status was reviewed by the nurse coordinator and consultant at the hourly board round. The escalation status of the department was calculated using a score system which took into account incoming ambulances, total arrivals, majors' cubicles in use, and resuscitation cubicles in use and total patients in department.
- Escalation status was communicated to and reviewed by the site manager and the designated trust duty manager. When the ED was at red or black status, the coordinator implemented the ED escalation policy.

Urgent and emergency services

- The trust had developed a number of initiatives to prevent unnecessary ED attendance and/or admission to hospital and thereby improve patient flow.
- From September 2014 all GP calls for an ambulance were handled by the Gloucestershire Single Point of Access run by a local community trust, where alternatives to ED attendance would be considered first. However, the speciality director told us that some GPs opted out of this system.
- There was an integrated assessment team provided by a local community trust to work in the ED and in 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. The service operated from 8am to 8pm Monday to Friday and from 9am to 5pm at weekends. The team was highly regarded and valued by the ED staff because of their proactive approach to admission avoidance. They aimed to prevent five admissions per day and had rapid access to social care and community hospital beds. We heard however, that the team was not always fully staffed, particularly at weekends.
- The trust's website provided advice to members of the public to encourage them to choose the most appropriate service when they needed urgent healthcare advice or treatment. The Advice ASAP campaign included a short video and a smart phone application which allowed people to search by service or by symptoms. There were links to a range of local services, including primary care (including out of hours), NHS 111, pharmacies and local minor injury and illness units. Live information was also posted on the website showing how busy each ED was and the average time patients would have to wait to be seen.

Learning from complaints and concerns

- Between November 2015 and October 2016 there were 37 complaints about urgent and emergency care at CGH. Ten complaints (27%) were categorised as 'patient care'.
- The trust took an average of 38 working days to investigate and close complaints. This was slightly longer than stipulated in the trust's complaints policy, which stated complaints should be responded to in 35 working days.
- Staff we spoke with were with were familiar with the complaints procedure. They told us they would try to arrange for complainants to speak with a senior member of staff or direct them to the Patient Advice and Liaison Service (PALS). There were complaints leaflets in the department which advised people how to complain and these were also available via the trust's website.
- Complaints were discussed at governance meetings. A consultant was the designated lead for complaints within the department and was responsible for identifying themes and disseminating learning. Communication methods included 'Message of the week' where short catchy reminders were displayed around the department.
- The trust had introduced a new digital methodology for the friends and family test in July 2016 and this had resulted in a big increase in the response rate for September 2016 (26% trust-wide).

Are urgent and emergency services well-led?

Good

We have rated this service as good because:

- There was a strong, cohesive and well informed leadership team, who were highly visible and respected.
- There was a detailed improvement plan in place with clear milestones and accountability for actions.
- The emergency department produced high quality information which analysed demand capacity and patient flow, and which was used to inform the improvement plan.
- There were robust governance arrangements in place. Clinical audit was well managed and used to drive service improvement. Risks were understood, regularly discussed and actions taken to mitigate them.
- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the department was under pressure.
- Staff felt respected, valued and supported. Morale was mostly positive, although to an extent, undermined by workload pressures.
- Service improvement was everybody's responsibility. Staff were encouraged and supported to undertake service improvement projects.

However;

- The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team but it did not appear that the risks relating to staff wellbeing, resilience and sustainability, had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- There was a limited approach to obtaining the views of people who used the service.
- Workload pressures prevented opportunities for staff reflection or meaningful staff engagement and involvement in shaping the service.

Vision and strategy for this service

- The vision for the service was for the provision of all strands of unscheduled care to be provided under one roof, 24 hours a day, seven days a week. This included the expansion of primary care services, mental health liaison and support, ambulatory emergency care, further development of the frail elderly care pathway (including short stay beds), and the provision of larger and updated premises to accommodate these services. It was anticipated that this would take several years to achieve.
- There was a trust-wide five year strategic plan and an operational plan for 2016/17. Priority areas were identified in the operational plan as;
- address the inability of the local health and social care system to manage demand within current capacity,
- match work force with clinical needs,
- develop the physical estate.
- The emergency care pathway was identified as a trust priority for improvement and plans were set out in the emergency care programme. A series of external reviews had taken place of systems and to examine the issues affecting operational effectiveness and patient flow. Most recently an improvement Director appointed by NHS Improvement had undertaken diagnostic work which had resulted in the development of an emergency care programme. 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 board.
- A work programme was developed under the umbrella of an economy-wide plan monitored by the A&E Delivery Board. Six work streams, with defined objectives were developed and progress against each of the work streams monitored by the emergency care board. Work streams were:

  - Emergency Department,

  - Site management,

  - Safer patient flow bundle,

  - Clinical patient flow model,

  - Bed distribution,

  - Remove delays to discharge.

- Within the emergency department work stream the objectives were:

- To review staffing and skill mix
- To review four hour breaches
- To increase ED capacity

Governance, risk management and quality measurement

- There was an effective governance framework. Information was regularly monitored to provide a holistic understanding of performance, including safety, quality and patient experience.
- There was a bi-monthly clinical governance meeting attended by senior nursing and medical staff. A standard agenda included incidents and risk management, patient experience, including complaints, safety alerts, clinical guidelines and audit. Key messages were communicated by distribution of minutes, email, bulletins, teaching sessions and handovers. The emergency department clinical governance meeting reported to the divisional quality meeting, which reported ultimately to the board. Divisional quality reports monitored and reported on key safety and quality standards. There were also monthly operational meetings where items discussed included staffing and performance.

- One of the ED consultants took the lead overall for quality and governance. All ED consultants had designated specialist lead roles, such as clinical audit, complaints, mental health, paediatrics, elderly care, and missed radiological pathology.
- There was a monthly emergency pathway performance report to the board, detailing progress against the emergency care programme board milestone plan. Performance metrics included safety, patient experience, incidents, complaints, morbidity and mortality. There were a number of county-wide projects to streamline the urgent care system as detailed in a system-wide plan. This involved working with health and social care partners.
- The emergency department maintained a risk register which was regularly monitored and reviewed at departmental and divisional levels. Risks aligned with the areas of concern identified to us by managers and staff, with the highest risk being associated with demand, capacity and patient flow. However, risks in relation to staff wellbeing and resilience, whilst understood and articulated to us, were not identified in the risk register.
- There were good relationships with third party providers. For example, the director of nursing met regularly with their counterpart in the local mental health trust and there were regular meetings with ED and the mental health liaison service.
- There was a systematic programme of clinical audit which was used to monitor quality and safety. At our previous inspection we raised concerns that the audit was not well managed, actions arising from audits were not completed in a timely manner and we could not be assured that learning and improvements consistently took place. On our return visit we found this was much improved. Responsibility for managing the audit programme had been passed to another consultant, who had reviewed all audits going back to 2012/13, ensuring that all actions were completed. The lead consultant had a good overview of all ongoing audit, action plans and plans for re-audit. We reviewed a number of audits and saw action plans had been completed, discussed at mortality and morbidity meetings and learning points disseminated.

Leadership of service

- There was a local management triumvirate, comprising of a specialty director, matron and general manager. They were supported by an operations information manager. They were a well-informed, cohesive team who were highly respected by staff. They demonstrated passion and drive to meet the significant challenges in unscheduled care and to develop and improve their service.
- Staff told us the local management team was visible, approachable and supportive. During our visit they were all highly visible in the department and provided assistance when there were capacity issues. The triumvirate team felt well supported by the divisional management team and the new chief executive was described as “a breath of fresh air”. However, there was frustration expressed that the emergency department bore the risks associated with lack of patient flow, while responsibility for managing the exit block sat with others and progress in addressing this was slow.

Culture within the service

- Staff in ED told us they felt respected, supported and valued by their immediate managers and their peers. Staff morale was mainly positive, with many staff citing teamwork as one of the best things about working in the emergency department. We observed exceptional teamwork during our visits, with all disciplines and grades of staff working together seamlessly and helping each other out when needed.
- Morale was inevitably undermined by workload pressure and managers expressed concerns about the impact that workload was having on the physical and mental wellbeing of staff. This was most acutely felt by nursing staff but there were also concerns about the frequency with which consultants were working additional hours to support the department, particularly at night. A workplace stress risk assessment undertaken in May 2016 had identified some concerning messages. It was reported that increasing ED attendances and patient acuity, combined with delays in diagnostic and specialty review, and reduced bed capacity, had led to an excessive increase in staff workload without any additional staff to deal with it. It was noted that this had “a profound impact on the stress and wellbeing of staff. This was highlighted by :

- High staff turnover
- Concerns about workload and the working environment

- Concerns about a lack of communication within the department (difficulty releasing staff to attend staff meetings and in house teaching activities
- Staff feeling disconnected with changes at work.

Positive feedback was received in relation to:

- the skills and abilities of staff being matched to the demands of the job and the provision of training
- Staff said they were encouraged to use their skills and initiative
- Staff felt supported by their colleagues
- Staff had adequate feedback and resources to enable them to carry out their role.

An action plan was in place to address areas of concern.

Public engagement

- The ED used the friends and family test to capture patient feedback and this was discussed at governance meetings.
- The service provided us with no further examples of public engagement.

Staff engagement

- There were limited opportunities for face-to-face staff engagement, although staff were kept informed via email bulletins, newsletters and handover meetings. There were departmental meetings held for nursing staff. These took place infrequently and were poorly attended due to operational pressures.
- 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 ED staff we spoke with could articulate the department's vision or strategy.
- Staff told us that they were encouraged to raise concerns and they felt they were listened to.

Innovation, improvement and sustainability

- There was strong sense of drive to improve the service. There was an emergency department improvement plan which had been developed in response to a number of drivers, including our previous inspection report, recommendations from Monitor (now NHS Improvement), commissioning targets and audit findings.
- There was a Quality Improvement Academy established in the trust in June 2015. Staff were supported to undertake projects which were identified as areas which could make improvements to quality and safety. Projects in the emergency department included Biers Block (regional anaesthesia) for the reduction of colles fractures, early management of chest pain and ECGs, early management of asthma, improvement of pain management in emergency departments.

Medical care (including older people's care)

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

Information about the service

Medical services provided by Gloucestershire Hospitals NHS Foundation Trust are located on two hospital sites, the other being Gloucestershire Royal Hospital. Services at Gloucester Royal Hospital are reported in a separate report. However, services on both hospital sites are overseen by one management team (the medical division) and as such are 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.

The Medical care service at the trust provides care and treatment for nine specialties. There are 548 Medical inpatient beds located across 22 wards. In August 2016 in the medical services department, there were 358.42 nursing whole time equivalents (WTE) and 274.79 other clinical WTE.

A site breakdown can be found below:

• Cheltenham General Hospital: 200 beds are located within nine wards

• Gloucestershire Royal Hospital: 354 beds are located within 13 wards

The trust had 72,120 Medical admissions between April 2015 and March 2016. Emergency admissions accounted for 30,633 (42%), 1,671 (2%) of admissions were elective and the remaining 39,816 (55%) were day case.

Admissions for the top three Medical specialties were:

• General Medicine 28,108

• Medical Oncology 19,813

• Gastroenterology 10,486

We inspected the medical services between January 24 and 27 January 2017 and carried out an unannounced visit on 8 February 2016. We inspected the medical division inpatient wards: Avening (respiratory), the cardiac and coronary care unit, Hazelton (gastro-enterology), Kemerton (beds opened in response to the shortage of inpatient beds on the medical wards), Knightsbridge (respiratory and isolation), Lilleybrook (oncology), Rendcomb (oncology and haematology) Ryeworth (old age medicine) and Woodmancote (old age medicine). We also visited the endoscopy unit, the acute care unit and the discharge lounge.

We spoke with 53 members of staff including nurses, doctors, therapists, administrators and housekeepers. We spoke with eight patients and two relatives. We observed interactions between patients and staff, observed parts of board rounds, considered the environment and reviewed 10 sets of patient's notes to identify the care provided.

Prior to, during and after the inspection we looked at information requested and sent to us by the organisation, which included audit results, minutes of meetings, organisational policies, incidents, complaints and positive feedback.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot,

Medical care (including older people's care)

has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

The team included CQC inspectors and a variety of specialists including a retired consultant cardiologist, a matron and a senior nurse.

Summary of findings

We rated this service as requires improvement because:

- The trust did not assess the acuity of patients daily to ensure safe staffing levels were in place on each shift, particularly at night. This was of concern in the coronary care unit.
- The medical service did not consistently contribute to and review the effectiveness of care and treatment through participation in national audits.
- There were insufficient infection control and prevention facilities when entering and leaving some areas in wards and the cleanliness of equipment, such as commodes, was not always assured.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- Some areas were not fit for purpose and the fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in line with the trust's policy in all areas.
- There were new machines for checking of patients' blood sugar however, not all staff had had training so the old machines were also still in use. Staff did not always calibrate these daily in line with manufacturer's guidance.
- Fridge temperatures were not monitored consistently and medicines were not always stored correctly. Staff were unsure of when to dispose of some medicines in line with manufacturer's recommendations.
- Staff did not always comply with the trust policy and best practice when receiving controlled drugs from pharmacy.
- Records were not stored safely to ensure patient confidentiality was maintained.
- Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day. Patient acuity was not consistently assessed, discussed and recorded on each ward to ensure safe staffing. This was of concern in the coronary care unit and particularly at night.
- The delivery of cardiology services did not meet the needs of the local population.

Medical care (including older people's care)

- There were delays to discharges, which meant patient flow through the hospital was compromised.
- The service was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- There was not a systematic approach to mortality and morbidity (M&M) meetings. This meant there was a lack of overview and governance around mortality and morbidity (M&M) meetings.
- There was a limited approach to obtaining the views of patients and their relatives.
- Risks on the risk register were not always aligned with risks in the service

However:

- Staff understood their responsibility to report incidents and there was evidence of learning from incidents across the organisation.
- Staff were aware of their responsibilities for identifying and reporting safeguarding issues.
- There were safe processes to review patients and ensure care and treatment plans were reviewed.
- Ward staff in all areas we visited were seen to wear the correct uniform and use personal protective equipment, gloves and aprons as needed.
- Patients were positive about the way they were treated and cared for in the medical wards.
- We observed staff treated patients with kindness, dignity, respect and compassion.
- There was a dedicated helpline for oncology and haematology patients. This enabled patients to be assessed and, if required (for example when neutropenic sepsis was suspected), admitted directly to Lillybrook ward without the need to go through the emergency department.
- There was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills. Nurses were supported with revalidation processes.
- The endoscopy unit had safe processes in place to ensure staff decontaminated and sterilised equipment in line with best practice. The endoscopy unit held join advisory group (JAG) accreditation and had procedures in place in line with the national safety standards for invasive procedures.
- There was an effective framework for 'board round' and ward rounds which included input from staff from the multidisciplinary healthcare team.
- Processes were in place to ensure consultants reviewed patients seven days a week. .
- Staff were aware of mental capacity assessment and of deprivation of liberty safeguards applications.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services had been better than the England overall performance.
- Though information leaflets were not readily available for patients whose first language was not English, there was access to translation services Staff knew how to access this if needed.
- Staff felt supported by managers and senior management felt assured by the new executive team.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

By safe, we mean people are protected from abuse and avoidable harm. We rated safe as requires improvement because:

- Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day.
- The service did not assess or record the acuity of patients on each shift and on each ward to ensure safe staffing levels. This was of concern in the coronary car unit and particularly at night.
- Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- Some areas were not fit for purpose and the fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in line with the trust's policy in all areas.
- There were new machines for checking of patients' blood sugar however, not all staff had had training so the old machines were also still in use. Staff did not always calibrate these daily in line with manufacturer's guidance.
- Staff did not monitor fridge temperatures consistently or take actions where these fell out of normal range, which meant medicines were not always stored correctly. Staff were unsure of when to dispose of some medicines in line with manufacturer's recommendations.
- Staff did not always comply with the trust policy and best practice when receiving controlled drugs from pharmacy.
- Records were not stored safely to ensure patient confidentiality was maintained.
- Some wards scored low for compliance with harm free care and it was not obvious what actions were taken to improve practice.
- Staff did not always assess risks to patients or follow up identified risks with mitigating care interventions.
- Patient acuity was not consistently assessed, discussed and recorded on each ward to ensure safe staffing. This was of concern in the coronary care unit and particularly at night.

However:

- Staff understood their responsibility to report incidents and there was evidence of learning from incidents across the organisation.
- The endoscopy unit had safe processes in place to ensure staff decontaminated and sterilised equipment in line with best practice.
- Staff were aware of their responsibilities for identifying and reporting safeguarding issues.
- There were safe processes to review patients and ensure care and treatment plans were reviewed.
- Ward staff wore the correct uniform and use personal protective equipment, gloves and aprons as needed.
- Staff were supported with revalidation practices to ensure continued professional registration.
- There was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills.
- The endoscopy unit held join advisory group (JAG) accreditation and had procedures in place in line with the national safety standards for invasive procedures.

Incidents

- There had been no never events between December 2015 and November 2016 for medical care. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be deemed a never event.
- In accordance with the Serious Incident Framework 2015, Cheltenham General Hospital reported seven serious incidents (SIs) in medical care, which met the reporting criteria set by NHS England from December 2015 to November 2016. Of these, the most common type of incidents reported was slips/trips/falls and healthcare associated/acquired infection control incident, both with two reported incidents.
- There was a good incident reporting culture and staff were actively encouraged to complete electronic

incident reports. Staff were aware of their responsibility to report incidents. We saw evidence that lessons were learnt and improvements were made when things went wrong.

- When staff reported an incident on the electronic incident recording system, they received an email acknowledging and thanking them. Once an investigation was complete, staff also received a report of any actions or outcomes associated with the incident.
- Senior nurses had oversight of incidents and investigated any concerns. We reviewed some incidents reported by staff prior to the inspection, which the trust had investigated. Learning was fed back to staff in the medicine division and the wider hospital when appropriate. For example, during non-invasive ventilator therapy, the type of facemask used had caused pressure ulcers on the tips of patients' ears. Following introduction of full-face masks in September 2016, there had been no further reported incidents of these on Avening ward.
- The clinical risk lead reviewed reported incidents from the medical services. Any potential serious incidents were discussed with the ward staff and additional information gathered. Serious incidents were reviewed at a scoping meeting and an investigator allocated to carry out an investigation of the circumstances and outcomes. Incidents that were not considered to be serious incidents were investigated appropriately and actions identified and taken. The clinical risk team prepared reports, which they shared with senior staff in meetings. Flyers with information about learning from specific incidents were distributed to staff by email. The most recent flyer had informed staff that there was a concern about the lack of escalation following deteriorating NEWS scores and the action that was required to be taken.
- Trends and patterns of incidents were analysed by the clinical risk team and reported to the medicine divisional leads. The top five incidents reported within the medicine division were regarding falls, pressure damage, violence and aggression, medicine errors and staffing.

Duty of Candour

- The Duty of Candour refers to Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Medical and senior nursing staff demonstrated an understanding of duty of candour and the process involved. Junior staff were aware of duty of candour, but stated they would seek advice from senior staff.
- We looked at investigations into serious incidents. There was a section within the standard framework, which detailed support given to patients and carers.

Safety thermometer

- The hospital reported data on patient harm to the NHS Health and Social Care Information Centre each month using a tool known as the 'patient safety thermometer'. 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 undertook monthly safety thermometer audits, which were sent to the clinical audit department. Safety thermometer audits were kept in files in the manager's office. We observed that safety thermometer results were displayed in most ward areas. For example, the ward manager in the acute assessment unit (ACU) displayed the results of the December 2016 safety thermometer which showed 93% harm free care. On Woodmancote ward, the audit results for December 2016 showed 72% harm free care with incidents of hospital acquired pressure ulcers and catheter associated urinary infections occurring. However, there were no actions required or taken noted in the results displayed which meant patients and visitors could not see if actions were being taken to improve results.
- Data from the patient safety thermometer showed that the trust reported 86 pressure ulcers, 39 falls with harm and 38 catheter urinary tract infections between November 2015 and November 2016. The data showed that the prevalence of pressure ulcers and falls were both reducing over the period and there was a similar trend for catheter urinary tract infections
- There had been an increase in reporting of pressure ulcers because trust policy required staff to report all pressure ulcers (grade 1-4) as an incident. However, not all staff were aware that all pressure ulcers, including grade 1 pressure ulcers, had to be reported. Although there was an increase in pressure ulcers reported, all

grade 2 pressure ulcers were now reviewed by a tissue viability specialist nurse and as a result, there had been a decrease in pressure ulcers deteriorating. Subsequently, fewer grade 3 and grade 4 pressure ulcers were reported as occurring.

- The trust had access to medical photography to help document the severity of the pressure ulcers when first noted. This helped staff to evaluate the effectiveness of treatment and care. The tissue viability specialist nurse explained a change in how dressings for pressure ulcers were stored. Each ward now had a pressure ulcer dressing trolley with a draw with dressings suitable for each category of pressure ulcers from grade 1 to 4. This meant nurses were supported in choosing the correct type of dressing to suit wounds and therefore improved healing of pressure ulcers. The trolleys also contained the 'European pressure ulcer advisory panel' (EUPAP) grading tool, the trust's skin care protocol, care plan (SSKIN bundle), patient information leaflets, wound care assessment chart and different types of dressings.

Cleanliness, infection control and hygiene

- There were not always reliable systems in place to prevent and protect patients from a healthcare associated infection.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH). Chemicals and substances that are hazardous to health were observed in areas that were not locked and therefore accessible to patients and visitors to wards. Chlorine tablets were routinely kept in the sluices, which were unlocked.
- On the acute medical assessment unit (ACU) there were four bays. However, the sink in these bays was located at the back of the bay and there was no gel for decontaminating hands on the entrance to the bays. We did however see there was a small container of gel available, attached to each bed.
- On the acute medical assessment unit, we noticed one patient had been admitted into a bay with diarrhoea and vomiting but there were no signs alerting staff to enhanced infection control measures to stop cross contamination. It was not clear why the patient had not been admitted to a side room.
- When side rooms were used for the isolation of patients with an infection, systems were in place to inform staff of what level of protection and isolation was required to maintain safe hygiene practices. However. the side rooms used for isolation of patients with infections on Avening ward had no en-suite facilities, therefore considered not fit for purpose. The manager stated this was on the divisional risk register until a solution was found.
- Ward staff wore the correct uniform and used personal protective equipment such as gloves and aprons as needed. Staff followed the hospital policy of being bare below the elbow. However, we saw a domestic member of staff with a watch on and a band 5 nurse with very long finger nails which is not in line with best evidence-based care for infection control and prevention.
- The wards had fabric curtains to help provide privacy and maintain dignity for patients. We were told domestic staff would always change the curtains if a bed space, side room or ward bay was deep cleaned following the discharge of a patient with an infectious disease. However, ward staff, including domestic staff and ward managers, did not know when the curtains were last washed. The supervisor in the linen department in Gloucester Hospital, told us they changed the curtains every three months regularly, more often if visibly dirty or following the discharge of patient with an infectious disease. An outside contractor collected the curtains and laundered these off site. This followed the trust's 'curtain procedure policy and action plan'. We checked the Department of Health: Health Building note 00-09: 'Infection control in the built environment' and concluded that practice was in line with recommendations for curtains in clinical area.
- We saw audits of hand washing compliance conducted across the medical division in 2016. The trust's target was 95%. We saw that staff regularly exceeded this target with the exception of October 2016 when 93% of staff adhered to correct hand washing techniques.
- We did not see completed, weekly equipment-cleaning checklists on all wards. A ward manager told us that they were kept in the domestics cleaning cupboard, which was locked at the time of our visit to the ward.
- We did not see a consistent method of informing staff that commodes were clean prior to patient use on several wards. Staff told us that the sticky labels were unreliable and they left the commode lid upside down to show it had been cleaned.
- In 2016, the majority of nursing staff had completed their training in infection prevention and control. The trust target of 90% was met and exceeded with 94.6% of

the nursing staff having undertaken infection, prevention and control training. However, medical staff were not meeting the trust target, with only 85.4% of medical staff having completed the training.

- Knightsbridge ward was a designated infection control ward with 12 side rooms for patients admitted with infectious diseases. We observed staff adhered to infection control and prevention measures. Audits demonstrated staff compliance with hand hygiene was 100% in December 2016 and January. 2017.
- The trust reported one case of methicillin-resistant staphylococcus aureus (MRSA) bacteraemia and 12 cases of clostridium difficile (CDiff) multiple drug resistant organisms, between August 2016 and January 2017. The standard set was to have nil cases of MRSA bacteraemia. The standard for Cdiff infections (post 48 hours as an inpatient) was 30 cases of Cdiff per year (running total). The trust monitored this and the number of cases did not exceed this standard from January to October 2016.
- The endoscopy unit had three procedure rooms, one of which had negative pressure ventilation. This allowed the unit to carry out bronchoscopy (a procedure used to examine airways by the insertion of a small camera) procedures in patients with active tuberculosis. Staff took used dirty endoscopes directly from the endoscopy rooms to the cleaning room, which was well laid out and spacious.

Environment and equipment

- The design, maintenance and use of facilities and premises did not always keep patients safe. The wards appeared clean and generally tidy however, Avening and Ryeworth wards looked tired and required redecoration. On Ryeworth ward, the dayroom was not fit for purpose as it was very small and had no window. However, the ward manager was planning to swap the dayroom with the doctor's office and was exploring the financial implications of this.
- Avening ward was an old-fashioned 'Nightingale' styled ward. There were problems in maintaining a suitable temperature on the ward. Staff told us it was too hot in summer and there were issues getting the heating turned on in the winter. The ward manager told us thermometers would be fitted to monitor the situation. There was a fire door at the end of the female bed, which was locked. Staff told us it could be unlocked in the event of fire but remained locked to keep patients with dementia, who may be wandering, safe.
- On the acute medical assessment unit (ACU), there were strips of tape holding down the vinyl flooring where this had cracked. This is not in line with the Department of Health: Health building notes 00-09: Infection control in the built environment (2013). The ward manager stated the sluice facility was not fit for purpose as the flooring was damaged, the macerators were too small and the sink did not comply with infection control guidance however, this was not on the medical division risk register. The manager explained that this was an ongoing issue under discussion however, it was not entered on the risk register.
- All the wards we visited had portable resuscitation trolleys for use in an emergency. Records showed that staff did not always document the checking of the trolleys including the defibrillator daily. The defibrillators on the top of the trolleys had been serviced but not all wards kept a log of daily testing. For example, on the acute medical assessment unit (ACU), staff signed the test strip on top of the defibrillator, however, there was no audit trail of documentation available.
- The trolleys contained medication and equipment to for use 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. On Ryeworth ward we found an airway which had an expiry date of 2011. This was brought to the attention of the ward manager who replaced it.
- The trust was in the process of introducing new machines for checking of patients' blood sugar however not all staff had had training so the old machines, which staff had to calibrate daily, were also still in use. On Woodmancote ward, we found a blood glucose meter (a small device used to determine the approximate concentration of glucose in the blood) that was last calibrated on January 22 2016 and the ketone meter (a small device used to test for ketone in the blood) was last calibrated in November 2016. When we returned for an unannounced visit, we found a blood glucose meter that was last checked in November 2016. We raised this

with the sister-in-charge who told us that these were no longer used and that they should all have been taken out of service however, the blood glucose meter was not removed at the time of the visit.

- Equipment was clean and functional and items were labelled with the last service date Staff were aware of how to report faulty equipment and stated that Gloucester engineers held records of when different equipment was due for service and maintenance. We checked equipment in many areas and we did not find any equipment overdue for maintenance.
- Staff from many ward areas spoke of inadequate storage space for equipment. We saw many examples of hoists and other equipment stored in bathrooms and overfilled storage facilities. This meant that cleaning of equipment and the rooms used was difficult and we found visible dust on equipment and floors in these areas.
- On several wards the sharps box lid was open when it should have been closed when not in use. However, they were all situated in locked treatment rooms and not in public areas.

Medicines

- Most arrangements for managing medicines, medical gases and contrast media kept people safe. However, staff did not consistently check the medication fridge temperatures daily. In the discharge waiting area, there was no medicine fridge. This meant staff kept medicines that needed to be stored in a fridge, in the patient food fridge. As this lacked a thermometer staff were unable to check fridge temperatures daily. There was also no lock to keep medicines secure.
- On the wards we found controlled drug cupboards were closed and locked. However, the controlled drug check was not always completed on a daily basis. On the acute medical assessment unit (ACU) staff had not checked the controlled drugs on 16 days between December 19 2016 and January 25 2017. We did a spot check of the controlled drugs and found that though routine checks had not been consistently carried out, all drugs correlated with the documented volumes in the controlled drugs register.
- Controlled drugs (CD) were stored in an appropriate cupboard. CD keys were kept by a registered nurse at all times and were kept separate from the main bunch of keys. Records demonstrated two nurses checked CDs for administration and we saw daily stock checks recorded in the back of the CD record book. However, nurses did not always sign the received section of the order book when receiving delivery of controlled drugs. This was against the trust policy: Safe and secure Handling of controlled drugs, (November 2016) and good practice. This meant the trust would not easily be able to investigate incidents involving delivery of CDs. In Endoscopy, pharmacy staff identified that medical staff did not sign for the CDs they administered to patients. A recent pharmacy audit over three months up to 5 December 2016 identified two unsigned entries. As a result, post procedure briefing was introduced and since then there have not been any unsigned entries
- We found that all medication trolleys were securely attached to the wall when not in use and we did not find any medicines past their expiry date on the wards. However, nurses were not always clear what the trust policy was for the storage of liquid medicines and insulin. Insulin pens in use for patients were stored in the refrigerator, which was not in line with the trust guidance. The pharmacy department recognised that the trust policy was not clear and that the guidance was being looked at by the medicine information department.
- The nurse prescribing staff and the doctor in ambulatory care had access to a prescription pad for patients who required new medication. A system was in operation to identify which member of staff had used each prescription. There were six prescriptions, which had not been signed for in the last six months. Staff told us that the prescriptions should be included within the daily checks in the department so that if a signature was missing, the member of staff on duty could be identified.
- We looked at three prescription charts on Woodmancote ward and found all three charts had patient details correctly documented, allergies recorded, signed and dated and medicine reconciliation was documented. The prescribed duration and indication was recorded for antibiotic prescriptions, but two prescriptions were not sign and dated by the prescriber. We found five blank boxes across the three charts where there was no record of actions taken in response to blank boxes. This meant that patients did not have all the medicines prescribed. The standard set in the trust policy: policy for ordering, prescribing and administering medicines (POPAM)(2014) was 'zero blank boxes.

- Staff did not always check resuscitation trolleys daily. For example, on Woodmancote, ward staff did not document the daily stock check on three days between 25 December 2016 and 25 January 2017. We found a broken seal on an emergency drug, which staff had documented on 17 January 2017 but remained on the trolley. The resuscitation trolley was placed in a corridor by the entrance to the ward. The receptionist could see the trolley but the reception was not occupied 24 hours a day. This was not in line with trust policy or UK resuscitation council guidelines (November 2016), who also recommend that such incidents are investigated. When we went back on an unannounced visit, staff had replaced the drug.
- 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 patients were taking the correct medication.
- Some wards had 'pods' within the bedside locker, which stored patients' medicines which nurses assisted patients to administer when needed.
- Medication administration records were complete and included a record of allergies. Medications, which were prescribed 'as required', were recorded clearly with instructions for staff about doses and range of administration.
- Medicines were available to enable staff to treat patients with a diabetic hypoglycaemic event (a drop of glucose on the blood stream) quickly. They were stored in orange coloured 'hypo boxes' which were located in the locked clean utility rooms on the wards.
- On Lilleybrook ward, radioactive seeds (radioactive material used for treatment in some forms of cancer) for treatment were kept locked in an appropriate and separate cupboard.
- Some patients attending the endoscopy unit received light sedation when having procedures. Staff explained the trust had a 'sedation policy', however, staff were unable to find it when we asked to see it. This meant that we could not be assured the policy and best practice was always followed.

Records

- Patients individual care records were not always managed in a way that kept patients safe. We looked at ten sets of care plans and found these were not consistently up to date. Most records showed that staff had identified risks to patients and put care plans in place. For example, we saw a patient who was at high risk of developing a pressure ulcer had received an assessment, had a pressure relieving mattress on his bed and was turned regularly. However, several patients had no manual handling plan, a catheter care plan was not signed, dated or personalised. We noted a 'this is me' (a tool used for patients with dementia that help inform healthcare professionals about their needs, interests, preferences and dislikes) for cognitively impaired patients, had not been completed. We noted a care rounding chart (evidence of nursing attention) was only completed seven times in three days, when it should have been completed every one to two hours, day and night. This meant we could not be assured the patient had received the care required.
- Patients' medical records were not always stored securely on the wards in locked trolleys or within locked offices. However, on Ryeworth ward, we found records stored in open trolleys at the side of the nurse's station, which was not always manned. On the acute assessment unit (ACU), we found notes stored in open trolleys and staff had not logged out of a computer in a bay. This meant, unauthorised people could get access to confidential information about patients. Medical records in the discharge waiting area were stored on a shelf in the reception area as there were no facility for staff to lock medical records away.
- A new computer system had been introduced in December 2016. This was a healthcare information system that enabled coordinated care within a hospital or across care settings. Staff told us there had been a number of teething problems with the system. Staff did not feel prepared enough, they could not access the e-learning module from home, the training database was not the same as the live system and that it was not responsive to their needs for example, discharge summaries had several steps requiring the staff to go in and out of the system. However, the organisation was aware of the concerns and were working hard to address the issues.

Safeguarding

- There were safeguarding systems, processes and practices in place to keep people safe.
- The trust provided safeguarding training in children's and adult safeguarding. The training included

safeguarding awareness and safeguarding training at level two for both adults and children. The trust had a target of 90% for completion of children's and adult safeguarding training and reported on training compliance across both hospitals. Training records demonstrated medical and dental staff were compliant with adults safeguarding awareness at 93.1% and was only slightly below target for the level 2 safeguarding at 89.8%. The trust met and exceeded its target completion for nursing staff for both adult safeguarding modules in 2016. Adult safeguarding awareness at 95.2% and level 2 safeguarding at 95.2%

- Staff were aware of their responsibilities for identifying and reporting safeguarding issues. Staff we spoke to knew how to report concerns about disrespectful, discriminatory or abusive behaviour or attitudes through the trusts' electronic incident reporting system concerns. Staff were also familiar with, sign and symptoms of female genital mutilation (FGM) and how to escalate concerns. Staff knew how to make referrals to the mental health liaison team and how to contact the crisis team if required
- On Woodmancote ward, we observed staff raise a safeguarding alert about a patient's safety on discharge to the patient's usual home address.

Mandatory training

- The trust provided mandatory training in 12 subjects including basic adult life support, fire, infection control and manual handling and the trust had set a target of 90% compliance. The trust reported on compliance across both hospitals for different healthcare professionals. The trust met their target for medical staff for four of the twelve modules. The remaining eight modules were only just below the target with completion rates between 84% and 89.7%. The trust met their target for nursing staff for nine of the twelve modules. The remaining three modules were only just below the target with completion rates between 87% and 88.3%.
- Staff we spoke with told us they were able to attend regular mandatory training in subjects such as manual handling, fire and infection control.

Assessing and responding to patient risk

- There were processes in place to ensure consultants or senior medical clinicians reviewed patients. The different specialities had consultant cover during the week from 8am to 8pm. There was a daily 'board round' on the wards at 8.30am, which was attended by doctors, nurses, physiotherapists and discharge coordinators and who discussed each patient to identify actions to support the treatment, care and discharge planning. 'Board rounds 'allow staff to discuss patient treatment plans and concerns away from the bedside and is used to gain an overview of patients' progress. There was a consultant ward round and a second 'board round/ huddle' followed this at 3.30pm to ensure staff had achieved all actions. The wards used a 'red/green' action framework to ensure all patients had received a positive action to progress their recovery. The trust audited the effectiveness of the board rounds. These audits included data such as who was present, the length of time, the use of red/green framework and actions to help discharge planning, however, it was not clear how the service planned to use this information.
- In acute medical assessment unit (ACUC) the physician consultant on call reviewed newly admitted patients, whilst the other consultant completed the board round. This way, all seriously ill or deteriorating patients were identified and treated promptly.
- Comprehensive risk assessments were carried out for people who used services and risk management plans were developed in line with national guidance. We saw nursing risk assessments relevant to patients' needs. These included pressure ulcers, nutrition, mobility and falls. However, not all risk assessments were completed or scored correctly. On Woodmancote ward, we found that medical staff had not completed the venous thromboembolism (VTE) (formation of blood clots) assessment correctly and two of them were not reassessed within 24 hours documented.
- The service managed non-invasive ventilation (NIV) (administration of ventilator support without using an invasive artificial airway) well and ensured patients only received this treatment with correct support. If patients required NIV, staff transferred patients from their normal ward to Avening ward. This was to ensure that staff with the right skills provided this specialised care.
- Staff we spoke to understood and followed the trust Sepsis (a potentially life threatening condition in response to severe infection) policy. Staff were aware of signs and symptoms of sepsis. We reviewed the patient record of a patient with sepsis and found staff had followed the 'sepsis bundle' including the administration of antibiotics within an hour.

- Staff told us band 7 nurses and porters attended 'safe holding' training to help manage patients demonstrating violence or aggressive behaviour. There was a dedicated telephone number for clinical emergencies including aggressive and violent behaviour however; this information was not always shared with agency staff.
- The endoscopy unit used a modified version of the World Health Organization (WHO) checklist and staff held a team briefing before and after each investigation.
- All medical wards and areas used a national early warning score (NEWS) to determine whether patients were deteriorating. However, we found in four patients records where NEWS had been miscalculated and as a result issues had not been escalated appropriately

Nursing staffing

- Staffing levels and skill mix did not always keep patients safe. Substantive registered nurse staffing numbers were below establishment for the medical division. In August 2016, six of the nine wards were below establishment and overall, there was a deficit of 10.59 full time equivalent registered (FTE) nurses. On the day of the inspection, all the medical wards visited had the correct number and skill mix of staff required. However, on several of the wards, the Band 7 (Ward Manager) nurse was working more clinical than supervisory shifts due to a shortage of registered nurses.
- On Woodmancote ward, a band 6 nurse-in-charge told us they had increased their staffing levels because of increased care needs of the patients. Despite the increase in staff, the ward reported an increase in patient falls. On the day we visited, there was a healthcare assistant allocated to a bay where staff had 'pooled' all the female patients at risk of falling together. This meant that there was a member of staff at all times to supervise the patients.
- We looked at ward staffing rotas and saw that staffing levels were inadequate on several wards, with agency and hospital bank staff used when required to cover increased demand and vacancies. Staff told us they considered staffing levels were not safe at times. We visited one ward where staff described staffing levels as poor and not safe. Some of the nurses on duty had not had a lunchbreak at 4pm despite starting their shift at 7.15am. The nursing and midwifery council (NMC) recommends a break of 20 minutes for shifts over six hours but also states that one 20 minute break for staff working a 12 hour shift would not be sufficient. Staff told us they did not report shortage of staffing as an incident on the electronic incident reporting system.
- We spoke with medical staff on one ward, who had concerns about the skills and decision making abilities of nursing staff which could have a negative impact on patients, such as delayed intravenous fluids for a patient with acute kidney injury. The concerns had been raised with both the ward manager, matron and consultants and were largely caused by a vacancy rate of 6.5 full time equivalent (FTE) against an establishment of 18.3 FTE . However, the medical division have action plans in place to support nursing skills , knowledge and decision-making. These include wards 4a, 8a and Woodmancote.
- Avening ward was a respiratory ward looking after patients receiving non-invasive ventilatory support. Nurses wee not aware of daily acuity assessment (a term used to describe the level of care required) and these were not recorded at ward level. This meant we were not assured that regular acuity assessments were carried out to ensure safe staffing levels. Avening ward had two FTE vacancies for trained staff. This did not include the two registered nurses on maternity leave and the registered nurse about to go on maternity leave. These were not routinely back filled but covered by the use of agency and/or bank staff. The Band 7 senior nurse was also retiring in March.
- The cardiac ward had 21 beds, which included a coronary care unit with six bed spaces. The cardiac ward was staffed by five registered nurses two of which were allocated to work in the coronary care unit during the day. However, on the night shift, this was reduced to one registered nurse for six patients with varying acuity. If patients required transfer overnight to another hospital, this meant there were only two nurses to care for 21 patients (including coronary care patients). This had occurred between 30 – 35 times in the last 12 months across the two sites.
- We asked the specialist director about staffing levels depending on the acuity of the patients. They explained the trust reviewed nurse staffing establishment twice a year using the 'Hurst model'. The service did not assess or record the acuity levels of patients on each shift or on a daily basis to ensure the correct staffing was always on duty. If the nurse-in-charge felt more nurses were needed, to ensure safe patient care, this would be

escalated. This happened for example if they had patients at risk of falling. Staff had not reported any incidents that could be attributed to inadequate staffing levels and we were told that staff worked hard to ensure the patients were kept safe. For example, they would go without a break if the needs of the patients were such that they deemed it unsafe to take a break.

- We spoke with the associate director of nursing, who undertook a safe staffing assessment and asked for clarification of the acuity model they used. They explained they used the association of UK university hospitals (AUKUH) acuity and dependency tool twice a year to plan the nursing establishment of the medical services and the trust did not measure acuity on a daily basis. We asked for the latest assessment. This was conducted in August 2015. The lack of acuity assessment on a shift-to-shift basis was not in line with the guidance outlined in the National Quality Board: How to ensure the right people, with the right skills, are in the right place at the right time. The national institute for clinical excellence (NICE) guidelines: Safe staffing for nursing in adult inpatient wards in acute wards (2014) also recommend a systematically assessment of the available nursing staff for each shift or at least daily to ensure it is adequate to meet the actual nursing needs of patients. It further recommends so-called 'red flag events' (incidents that may be prevented if adequate staffing was available) are monitored, These events includes nurses missed breaks
- The AUKUH tool describes the levels of care depending on certain criteria and care required. Patients in a coronary care unit often require an increased level of care, referred to as level 2 care. Patients may receive non-invasive ventilator support, continuous infusion of vasoactive drugs and intravenous pain management and therefore require closer monitoring. However, staff did not assess acuity on a shift-to-shift or daily basis and therefore we could not be assured there were adequate staffing levels particularly at nights to ensure safe patient care. The British Association of Critical Care nurses (BACCN) recommends a staff to patient ratio of one nurse to two patients when patients acuity is at level 2.
- We looked at ward staffing rotas and saw that staffing levels were inadequate on several wards with agency and hospital bank staff used when required to cover increased demand and vacancies. Staff told us they considered staffing levels were not safe at times; one ward had approximately 55% agency/bank usage due to vacancies and maternity leave. Ward managers told us that they were able to block book agency staff in order to provide continuity of staffing on the wards.
- We observed staff handovers, which were clear and concise. On the medical wards, staff printed a handover information sheet and shredded the sheets at the end of the shift.
- The site and bed management team had a number of vacancies at both band 7 and band 5. A review of the structure of the team had taken place and it was planned to appoint an additional band 7 site manager. This was in order to enable the hospital to have two band 7 site managers on duty overnight rather than one band 7 and one band 5. However, staff were of the opinion the current staffing was sufficient, given the emergency department was closed overnight and therefore the hospital tended to receive less admissions.

Medical staffing

- The trust supported the medical division with a 24-hour consultant led service. During the day, consultants worked within their speciality areas supported by junior doctors who were ward based. Consultants and registrars supported junior doctors (F1/F2 foundation doctors). Junior doctors rotated across specialities and therefore had access to a wide range of learning opportunities throughout medicine. Out of hours, there was a consultant on call, with registrars supporting junior doctors at night. We spoke with medical staff across the specialities who told us they were busy but felt well supported.
- There were some consultant vacancies in the trust. For example, the cardiac services had a consultant vacancy, which had been open for the last 12 months. The service also had a consultant who was retiring which would leave another vacancy. Recruitment to consultant vacancies was difficult and some consultants felt there were also additional problems because the workforce was divided across the two hospital sites.
- We spoke with a fifth year medical student on Woodmancote ward who felt well supported and part of the team. They said the placement was a good learning environment for medical students.
- A locum registrar, who had worked in the ambulatory department for the past year, provided the medical cover for patients attending the ambulatory emergency care unit. Staff made positive comments about the

effectiveness of having the same registrar providing this cover. However, the lack of consultant led care in the department meant that some ambulatory patients with complex care needs were not able to be treated. This meant they may require admission to a ward with the potential to stay longer in the hospital.

- A consultant described an impressive consultant cover in the acute assessment unit (ACU) was because of a dedicated and very hard working team. Junior medical staff cover was provided on a rolling 16-week rota. Consultants stated it was a struggle to fill middle grade posts, which led to the extensive use of locums. There were significant pressures at consultant level because of unfilled vacancies. At the time of our inspection, there were three full time established acute medicine consultants and one full time locum, with additional support on the acute medicine rota from a consultant gastroenterologist and two renal physicians.
- Medical staff cover at night was described as 'a bit thin'. An on call medical registrar supported by one junior doctor and a senior house officer, covered all of the medical wards in the hospital at night. On call consultants were always happy to take calls directly from nursing staff.

Major incident awareness and training

- The trust had major incident and business continuity plans in place. We spoke to senior nursing staff who knew what action to take if a major incident took place. We saw information and guidance folders were available to staff on wards and in departments regarding the action they were required to take should there be a major incident. The guidance included a set of action cards, which informed staff on the action to take and a policy and procedure. Staff we spoke with were aware of which ward would be evacuated in order to make room for casualties should this be required and the cascade system to call additional members of staff to duty.
- Staff told us there had been a drill within the hospital within the last year to prepare them for the action to take when a major incident occurred. However, they added that the last drill did not go as planned and was abandoned. The trust had not provided staff with any feedback or future drills.

Are medical care services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. We rated effective as requires improvement because:

- The medical service did not consistently contribute to and review the effectiveness of care and treatment through national audits.
- There was not a clear overview of Mortality and Morbidity (M&M) meetings held in line with the trust's M&M meeting schedule.
- The trust had evidence-based care pathways but these were not always reviewed and updated in a timely manner.
- Compliance with annual appraisals were below the trust's target.
- Information was not always accessible to staff including information about care and treatment pathways.
- The trust had evidence-based care pathways but these were not always reviewed and updated in a timely manner.
- Staff did not always put actions in place when patients were at risk of malnutrition and hydration.
- Information was not always accessible to staff including information about care and treatment pathways.

However:

- Staff were supported with revalidation practices and there was a competence training and assessment framework in place to ensure nurses were competent to carry out extended skills.
- The endoscopy unit held joint advisory group (JAG) accreditation and had procedures in place in line with the national safety standards for invasive procedures.
- There was an effective framework for 'board round' and ward rounds and included input from staff from the multidisciplinary healthcare team.
- There were effective processes in place to admit patients directly to Lillybrook ward when neutropenic sepsis was suspected.
- Staff were aware of mental capacity assessment and of deprivation of liberty safeguards applications.

Evidence-based care and treatment

- Staff delivered patient care and treatment in line with best evidence-based practice. We saw many examples of medical services following best evidence-based practice and staff were knowledgeable about national guidelines. Staff knew how to access the guidelines and pathways to ensure best practice. For example, there were core care plans for patients known to have dementia based on the Royal College of Nursing: SPACE model for dementia care in hospitals 2012. For patients with peripherally inserted central catheters (PICC), care practices followed best guidance from the Royal Marsden NHS Trust Manual of Clinical Procedures third edition.
- However, the cellulitis treatment pathway was out of date with a proposed review date of September 2015. The trust was classified as a Dr Foster outlier for mortality in patients admitted with cellulitis or subcutaneous skin infections. Although the trust concluded the increased mortality was related to miscoding of primary cause of death, we could not be assured that patients received best evidence-based care for cellulitis or subcutaneous skin infections.
- We found no documentation to show that patients with diabetes had their feet assessed on admission to hospital, as per the guidance from the national institute for clinical guidance (NICE guidance 19). Staff we spoke to were not aware of this requirement. They also told us it was difficult to get the diabetic podiatrist to visit patients on the ward, although they would offer advice over the phone.
- The endoscopy unit had joint advisory group (JAG) accreditation which was assesses every three years and was last assessed in 2015. The assessment included multiple audits, mortality data, and details of staffing, training, equipment, and protocols. Staff in the endoscopy unit followed guidelines for invasive procedures in line with national safety standards for invasive procedures (NATSIPPS). Nurses spoke of these procedures, which demonstrated they were embedded in their practice.

Pain relief

- Staff assessed pain as part of undertaking observation of vital signs. Staff documented pain scores on the national early warning score (NEWS) chart and on completion of the 'Gloucester Patient Profile', which was the document used to record care given. Patients told us nurses regularly asked them about their pain and offered them painkillers if required.
- Staff used the 'Abbey Pain Scale' tool to assess whether patients were experiencing pain and when they had difficulty communicating. The trust also had a pain management chart, with a pictorial pain score assessment tool, however, we did not see this in use.

Nutrition and hydration

- Patients' nutrition and hydration needs were not always assessed and met. Staff used the Malnutrition Universal Screening Tool (MUST) to calculate and record patients' nutritional risk. We reviewed five inpatient's records on ward 7A, where three MUST scores had not been calculated to identify the appropriate actions to put in place to support patient's hydration and nutrition. The trust audited compliance with MUST assessment in January 2016 (published June 2016) and found that of 175 audited patient records, 69% had their first assessment completed on the day of their admission. 22% (38) of these patients these were assessed as 'red' with a need for a care plan, but of these, 25 patients, (66%) did not have a nutrition care plan in use. This meant there was low compliance with the trust's standards for assessment of patients' nutrition needs and a risk to the patient that they would not receive the nutritional support required in a timely manner. Action points were identified and the trust planned to re-audit in December 2016. However, this had not commenced at the time of inspection.
- There were magnetic boards above each bed where information/pictures were displayed about food and drinks to suit the needs of the patient. These boards supported staff awareness of individual patient needs.
- The emergency ambulatory care unit provided care and treatment to patients who did not require overnight admission to the hospital. Patients who were in the department at lunchtime were offered a light lunch of sandwiches and desert. There was fresh fruit and cold drinks available in the waiting area for patients to help themselves when they wanted.. Staff provided patients with hot drinks regularly throughout the day.
- The patients view on the hospital food was good. Most patients felt the portion size and menu choice was more than sufficient and they enjoyed the food. One patient told us "it's like being in a hotel". Patients also told us

they could access food late in the evening as staff would get them a sandwich and they knew where they could access snacks. Patients also told us that the tea trolley came around often. We observed notices for protected mealtimes on the wards and that flexible visiting was allowed for carers to come in and assist their relatives to eat. However, in a patient-led assessment of the care environment (PLACE) (2016), the score for food satisfaction was only 77% on Lillybrook ward and 86% on Avening ward.

- Patients in the discharge waiting area had hot meals and hot drinks, which the healthcare assistant collected from Avening ward. There was no dishwasher so dirty dishes were taken back to Avening ward to be washed. The nurse in charge told us that at dishwasher had been approved but had not yet arrived.

Patient outcomes

- The medical service did not regularly contribute to and review the effectiveness of care and treatment through national audits. Information about outcomes of patient's care and treatment was not always routinely collected. The trust provided the latest available audit results from 2016 for the Sentinel Stroke National Audit (SSNAP), the Heart Failure Audit (reflecting data from 2015), National Diabetes Inpatient audit (reflecting data from 2015), the Lung Cancer Audit (reflecting 2015 data). More recent data was not available as these were not published at the time of our inspection. However, for the Myocardial Ischemia National Audit Project (MINAP), the latest audit information the trust provided was from 2013/14. We met with the divisional audit lead who explained the MINAP data was incomplete because of lack of resource within the department to submit data. This meant that the trust did not have up to date benchmarking on all their performance.
- The trust took part in the quarterly Sentinel Stroke National Audit programme, however, Cheltenham general hospital does not provide stroke services.
- The hospital's results in the 2015 Heart Failure Audit were worse than the England and Wales average for all of the four standards relating to in-hospital care and better than the England and Wales average for three of the seven standards relating to discharge, all of which were 100%.
- Results in the 2015 National Diabetes Inpatient Audit were better than the England average in five metrics and worse than the England average in 12 metrics. There was an improvement in six metrics when compared to the 2013 audit and a decrease in twelve metrics, including 'overall satisfaction' and 'all or most staff know enough about diabetes".
- The hospital took part in the 2013/14 MINAP audit and scored better than the England average for treatment of NSTEMI (a type of heart attack that does not change the a specific component of the ECG heart trace) patients that were referred for or had angiography (a procedure to treat acute heart attack). The remaining two metrics scored lower than the England average for referral to a cardiologist and admission to a cardiac unit. All three metrics had shown decline when compared to the 2012/13 audit.
- The hospital took part in the 2015 National Diabetes Inpatient Audit. They scored better than the England average in five metrics and worse than the England average in 12 metrics. The hospital had seen improvement in six metrics when compared to the 2013 audit and a decrease in twelve metrics.
- The trust participated in the 2015 Lung Cancer Audit. The proportion of patients seen by a Cancer Nurse Specialist, at 84.1%, was worse than the audit minimum standard of 90%. Other results were not significantly different from the national level, for example the proportion of patients whose histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 22.6%; the proportion of fit patients with advanced (NSCLC) receiving chemotherapy was 48.5%; and the proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 61.1%.
- The trust was a 'Dr Foster' mortality outlier' for increased mortality rates for patients admitted with skin and subcutaneous tissue infections. There had been 11 deaths between October 2015 and March 2016 compared to an expected 6.7 deaths. A thorough review of each patients' notes were carried out. The trust concluded that this was a group of patients with complex and multiple medical problems in whom cellulitis was incorrectly identified as the primary diagnosis.
- The medical divisional audit lead described mortality and morbidity (M&M) reviews conducted in the medical service. These occurred for about 60% of patients who died in the trust under the care of the medical division, although an independent medical examining team reviewed all deaths and reported to the local coroner. Following our last inspection, a framework had been

developed and agreed with future monitoring through the divisional quality report. We reviewed the medical divisional board report from September, October and November 2016 and found the new framework (a structured judgement review) was introduced in October 2016. Each speciality had a clinical M&M lead and every sub-speciality held M&M meetings at least every quarter, whilst others held M&M meetings every month. However, we did not see any evidence that meetings were held in cardiology and endocrinology in 2016. Most data was collected electronically however, cardiology and endocrinology kept written notes only which were held by the consultants. Minutes of M&M meetings showed presentation of case notes, although we did see one example of notes that clearly described learning following patients' death, which was shared with colleagues via email. However, this was not a systematic approach across all medical specialities.

Competent staff

- Not all staff had received an appraisal in the last year. In the year 2016/17, 78% of staff within the medical care division at the hospital had received an appraisal, compared to the trust target of 90%. Nursing staff achieved 79%, medical and dental staff 75%, allied health professional 91%, healthcare assistants 78% and administration and clerical staff achieved 74%. Without an appraisal, learning needs may not be identified and an appropriate plan put in place to support staff to develop their practice. Some staff felt the effectiveness of appraisals depended on who carried out the appraisal with them. Staff preferred senior staff or the ward managers to carry out appraisals and felt they were less effective if carried out by more experience peers such as a senior healthcare assistant. Individual ward managers monitored registered nurses revalidation in the medical division and we saw evidence of spreadsheets monitoring this. There was no formal or regular clinical supervision planned or recorded for registered nursing staff within the medical division. However, we were shown evidence of ad hoc supervision in personal files kept by a ward manager.
- The trust had a competency assessment programme for registered nurses, which included: nasogastric tubes, tympanic thermometer, pulse oximetry (a device used to check pulse and oxygen levels), male and female catheterisation, phlebotomy (obtaining venous blood samples), cannulation, aseptic non-touch technique and the use of warming blankets. There was refresher training on each of these every year, which staff could access via the trust intranet.
- Medical staff told us they were offered timetabled teaching however, they were only able to access about 75% of the teaching offered because of organisational pressures to ensure ongoing patient care and treatment. Medical staff said study leave varied between departments and divisions. Junior medical staff stated they felt supported by their consultants and registrars, but in some areas also felt challenged by the number of junior doctors and the high turnover of patients.
- Some registered nurses and doctors working on the oncology ward had completed in-house training to administer intrathecal (a route of administration for drugs via an injection into the spinal canal, or into the subarachnoid space so that it reaches the cerebrospinal fluid) and intravenous chemotherapy. This comprised of practical sessions and supervised practice with a yearly update. The staff member's competencies were then assessed to ensure their practice was safe. The trust kept a register of all competent staff who must complete at least one administration a year otherwise they would be taken off the register. We saw that each member of staff had a competencies folder and that training dates were recorded on an electronic spreadsheet.
- Registered nurses on the respiratory ward had undertaken further training to support patients receiving nob-invasive ventilation therapy and worked from a patient group direction (PGD) in order to titrate the administration of oxygen according to oxygen saturation levels.
- In coronary care, staff were supported to complete a post registration course (adult coronary care) run by a local university. At the time of our inspection, 50% of nurses had completed this course. Nurses completed competence assessments in extended skills such as 'balloon pump therapy'. Staff had looked after 12 patients receiving balloon pump therapy in the last 12 months.
- We spoke with staff about opportunities to access courses for professional development. A pharmacist technician explained how they had obtained competence training via the South West accreditation programme scheme and supported onsite by an allocated mentor.

Medical care (including older people's care)

Multidisciplinary working

- Effective multidisciplinary working was evident in all areas of the medical and specialist services we inspected. We observed board rounds taking place on wards, which demonstrated multi-disciplinary working. This was an opportunity for a multidisciplinary discussion about each patient's treatment to ensure treatment or discharge plans were in place for all patients.
- We reviewed patients' notes and saw evidence of multidisciplinary team working. For example, in one medical patient's record we saw evidence of input from the learning disability nurse, occupational therapy and a social worker.
- We observed a multi-disciplinary board meeting where we saw how staff worked together to assess and plan ongoing care and treatment. All necessary staff, including those in different teams and services were involved in assessing, planning and delivering patient's care and treatment. For example, we observed a multi-disciplinary 'huddle' at 3pm on Woodmancote ward which was attended by doctors, discharge coordinator, band 6 nurse, two physiotherapists and an occupational therapist.
- Staff on Hazelton ward described the support from 'alcohol support nurses' as fantastic and that it was also easy to get hold of older people's mental health services.
- The bed and site management teams worked at both Cheltenham and Gloucester hospitals. This enabled them to become a cohesive team and understand the pressures on both sites. Daily site management meetings took place with the two sites dialling into a telecom facility. However, we observed the Cheltenham team were advised to disconnect from the telecom once they had provided information on their bed availability and any identified issues. This did not enable them to always have the most relevant and up to date information regarding the situation at Gloucester Hospital.
- We looked at data about delayed discharge and found that in November 2016 the trust recorded 2015 delayed discharges of which the three most common reasons were: completion of assessment (876), arrangement of care package in patient's own home (615) and further non-acute NHS care such as transfers to community hospitals (412). Ward staff spoke of the difficulties in arranging discharge of patient who required a package of care in the community. Patients were only assessed once they were 'medically fit for discharge' however, it would then take an additional one to two weeks to arrange care in the community, which delayed discharge. The trust was working with the community care providers to address these concerns.

Seven-day services

- The cardiac catheter laboratories was closed out of hours and at weekends. This meant that patients requiring primary cardiac intervention out of hours and at weekends were transferred to other NHS hospitals
- Consultants provided cover between 8am and 8pm during the week and 8am to 5pm at weekends at both sites. There was an on-call rota for consultants covering out of hours and weekends.
- All oncology and haematology patients had access to a designated helpline. If they were unwell at home, they could access Lilleybrook ward for assessment and possible admission. This prevented immuno-compromised patients with possible sepsis waiting for long periods of time in the emergency department. This service and helpline was open 24 hours a day, seven days a week.
- The ambulatory emergency care unit was open for five days each week from 10 am until 6 pm. The long-term plan for the service was to become a seven day service. However, due to vacancies in nursing and medical staffing, this was not possible at the time of our inspection.
- There was pharmacy cover at weekends. For example, a pharmacist visited ACUC on Saturdays and Sundays, but there was no routine pharmacy visits to other wards in the hospital at weekends.

However, the pharmacy was open at weekends from 9am to 12.30pm on Saturdays and 10am to 12.30pm on Sundays. There was an on call pharmacist available at all times.

- The endoscopy unit provided services seven days a week, although there was reduced capacity at weekends. Staff were on call to cover out of hours emergencies and there was consultant on-call cover 24 hours per day in line with recommendations by the National Confidential Enquiry into Patient outcome and Death (NCEPOD) 2015: Time to get control guidance.

- Physiotherapists were part of an on call rota to ensure provision for physiotherapy seven days a week for urgent treatment such as chest physiotherapy.

Access to information

- The trust had effective processes in place to review patients every day. We asked about arrangements for ward rounds, which varied a little from ward to ward. There were consultant ward rounds every day Monday to Friday, with consultants reviewing new admissions or very sick patients over the weekend.
- The medical service sent care summaries to GPs on discharge to ensure continuing care. The trust audited patient discharge summaries sent to GPs within 24 hours. In October 2016, the result across the trust exceeded the target of 85% with 88.2% of summaries being sent to GPs within 24 hours. Staff also gave patients a copy of the discharge summaries when they left to ensure they had up-to-date information about their health in case of emergencies.
- The ambulatory emergency care unit provided a discharge summary for each patient who attended the department. A copy was retained within their medical records and a copy sent to their GP. We reviewed a number of the summaries and saw they were detailed and informative.
- Information about resuscitation status was kept in the front of medical notes. We reviewed two 'do not attempt cardiac pulmonary resuscitation' (DNACPR) forms and found that these were correctly completed, including documentation of the discussion with the patient and their next of kin/family. There were four different DNACPR decisions, which meant varying medical input would be but in place if a patient's condition deteriorated. In most cases staff communicated these decisions at handovers and when patients moved between departments.
- Medical staff described good medical handover meetings with the attendance of junior doctors of different grades coming on duty or finishing a shift. A pharmacist also usually attended the handover meeting.
- Staff in the endoscopy unit stated that obtaining medical notes could be a challenge, but GP referral letters could be printed off the electronic system they used and cancellations because of missing medical notes were rare.
- Medical records were in a paper format and obtained from the medical records department. Staff commented these arrived promptly when requested.
- The trust introduced a new electronic patient record system in December 2016. This had caused problems for staff initially with the inability to access the records cited as a concern. Patient feedback on the acute medical assessment unit (ACAU) within a completed family and friends survey had identified that the new records system had caused 'chaos' on the unit whilst they were a patient in December 2016. We discussed this with staff who stated there had been issues with the electronic patient record system but the system was improving. The trust used a large proportion of agency staff to ensure adequate staffing, however agency nurses did not have access to electronic resources including guidance about care and medicines. We asked what the impact of this was, but were told agency staff always worked alongside permanent members of staff who supported them to access the information they required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff received training in awareness of 'mental capacity act' (MCA) and 'deprivation of liberty safeguards' (DOLS). Training compliance was at 88.9% for MCA training and 88.9% compliance for DOLS training for all staff (medical staff, nurses, healthcare assistants and administration support staff) within medical care (October 2016). The compliance fell slightly below the trust's target at 90%. However, 90.8% of nursing staff and 90.6% of medical staff had completed both MCA and DOLS training.
- Staff obtained patients' consent to care and treatment in line with legislation and guidance. Staff had a clear understanding of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards (Dolls) and patient consent. In patient records, we observed consent had been obtained and recorded, and where consent was refused or not able to be provided, this was clearly documented. We observed staff ask for consent before undertaking any care or treatment interactions.
- We saw evidence of correctly documented mental capacity assessments and DOLS pathways. We looked at one patient record for a patient with a DOLS application in place. Staff had completed all documentation correctly and in a timely manner although there were some difficulties about notifying the correct local

authority, as the patient's usual place of residence was outside of the area. The trust is required to notify the CQC about all decisions to allow DOLS however, the CQC had not received notification of this application.

- However, in two records we reviewed, we observed that a mental capacity assessments had not been undertaken and recorded for patients who were identified as lacking in mental capacity.

Are medical care services caring?

Good

We rated caring as good because:

- Patients were positive about the way they were treated and cared for in the medical wards.
- We observed staff treated patients with kindness, dignity, respect and compassion.
- We observed how staff took the time to interact with patients and relatives in a respectful and considerate manner.

However:

- Information about patients was not always kept confidential.
- The results from a patient-led assessment of the care environment demonstrated that privacy for patients were not always provided.

Compassionate care

- Staff treated patients with kindness, dignity, respect and compassion while they received care and treatment. Staff took time to interact with patients and relatives in a respectful and considerate manner. We also saw that staff showed encouragement, sensitivity and a supportive attitude to patients and those close to them.
- Staff we spoke to knew how to report concerns about disrespectful, discriminatory, abusive behaviour or attitudes through the trusts' electronic incident reporting system. Staff had not encountered any type of these incidents.
- The Friends and Family Test response rate for medical care at the trust was 14%, which was worse than the England average of 25% between November 2015 and October 2016. We looked at responses from October 2016. The highest score was in the cardiac unit with a score of 98% from 46 responses and the lowest score was at Woodmancote ward with a score of 89% however this was from only 9 responses.
- Staff ensured that people's privacy and dignity was respected, including during physical or intimate care. However, on Woodmancote ward, a patient told us staff told them not to lock the door when they went to the toilet and that as a result, staff just walked in. A patient-led assessment of the care environment (PLACE) (2016) assessed provision of dignity in care, Rendcomb ward scored 96% and Woodmancote ward scored 94% for privacy. However, Ryeworth ward scored 59% and Lilleybrook ward scored 78%.
- Most wards had a place where private discussions could take place. However, on the oncology ward, the helpline telephone was within earshot of patients who were in for assessment. Ward staff told us that this situation was not ideal and that work was planned to create a separate office space for privacy and to maintain confidentiality when taking phone calls.
- On Woodmancote ward, we observed a healthcare assistant (HCA) providing one to one care for a patient with advanced dementia who was a risk of falling. The HCA was compassionate, calm and respected the dignity of the patient, in the manner that she care for her and spoke with her about a magazine they were reading.
- Patients attending the emergency ambulatory care unit did not always have their privacy and dignity respected. This was due to the environment with insufficient space for private and confidential conversations. Staff addressed this by using the office when possible however, this did not provide a therapeutic or comfortable area for such conversations.

Understanding and involvement of patients and those close to them.

- Patients and those close to them were involved as partners in their care. We spoke with patients who praised the communication skills of staff when they needed further information or asked questions. They told us that they were involved in decision making with doctors and nurses about their care and treatment.

Medical care (including older people's care)

- A relative said that care 'slipped a bit' when nursing staff were busy, but their relative had had good care overall. Another relative told us that the staff allowed them flexible visiting times due to the distance they had to travel to the hospital.
- Staff in the ambulatory emergency care unit spent time with patients explaining their care and treatment needs. Staff were positive regarding the one to one time they were able to spend with patients. We observed one member of staff providing a thorough explanation of the required treatment to a patient and their relative.

Emotional support

- Patients received the support they needed to cope emotionally with their care, treatment or condition. Patients with cognitive impairment who used the oncology service, were empowered and supported to manage their own health, care and wellbeing and to maximise their independence with the introduction of a hospital diary. The diary was used as a communication tool between the hospital, patients, relatives and carers and anyone could write in it. The aim was to promote confidence for patients for example remembering appointments and treatments. This was introduced two weeks before the inspection and its effect had not yet been evaluated.
- The hospital had a department for spiritual care who supported patients and their relatives/carers. There were a chapel and a prayer room, which were open 24 hours a day. The service also offered bedside ministry for patients who could not access the chapel or prayer room, as required.
- People who were main carers of patients admitted to the hospital could be eligible for a carers passport which gave carers access to drinks, toilet and washing facilities, appropriate car parking concessions and access to visiting outside of normal visiting hours.

Are medical care services responsive?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs. We rated responsive as requires improvement because:

- There were delays to discharges, which meant patient flow through the hospital was compromised.
- There was a waiting list for patients requiring endoscopic procedure.
- The environment did not meet the needs of patients with dementia.
- The service was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- The hospital did not always respond to complaints in a timely manner.

However:

- The trust's referral to treatment time (RTT) for admitted pathways for medical services was better than the England overall performance.
- Staff knew how to arrange for translation services if required.
- The oncology service provided a 24-hour helpline and facilitated direct admissions when sepsis was suspected in patients with neutropenia.

Service planning and delivery to meet the needs of local people

- Medical service were mostly planned and delivered to meet the needs of people. For example, the hospital provided ambulatory care for some patients, who required hospital services, but who did potentially not need to be admitted for an overnight stay. This service was available Monday to Friday from 10am to 6pm.
- The cardiac catheter laboratory was not open out of hours and at weekends. The emergency department did not admit patients brought in by ambulance after 8pm. This meant that patients were admitted to Gloucester Royal hospital or to other NHS hospital trusts.
- There were regular meetings to manage availability of beds. In these meetings senior staff discussed support for potential and planned discharges to free up beds for people who need to be admitted to hospital.

Average length of stay.

- The average length of stay for elective patients was 5.2 days, which was longer than the England average of 3.9 days. The average length of stay for non-elective patients was 6.2 days, which was lower than the England average of 6.6 days.

- Haematology had the highest average length of stay at 10.8 days for elective compared to the England average of just 5.6 days for this speciality, and for non-elective patients the average length of stay was 8.0 days compared to the England average of 6.6 days.
- Between March 2015 and February2016, patients at the hospital had a lower than expected risk of readmission for the top three specialities for all non-elective and elective admissions.

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Access and flow

- The trust had processes in place to monitor access and flow issue during the day. Bed occupancy was under constant review. There was daily teleconference with partners and a separate teleconference where staff discussed bed availability, potential number of discharges as well as any staffing issues that may compromise capacity.
- The site management team held meetings at intervals throughout the day to review and assist with the flow of patients through the hospital. The frequency of the meetings during the day was dependent on the status of the hospital. For example, when the hospital was in 'black escalation,' which indicated there were few or no free beds but patients still in the emergency department waiting for beds, meetings were more frequent. A policy was in place to guide and inform staff on the site management meeting schedules, who needed to attend which meetings and the responsibilities of certain staff at the meetings depending on the escalation status. These were referred to as action cards. Meetings were focussed on potential patient discharges and support required to help manage discharges promptly.
- There was a daily teleconference with commissioners, the local authority, the ambulance service and both hospital locations to discuss the availability of beds and any patient flow issues. Matrons within the medical division held a further and separate teleconference each morning to assess the staffing levels and skill mix on each ward. This enabled them to review the patients on the medical wards and established if there were any problems with planned discharges. This was to enable them to assist with the flow of patients through the hospital.
- Within oncology, staff met at 9 am to consider bed management within the unit. This included consultants, junior doctors, bed manager, nursing staff, therapists and the liaison nurse (who dealt with fast track NHS Continuing Healthcare funding applications for discharge of terminally ill patients who wanted to die at home). They discussed all the patients and identified any hold ups in their care such as delayed tests. They would meet again at 3pm to check on the status of the delays and the consultants would expedite any hold ups in which helped identification of patients experiencing delayed discharges.
- The trust had an occupancy rate of 92-94% between January and June 2016. It is recognised that a bed occupancy rate above 85% may affect the flow of patients from admission to discharge and affect the quality of care and treatment. The board report from November 2016 showed there were 2,355 bed days occupied by patients deemed medically fit for discharge in October 2016. In the same month, there were also 45 delayed discharges.
- Between November 2015 and October 2016, the trust's referral to treatment time (RTT) for admitted pathways for medical services was better than the England overall performance. The latest figures for October 2016 showed 93% of this patient group were treated within 18 weeks compared to the England average of 90%.
- The trust reported in there was a continuing waiting list for diagnostic endoscopy, but that this was reduced from 600 patients in June 2016 to 428 patients in November 2016. The trust had appointed two non-medical endoscopists (these are not medical doctors by background but often nurses who receive specialist training and supervision) to help with the waiting times.
- Between September 2015 and August 2016 there were 15,816 medical admissions. Of these admissions, 8,881 patients (29%) moved wards at least once, 2,636 (8%) moved twice, 1,210 (4%) moved three times and 867 (3%) were moved wards more than four times during their admission.
- There were 13 mixes sex breaches from October 2015 and August 2016, occurring on acute medical assessment unit (ACU). The impact was patients received care in a mixed sex environment instead of a single sex environment, which potentially violated their privacy and dignity.
- We spoke with ward managers who describe the crucial role of the occupational therapist in supporting discharges, as their assessments often included

relatives. We spoke with a palliative care nurse specialist who praised staff on Hazelton ward for making appropriate and timely referrals for patients towards the end of life.

- The hospital had a discharge waiting area for patients waiting for transport or whom family members were collecting. There were eight chairs and four cubicles for beds. The cubicles were very small and had no emergency equipment such as call bells, oxygen or suction although staff had immediate access to portable oxygen and suction equipment. The discharge area received approximately 10 to 16 patients daily. It was open Monday to Friday from 8am to 8pm, and if patients had not left the department at 8.30pm, staff would arrange for the patients to return to a ward.
- The ambulatory emergency care unit provided data, which showed approximately 14 patients attended the department each day. The majority of those returned home and did not require an overnight staff.
- The acute medical assessment unit (ACU) unit received patients admitted from the emergency department however, this was closed overnight so paramedics and GPs called the medical registrar out of hours who decided if the patient could be accepted on to the unit as a direct admission.

Meeting people's individual needs

- We observed appropriate arrangements to take account of individual needs of patients being discharged that have complex health and social care needs. Discharge team members attended board rounds on the wards and liaised with outside agencies to ensure smooth discharge arrangements for older people with complex needs.
- Staff knew how to access the learning disability nurse. On Avening ward, we observed staff care for a patient with learning disabilities. Staff explained they were supported by the trust's learning disability liaison nurse and worked closely with the wider multidisciplinary team to ensure safe discharge planning
- We spoke to staff who knew how to arrange for people who needed a translation service. However, we could find no evidence of patient information leaflets in other languages on the wards. Staff had access to a telephone interpretation service to support patients whose first language was not English. Staff told us they had used the telephone service in the past and found this to be an efficient and useful service. One member of staff advised us that on occasions they had communicated with a patient through their relative. It was not clear how staff could ascertain that the patient consented to their relative knowing their medical information. In guidance from NHS England: Principles for high quality interpreting and translation services, it is strongly suggests that translation by family members should be avoided.
- We saw that most wards had large dementia friendly signage. A ward manager told us there was an expectation that all band two healthcare assistants attended an in-house training course to prepare them to give one to one care for dementia/confused patients. Following a risk assessment, an extra band two care assistant could be booked to provide that level of care on the ward. Staff could access 'twiddle mitts' from main reception for dementia patients. These are a sensory type of glove providing different textures for restless hands to twiddle with. The trust was in the process of introducing 'this is me' diaries for patient with dementia where relatives could add information about the patient to help inform nurses and other healthcare professionals of specific likes and dislikes of the patient. This would promote understanding and communication. We saw these diaries in use on some ward areas. Ryeworth ward held reminiscence and cognition sessions on Tuesday mornings for all patients who wished to participate.
- Wheelchair access was good on all the wards and some wards told us that they were considering purchasing large clocks for the wards for the visually impaired.
- Lilleybrook ward had a relative room for private conversations, which also had a fold-up bed relatives could use if they needed to stay the night. They also had a pleasant day room with doors that opened out onto a small garden.
- A four-bedded bay on Lilleybrook ward, was allocated for patients who had accessed care through the designated helpline. The helpline averaged 57 calls in 24 hours and fifteen patients were admitted over the Christmas period. The staff had special stickers for the pathology specimens, and received results usually within five minutes to ensure prompt and timely treatment of confirmed sepsis.
- Staff did not consistently obtain information about people's communication needs, which did not comply with best practice. The Accessible Information Standards (2015) directs and defines a specific and

consistent approach to identifying, recording, flagging, sharing and meeting information and communication needs of patients, where those are related to a disability, impairment or sensory loss. While the trust used visual reminders to alert staff to additional care or communication needs, we found the assessment documentation was not consistently completed.

- The endoscopy unit had two separate recovery areas and an isolation room. This meant patients were recovering in single sex bays after their procedure
- Staff did not always respond to nurse call bells in a timely manner. We observed call bells ringing in excess of ten minutes without staff answering the bell.

Learning from complaints and concerns

- People's concerns and complaints were listened and responded to and used to improve the quality of care. Between November 2015 and October 2015, there were 109 complaints about medical care. The trust took an average of 40 working days to investigate and close complaints, this is not in line with their complaints policy. The trust's internal standard states 95% of cases should be responded to within 35 working days. Patient care was the most complained about theme with 34 complaints, followed by admission & discharges with 31 complaints. The profession 'nursing' received 64 complaints.
- At Cheltenham General Hospital, there were 30 complaints of which patient care received the highest number of complaints: 10 (33%) in the period from November 2015 to October 2016. Staff received feedback from incidents and complaints in ward meeting and some wards displayed feedback in staff rooms under the heading 'lessons learnt.'
- Safety bulletins were issued by email to all staff by the clinical risk team who stated they had received positive feedback about the usefulness of this. The most recent flyer had informed staff there was a concern about the lack of escalation following deteriorating NEWS scores and the action that was required to be taken.
- A newsletter was produced in the medical division, which provided information about learning and sharing experiences from incidents had been included in this and distributed to all staff. However, we were told there had not been a newsletter produced in the last year.

Are medical care services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, support learning and innovation, and promotes an open and fair culture. We rated well-led as requiring improvement because:

- There was not a systematic approach to mortality and morbidity (M&M) meetings. This meant there was a lack of overview and governance around mortality and morbidity (M&M) meetings.
- There was a lack of understanding of the risk to safe patient care, the acuity of patients on daily basis have.
- Risk were not always aligned with the risk registers.
- There was a limited approach to obtaining the views of patients and their relatives.

However:

- The trust had a clear vision and some specialities within the medical division had a vision to expand and improve services.
- There was a clear divisional structure and monthly quality and performance committee meetings and monthly quality reports. Staff felt supported by managers and senior management felt assured by the new executive team.

Leadership of service

- Leadership of the medical division encouraged openness and promoted good quality care. However, we found there had been limited progress made since our last inspection in 2015.
- Divisional leads told us there was now an established management team and that this provided stability. There was an organised management structure, which was focussed with clear direction and people were held to account. However, some staff had not met or seen the new chief executive in their ward area and some staff felt only senior managers engaged with the executive team. We spoke to members of staff who described the new chief executive as being 'very helpful, supportive and responds to emails'. A ward manager stated "I haven't seen her but I love her weekly blog which is always well written and very interesting'.

- Nursing staff told us managers were very accessible and operated an 'open door' policy. Senior ward nurses and ward managers felt they were well supported by matrons. Staff felt they could raise concerns about care to managers or matrons if required.
- Medical staff said they felt well supported by senior medical staff and consultants.
- Specialist nurses spoke of Hazelton ward being well-led and that the culture of the ward was positive. Nurses were happy and smiling and patients received good standards of care.
- Band 7 staff led the bed and site management team at the hospital on site, with support from senior managers at Gloucester Royal Hospital. The site management team were clear what decisions could be made on site and when they would defer to senior staff. For example, admitting patients into day surgery beds would be deferred to senior staff.

Vision and strategy for this service

- The Trust's vision was to provide the best care for everyone and spoke of the five pillars of transformation to achieve this. These included building capacity and capability, improving patient flow, modernising their hospitals, working in partnership and delivering best value. Staff were aware of the trust's values and information was shared on wards and in corridors.
- There were a strategy in cardiology to combine cardiac services across the two sites into one location. Senior staff felt this would improve patient care and treatment, help to recruit and retain staff and enable consistency in training opportunities for nurses.
- The ambulatory service had a long-term plan to become a seven-day service but due to the vacancies in nursing and medical staffing this was not possible at the time of our inspection.

Governance, risk management and quality measurement

- The trust had a governance framework that set out responsibilities for managing quality, performance and risks. There was a clear divisional structure and monthly quality and performance committee meetings and monthly quality reports. These were presented to divisional board meetings for discussion about quality and performance.
- The trust held morbidity and mortality (M&M) meetings to identify learning and formulate actions to improve care and treatment of patients. However, there was a lack of overview and governance. Meetings were not held regularly or consistently applied across all medical specialities. We reviewed information about M&M meetings were held in the last 12 months. There were regular meetings in most services but we did not see any reference to a cardiology M&M meeting held during 2016. Where meetings were held learning points were identified and shared via email with colleagues However, in the neurology/stroke service only two meetings were held in 2016 and no actions or learning was identified.
- The trust with had an annual clinical Improvement and audit plan 2015-2016 for local and national audits which included venous thrombo-prophylaxis, confusion proforma/dementia screening, acute kidney injury and the escalation policy/DNACPR. Audit results were submitted to the strategic clinical improvement and audit committee. We asked for the current audit plan as part of the data obtained prior to the inspection and we were sent the audit plan for 2015-16.
- There was a trust risk register and a medical division risk register with identified risk that could affect the effectiveness or safety of the medical service. The risk register for the medical division was maintained electronically. The general managers and matrons added risks to the register. We followed up three of the listed entries to the risk register to assess the effectiveness of actions taken to reduce the risks.
  - Risk of harm to patients due to inadequate numbers of skilled/trained nursing staff: Nursing staff vacancies were highlighted in almost all conversations we had with managers and other clinical staff. The trust had plans in place to increase recruitment and retention and the director of nursing submitted a monthly report to the board. However, there was a lack of understanding of the impact different levels of acuity had on safe nursing staffing levels to keep patients safe. The annual assessment of nursing staff establishment was not adequate to ensure safe staffing levels on a day-to-day basis. This was not reflected in the risk register.
  - Harm to patients due to errors in the prescribing of insulin. We spoke with a consultant about actions taken to improve practice. They told us a specific insulin chart allowing daily adjustments had been

introduced and these were audited. In addition, plans were in discussion about the feasibility of introducing specific insulin rounds across the hospital.

- Failure to comply with national patient safety alert (NPSA/2011/PSA001) Safer Spinal, epidural and regional devices. We reviewed the risk assessment carried out in response to the NPSA alert in 2013. This risk assessment was carried out in 2013 and mitigating actions were identified to lower the risk of the using the wrong type of needle. Staff on the oncology ward, where spinal needles were used to administer intrathecal chemotherapy, told us spinal needles were kept separate from other needles.

- We spoke with ward managers and consultants about issues that may be identified as a risk to either the safety of the patients or the effectiveness of the service. They spoke with confidence about the role of the risk register and how this fed into a robust governance framework however, they did not always add risks which when we asked they acknowledged should be on the risk register. For example, the ward manager on ACUC had not undertaken a risk assessment and added the condition of the flooring on the unit and the risk this carried for infection control onto the risk register..
- The trust had a safety experience review group and representation from the medical division, was by the attendance of the clinical risk manager, the divisional lead nurse and the medical director. This ensured that relevant safety information could be shared with staff in the medical division.
- The medical division health and safety committee met every month to review any issues that had arisen. The committee submitted a report every six months to the trust wide health and safety committee. This included, amongst others, incidents of needle stick injuries, falls, spillages, infection control and stress management. The health and safety committee also presented information for staff each month on a relevant topic. The most recent being stress. Staff were signposted to information on how to deal with stress, such as the trust policy and a checklist for teams to assess stress levels.

Culture within the service

- The senior divisional management team described a shared vision and felt part of a strong team and part of the solution to hospital wide problems. The divisional management team felt positive about plans for the future.
- Managers were proud of their staff, their resilience and dedication to provide compassionate care to patients. Staff mostly felt positive about working for the hospital although, all staff said they were always very busy with high volume of patients, staff shortages and the high usage of temporary staff. Staff on Avening and Hazelton ward told us it was a great team to work in, they felt supported and that they had learnt a lot. Staff told us there was an open culture and that ward managers were accessible and supportive. Whilst on other wards, staff were less enthusiastic about their job with some describing looking to change jobs to another ward. All staff expressed that they were short staffed most days.
- Some ward managers used secure social media apps to help cover shifts. Staff received this approach positively and staff did not feel obliged to come in on their days off. Managers said it worked well and in some wards, for example the acute assessment unit, they managed to cover most of their shifts with their own staff and mainly used agency staff for one to one nursing of difficult to manage patients.
- Staff were generally enthusiastic about their work but all staff said they were very busy. Band 6 nurses were often working as ward co-coordinators, with little or no time allocated for administrative duties. However, because of the high use of temporary staff, they felt their presence and clinical experience was needed on the wards.
- Staff denied ever feeling bullied or intimidated and knew how to escalate concerns if needed.
- When patients passed away on the oncology ward, staff had a team de-brief and could be referred for psychological support if required.

Public engagement

- The trust encouraged patients to comment on the care and treatment they had received in the medical service. However, the response rate was generally low at about 25%. There were posters displayed in ward areas encouraging patients and their relatives to complete the 'friends and family' test and the wards displayed feedback from these.
- The trust encouraged patient's receiving cancer services to provide feedback via a 'cancer patient experience

survey'. In November 2016, the results of the 2015 survey were published and demonstrated positive developments. The service's combined score was 8.6 out 10. The trust had sent out the survey to 1800 patients receiving cancer services.

- The hospital's charity focus fund helped raise money for the Gloucestershire Oncology Centre based at the hospital, with the support of a local artist. This was known as the Angel Appeal and involved a team of volunteers, students from a local university making and decorating angels by hand, which were sold in some local shops in December 2016, to help raise funds.

Staff engagement

- The trust undertook a staff survey in 2016 and from the results and an action plan was formulated to help improve staff engagement. Amongst the actions identified for the medical division were: re-branding and re-introduction of staff forums, launch of 'walk abouts' by speciality and divisional leads and to increase networking including exploration of safe use of social networking apps.

However, although actions were identified with timescales and responsibility assigned to different people it was unclear how effective these actions were. For example, we did not meet with any staff who had attended a staff forum in the medical division and staff were not sure when these were happening.

- Staff were generally enthusiastic about their work but all staff said they were very busy. Band 6 nurses were often working as ward co-coordinators, with little or no time allocated for administrative duties. However, because of the high use of temporary staff, they felt their presence and clinical experience was needed on the wards.
- The bed and site management team structure had recently been reviewed by the trust. There was a plan to appoint an additional band 7 site managers and reduce the number of band 5 bed managers. Staff told us they were disappointed they had not been consulted with in the plans for this restructuring.

Innovation, improvement and sustainability

- The trust had introduced a project to improve assessment and documentation with falls assessment stickers. The project also included a post-fall assessment protocol and a falls register both of which were included in the falls prevention care bundle. We saw the post fall assessment completed. Staff completed audits about the effectiveness of the stickers and the results demonstrated an increase in post fall assessment of signs of fractures, head injury and neurological assessments. The sticker prompted medical staff to make a clear management plan to follow up and review falls prevention.

Surgery

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

Information about the service

Surgical services provided by Gloucestershire Hospitals NHS Foundation Trust are carried out at two hospital sites: Gloucestershire Royal Hospital and Cheltenham General Hospital. Services provided at Gloucestershire Royal Hospital are reported on in a separate report. Surgical services for the trust are run by one management team (the surgery division) and, as such, are regarded by the trust as one service. For this reason, it is inevitable there is some duplication in the two reports.

Cheltenham General Hospital provides both elective (planned) and emergency surgery. Patients are admitted as both day-case patients and to wards as inpatients. The surgical specialties include general surgery, trauma and orthopaedics, breast, urology, ophthalmology, vascular and interventional radiology. The operating department at Cheltenham General Hospital has 12 theatres. There is a recovery area within the main theatres with 10 trolley spaces and separate recovery facilities at the other theatres located throughout the hospital. Cheltenham General Hospital has six surgical wards and two-day surgery units (one male and one female).

We visited the following areas; Guiting (vascular surgery), Dixton (trauma and orthopaedics), Bibury, Snowshill (both urology) wards and Eyeford (day surgery unit for ophthalmology), the preadmission clinic, Kemerton and Chedworth Suite (day surgery units), and theatres.

We spoke with 32 staff, including theatre managers, the head of nursing, matrons, ward sisters, consultants, doctors, junior doctors and nurses. We also talked with healthcare assistants and pharmacy staff and spoke with 11 patients. We observed care and looked at 13 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.

In the year April 2015 to March 2016, Cheltenham General hospital had 22,975 surgical admissions. Of these, 60% were day-surgery patients, 20% were elective (planned), and 20% were emergency-surgery patients.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Surgery

Summary of findings

We rated this service as requires improvement because:

- There had been since our inspection in March 2015, an increase in the number of surgical site infection rates for replacement hips but these had reduced at this inspection. However, the reduction of long bone surgical site infection rates were worse than the national average.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again. Not all staff within these specialities were aware of these never events and the learning from them.
- There were periods of understaffing on the surgical wards and operating theatres, where the trust's staffing numbers of qualified nurses were not met.
- The formal out of hour's interventional radiology consultants' rota was still not in place at this inspection.
- Mandatory training for all staff was not meeting the trust's target.
- The surgical division was not meeting the trust's target for staff appraisals.
- Due to pressure for beds and the demand for services, some patients had to use facilities and premises that were not always appropriate for inpatients and support services were not always set up.
- The trust had introduced a new computer system prior to our inspection that was causing some issues for staff resulting in work arounds to prevent any risks to patients.

However:

- The service encouraged openness and transparency from staff with incident reporting, and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- The trust had been identified as a 'mortality outlier' in to relation Reduction of fracture of bone (Upper/ Lower limb)' procedures, which included fractured hip. However, the actions they had implemented had made improvements and these were ongoing at the time of our inspection. for example, in the 2016 hip fracture audit which had shown an improvement on 2015 audit
- Training in safeguarding of adults and children had met the trust target for completion.

Surgery

Are surgery services safe?

Requires improvement

We rated safe as requires improvement because:

- Since our last inspection, the number of surgical site infection rates for replacement hips had increased but these had reduced at the time of this inspection. However, the reduction of long bone surgical site infection rate was above the national average.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again. Not all staff within these specialities were aware of the never events and the learning from these.
- There were periods of understaffing on the surgical wards and operating theatres where the trust's planned staffing numbers of qualified nurses were not met.
- The interventional radiology consultants out of hour's formal rota was still not place at this inspection.
- Mandatory training for all staff was not meeting the trust's target.
- Kemerton and Chedworth Suite was at times being used as an inpatient ward but there was uncertainty from staff about how to arrange domestic cover for weekends to provide cleaning and at times drinks to patients when the nursing staff were busy.

However:

- The service encouraged openness and transparency about incident reporting and incidents were viewed as a learning opportunity. Staff felt confident in raising concerns and reporting incidents.
- Safeguarding training in adults and children for all staff in the surgical division was meeting the trust's target for completion.

Incidents

- Not all staff were receiving feedback from incident reporting. Staff told us they were encouraged to report incidents on the computer system. This lack of feedback had been identified at our last inspection. At that time, the divisional surgical management team told us they were working on how to improve the feedback to staff following incident reporting. However, some senior staff we spoke with on the wards told us they did provide feedback to their staff following incident reporting and incidents were also discussed at team meetings. Following our inspection the trust old us staff were able to view the outcome to their incident report using this system.
- All staff employed by the trust (excluding agency staff) were able to report incidents electronically via the intranet.
- We spoke to a band 7 (senior) nurse in theatres whose role was to spend three-quarters of their time on managing risk. They were responsible for ensuring all clinical incidents were investigated thoroughly and learning was identified and shared with all staff. The theatre team aimed to fully investigate all clinical incidents within 28 days. Each investigation would start with a scoping meeting, which involved all grades and specialties of staff to identify where things went wrong and how to ensure that it would not happen again.
- From September to December 2016, there had been an increase in needle stick injuries (injuries from needles). The theatre risk nurse had produced a quarterly update and circulated this to all staff to remind them about the safe use of sharps. Following this, they reported a decrease in the number of needle stick injures in January 2017.
- The trust had reported two never events in surgery in the year from December 2015 to November 2016. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. One incident was where a piece of equipment was left in a patient by mistake, and the other was the insertion of the wrong strength intra ocular lens. Both incidents were attributed to this hospital, and were investigated by the trust and learning shared across the surgery division. Areas identified as needing improvement to reduce the risk of this happening again had action plans, or actions in the process of being agreed. Not all staff in the relevant specialises we spoke with were aware of both never events therefore any learning from these had also not been shared. The process for sharing of incidents and learning at Cheltenham General Hospital was not as established as at Gloucestershire Royal Hospital where all relevant staff were informed.

- Actions were taken from near miss events. A near miss is an unplanned event/incident that did not result in injury to a patient or staff, or damage to equipment or premises, but had the potential to do so. The incident we reviewed related to an implant used in orthopaedic surgery. During the procedure, the wrong implant was given to the surgeon. However, it was not used as the surgeon identified it was the incorrect implant prior to being used. We saw a copy of the action plan detailing all the changes made following this incident. All actions had been completed. Staff were able to describe and show us the changes made to practice to avoid this incident recurring.
- In accordance with the NHS England Serious Incident Framework 2015, the trust reported 10 serious incidents (SIs) in surgery in the year from December 2015 to November 2016. Of these, there were two incidents reported of 'surgical/invasive procedure incident meeting SI criteria' and two of 'healthcare acquired infection/infection control incident meeting SI criteria'. The other incidents were all unrelated. Where incidents of infections were reported, the service had carried out investigations and taken actions to reduce the risk of a reoccurrence.
- There had been an increase in incidents of surgical site infections. Staff within the wards and operating theatres were aware of this increase and actions had been taken. Actions taken in the operating theatres to reduce the surgical site infection rates included, for example, changes to dress policy. Staff were no longer permitted to wear scrubs in shops and cafes on the hospital site. A new testing regime had been introduced. Swabs were taken of equipment in theatres, including tourniquets, surgeons' and scrub staff's hoods used in orthopaedic theatres, to evaluate cleaning regimes. Environmental rules in orthopaedic operating theatres stated no one was permitted to enter the theatre once skin preparation had started unless in a sterile gown and wearing facemasks.
- Each of the surgical specialities reviewed patient mortality and morbidity (M&M). We reviewed sets of minutes provided for the general surgery division, which included colorectal, upper gastro-intestinal, vascular and urology. In the majority of meetings, they used the Clavien-Dindo classification tool. This tool is used to rate surgical complications for audit, clinical investigation and as a tool for quality improvement. We found there was variable input, content, and insufficient evidence to show how agreed actions were delivering improvements. In some where presentations were made staff discussed individual cases and the learning required. However, the minutes did not demonstrate if or how staff were accountable for all actions agreed from the reviews or demonstrate improvements from actions taken. The trust told us following our inspection that the governance leads had overall responsibility for ensuring actions were met.

Duty of candour

- Staff were able to tell us about the principles of the Duty of candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was introduced in November 2014. This Regulation requires the trust to be open and transparent with a patient when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff told us the regulations were about being open and transparent with patients following incidents and apologising to them.
- We spoke with a senior member of staff who was involved with one of the Never Events. They told us they apologised to the patient and explained what had taken place and the action needed to address the error. The Never Event was fully investigated and the report into this was due to be completed after our inspection. The senior member of staff told us this would be shared with the patient if they wanted to see it along with any action plans.

Safety thermometer

- NHS Safety Thermometer information was routinely displayed in most ward areas. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. This tool enabled wards and units to measure harm and the proportion of patients that were harm-free from pressure ulcers, falls with harm, urinary tract infection with catheters, and venous thromboembolism (VTE, or blood clots) during their working shifts.
- Data from the Patient Safety Thermometer showed that the trust reported 34 pressure ulcers, 20 falls with harm and 25 catheter urinary tract infections in surgery from November 2015 and November 2016.
- The prevalence rate for pressure ulcers had increased over time however, after October 2016 this had started

to reduce. Guiting ward had the most hospital acquired pressure ulcers for the Cheltenham General Hospital (CGH) from January 2016 to October 2016, with 18 reported. Staff told us this was because they had medical outliers (medical patients being cared for on a surgical ward) and vascular patients with a number of co-morbidities, which increased their risk of pressure ulcers. Staff were undertaking actions to reduce this risk by reviewing risk assessments and completing intentional or comfort rounds more frequently. The trust told us after our inspection that for monitoring purposes and good practice all pressure ulcers from grade 2 to grade 4 were reported.

- The prevalence rate for falls with harm was also reducing over time, but had seen a sharp rise in September 2016 and October 2016. November 2016 showed the prevalence rate to have fallen to zero. Guiting ward had reported the most falls for CGH from January 2016 to October 2016 with 88. The reasons and actions taken were the same as above.
- In all the patients' notes we reviewed, we saw they the majority had been assessed for their venous thromboembolism (VTE) risk within 24 hours of admission as per trust policy. This was completed to ensure their risk of developing a blood clot in their leg or lungs had been assessed and actions put in place to reduce the risk.

Cleanliness, infection control and hygiene

- Reliable systems were mostly in place to maintain standards of cleanliness and hygiene to reduce the risks to patients of catching a healthcare associated infection. For example, each theatre had an 'end of the day cleaning checklist' that needed to be completed.
- Hand hygiene results from January 2016 to October 2016 were rated as green but Alstone ward (elective orthopaedics) was rated as red for October 2016 and mostly amber for the rest of period. We were not informed as to why this was the case. The trust told us after our inspection Alstone ward had action plans in place to address this. The trust used a rating system based on red, amber and green. Green being the ward had met the trust target (which was 100%) and red the ward was below the target set by the trust.
- Bibury Ward (urology) staff audited their hand hygiene processes every two weeks, and had quarterly updates from the infection prevention control team, including training sessions. This has led to improvement with hand hygiene and blood borne viruses at 100% compliance since September 2016.
- At our last inspection, we found auditing of MRSA screening on emergency and elective patients was not taking place. However, the trust has since carried out audits. One was undertaken in September 2015, the results showed that screening from the nose and groin was over 90%. The data was taken over both hospital sites on one day and showed for surgery 14 emergency admissions patients had not been screened. This was less than 10% of total admissions that day. The trust was monitoring and investigating all new cases of MRSA and Clostridium difficile (C diff) and taking actions where needed.
- We observed staff in theatres maintaining strict infection control procedures to prevent the risk of infection for patients undergoing operations. We observed scrub staff and surgeons 'scrubbing' (this was where staff washed their hands up to their elbows using specialist soap and single use scrubbing brushes) and wearing sterile gloves and theatre gowns. All staff in the theatre made sure they did not touch these members of staff so they were as sterile as possible to prevent the risk of cross-infection.
- In theatre skin preparation was used to clean the operation site to make sure their risk of infection was minimised. In orthopaedic theatres, there were strict procedures for all staff to follow once this procedure was underway. For example, staff were not allowed to enter the theatre unless they were in a sterile gown and wearing a facemask.
- We observed staff in recovery cleaning and checking equipment at the start of their shift to make sure it was safe to use and clean. Staff told this was done daily and we saw records to demonstrate this.
- Staff on Bibury Ward told us about their 'catheter passport'. This leaflet, provided to patients, outlined the care required of catheters in order to reduce the risk of getting an infection. Staff told us patients found this very useful in caring for their catheter at home, and what to do if they required help.
- A care plan bundle was in place for the insertion of cannula (tube into a vein). This required staff to complete on insertion and respond to questions. For example, did they undertake hand hygiene prior to insertion and the use of specialist skin preparation to

reduce the chance of an infection. The use of cannula had to be reviewed daily and staff were required to consider whether it could be removed as not being used or if there were signs of infection when it must be removed. We saw these in place in some of the patient records we reviewed and they were completed in full.

- We observed staff following the infection control policy. This included being bare below the elbow and ensuring long hair was tied back.
- Patients who were known to be cross-infection risk were placed in rooms with clear labelling to indicate that appropriate cross-infection procedures should be carried out prior to entering. We saw all staff wearing aprons and washing their hands before entering the room.
- Clinical waste was managed in line with the trust's policy. Single-use items of equipment were disposed of appropriately, either in clinical waste bins or sharp-instrument containers.
- When Chedworth Suite and Kemerton (normally day surgery units) were being used for inpatients, due to the demands on beds and services, there was no domestic support at weekends to assist with cleaning both units. For example, patient toilets were therefore not cleaned, which was unacceptable. A senior staff member told us the units were able to arrange domestic cover but the staff we spoke with were not aware of how to do this. At the time of our inspection, both units were not being used as 'wards' and were closed at weekends and nights The use of these units for inpatients varied based on the demand on the beds in the hospital. Following our inspection the trust told us staff were aware of how to arrange to domestic support and they would send in rotas to support this. However, we did not receive the rotas.

Environment and equipment

- The surgery departments and wards at Cheltenham General Hospital were all located in different areas of the hospital. Lifts were available for patients and visitors to access the different levels. Ryeworth ward was the designated ward for patients with fractured neck of femur as the environment and equipment was specifically for their needs. For example, larger toilets, equipment storage and a therapy room to help patients with mobility post operation.
- Changes had taken place to the environment in the main theatres suite since our last inspection in March 2015. A new hybrid theatre had been built; this is a combined operating theatre and interventional radiology suite. The hybrid theatre could function either as a conventional operating theatre or as a radiology facility but crucially allowed intra operative and post-operative imaging and intervention to occur.
- Resuscitation equipment on each ward, unit and in recovery/theatres was checked daily, with records in place showing completion. However, we found on Guiting ward that checks were missed on 17 December, 13 and 25 January 2017. Medication within the resuscitation trolleys was stored in tamper-evident containers. This is in line with the guidance issued by the Resuscitation Council (UK).
- Resuscitation equipment was not available in the pre-assessment unit. Staff told us they had raised this as a concern. The issue had been risk assessed and it was felt resuscitation equipment was not required. However, staff told us it had since been agreed (there was no period given for when this was) that a basic box would be provided instead. At the time of our inspection this had not been provided. The nearest resuscitation equipment was on a different floor to the pre-assessment unit. Staff told us about a patient who had experienced chest pains following their appointment. As a result, staff had to take the patient to the emergency department in a different building in order to treat the patient. Staff also told us they had previously raised the issue to an executive board member who was visiting the unit in August 2016 and they agreed the equipment was required and would be provided. However, this had not materialised. The trust told us after our inspection that the portering service attend all emergency calls and bring with them the required resuscitation equipment.
- Staff also told us there was not enough equipment on the unit to effectively undertake pre-assessments. On the day of our inspection, we witnessed a patient pre assessment appointment and noted there was a delay whilst the nurse waited for an echocardiogram (ECG) machine to become available. We were told there was only one machine available on the unit and staff had to wait for one to become free in order to complete the patients planned assessment. We were also told that there were not enough vital signs monitoring equipment

on the unit which resulted in patients waiting. The trust told us after our inspection that they felt one ECG machine was adequate and as they had no evidence of equipment not being available when needed.

- Staff in the pre-assessment unit told us they were concerned about the lack of space within the unit. Staff felt the unit was already at capacity and covered orthopaedics, colorectal and upper gastrointestinal, breast, vascular, gynaecology and oncology patients. There were plans to include urology patients but staff told us there was no space within the unit to accommodate extra patients or enough staff to cope with the extra administration.
- The chairs provided in the pre-admission unit were not appropriate for vulnerable patients. They were plastic, very low and not adjustable. This made it difficult for patients with mobility problems. Staff also told us patients would often wait for up to three hours in the waiting area and would be staring at a blank wall during this time. The waiting area could be very cold, with patients often wearing coats while waiting for their appointments.
- The hospital had a central sterile services department (CSSD) on site, which decontaminated large volumes of medical equipment. The department had been accredited internally and externally, and was compliant with ISO13485 Medical Devices (this is an external accreditation to ensure the quality, safety and effectiveness of medical devices). Theatre staff spoke extremely positively about this service. Equipment provided by Central Sterile Services Department (CSSD) was also traceable. We also saw the tracking stickers from this equipment in patients' notes.
- Staff showed us the process for tracking and tracing of surgical equipment. This included removing stickers from the equipment and placing them in the patients' notes. This was important in case any issues with patients or the equipment after surgery were identified and needed to be followed up.
- In orthopaedic theatres, they did not cover equipment stored in corridors or spare areas staff told us night staff cleaned these each night. We had no concerns about the cleanliness of equipment we saw. Safety checks were undertaken on anaesthetic equipment in all theatres daily to make sure it was safe to use.
- We saw stickers on electrical and medical equipment that stated when it was last serviced and when it was due again. This was mostly done in house and all were up to date.
- Management in theatre told us that there is no equipment replacement programme. However, if a piece of equipment was broken they were able to submit a bid for it to be replaced. Staff told us that some of the operating tables were old and that this led to difficulties with maintaining a sterile environment. The trust had a system in place for all wards, departments and units to request equipment. Meetings took place monthly, attended by senior trust staff where decisions for the purchase of equipment over £5000 were made. For equipment costing over £100,000 a business case was also required before a decision was made by senior staff from the trust
- We were told operating tables had pressure-relieving qualities included to reduce the risk of patients developing pressure ulcers.
- Equipment was also available for bariatric patients including beds, hoists and some of the operating tables.
- During our inspection, the main lift to Eyeford (ophthalmology day unit) was not working and patients had to use a lift in outpatients, which brought them into the theatre department on Eyeford. Staff expressed concerns that patients could easily walk into a theatre by mistake. Also if a patient's condition deteriorated they could not fit the trolley with the patient on and staff easily into this lift. Staff told us this had been like this for several months but they were hoping the lift was going to be repaired the week of our inspection. A risk assessment had been completed and a process of getting patients into the smaller lift devised.

Medicines

- There were arrangements in place for the safe management of medicines and these were mostly followed. Medications were stored securely.
- We observed medicine trolleys were locked when unattended and secured when not in use.
- Nurses on Guiting ward were not clear what the trust policy was for the storage of liquid medicines and this had been recognised by the pharmacy department as they told us and who were in the process of reviewing this.
- A pharmacy technician visited Guiting ward and did a weekly check of the insulins in the medicines

refrigerator to ensure they were stored within safe temperatures for their use and were in date. Daily checks of the refrigerator temperatures were carried out and recorded, which were all within a safe range.

- We reviewed the arrangements for the management of Controlled drugs (CD) on Guiting ward and we found:
  - They were stored in appropriate secured cupboard.
  - Random stock check showed balances were correct and these were recorded in the back of the CD record book.
  - Two nurses were involved in checking CDs for administration and two signatures were seen in CD record book to support this.
  - CD keys were not separated from the main bunch of keys which was not in line with trust policy. However, the keys were kept on a registered nurse at all times to prevent unauthorised access.
  - We found daily checks on CD's were in also in place on the following wards/units where we examined medication, Ryeford ward and Kemerton.
- We reviewed eight Prescription charts and found the following;
  - All had patient details were filled in and allergies were recorded, signed and dated.
  - All had evidence of medicine reconciliation documented. This was where a pharmacist had reviewed the prescription chart.
  - Six out of eight had their venous thromboembolism (VTE) assessment documented incorrectly (these were included in the prescription chart). One initial assessment was not documented. Five had initial assessments but no reassessment within 24 hours documented as per trust policy.
  - One prescription was not signed and dated by prescriber. This was not in line with trust policy.
  - We found nine blank boxes seen across the eight charts. This meant there was no evidence to show if the medication had been administered or if not administered, the rationale behind that decision. There was also no record of actions taken in response to the blank boxes. Examples of medicines with blank boxes: paracetamol, dermol lotion, ranitidine 150mg, dalteparin 5000 units and bumetanide 1mg. The standard set in trust policy was 'zero blank boxes'.
- The ward manager had a folder of patient group directions (PGDs) in use on the ward. PGD provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber (such as a doctor or nurse prescriber). Authorisation signatures were not complete for PGDs (only signed by ward manager) and some were out of date (this corresponded with the out of date PGDs on the intranet used by staff), for example, paracetamol and instillagel had expired in October 2016.
- Medicine administration competency checks were seen for nursing staff. These were used to make sure nurses were safe to administer medicines in line with trust policy and the Nursing and Midwifery Councils guidelines (NMC).
- Staff on the wards and theatres/recovery told us all medication errors were reported via their incident reporting system so they could be investigated and actions taken to reduce the risk of them from occurring again. The nursing metrics showed the number of medication errors from January 2016 to October 2016, Guiting ward had the most with 21 were not told why they had this high number compared to the other surgical wards. We do not know the reasons for this. Alstone ward had two in the same period and Dixton ward had reported no medication errors.

Records

- Patient records were stored securely and were mostly in line with the patient's nursing needs and medical reviews. At the last inspection, we found patient notes were not being stored securely on Prescott ward. New lockable trolleys had been purchased for each ward.
- Nursing records were held at the end of patients' beds. Care pathways were in place for surgery patients. These included separate pathways for patients undergoing day surgery. Both nursing and medical were included in these. Records were comprehensive and included details of the patient's admission, risk assessments, treatment plans, and records of therapies provided. We saw preoperative records, including completed preoperative assessment forms. Medical records accompanied patients to and from theatre. However, in three we found the safer surgery WHO checklist sign out times had not been documented on the form.
- All consent forms we viewed were completed in full, signed, and dated by the patient and the consultant. All risks associated with the operation were also documented.

- Core risk assessments and care plans were in place for patients with mental health illnesses, for example, disorientation and memory loss, alcohol withdrawal management plan and patients at risk of self-harm. On the wards, we visited and the patients records we reviewed none of the patients required these plans, however staff were aware of where they could access these.

Safeguarding

- Arrangements were in place to safeguard adults and children from abuse and staff understood their responsibilities to report allegations. Staff told us they knew how to make a safeguarding referral and were aware of who were the safeguarding leads for the trust for adults and children.
- Information about safeguarding was displayed on a number of noticeboards across the surgery wards and units.
- The surgical division had exceeded the trust target of 90% completion of all four areas of training. These were; safeguarding awareness, safeguarding adult's level 2, safeguarding children awareness and safeguarding children level two. This was for medical/dental staff and nursing staff.
- The surgical divisional management team told us that patients over the age of 70 with fractured hips could have access to an orthogeriatrian to make sure their needs were met.

Mandatory training

- Staff were mostly up to date with training in safe practice, processes and systems. The trusts mandatory training for all staff included, basic adult resuscitation, blood transfusion, code of conduct, conflict resolution, equality and diversity, fire, infection control, information governance, manual handling theory and practical, medicines management and safety awareness.
- The surgical division across both sites had met the trusts target of 90% for three of the 12 modules for the medical and dental staff group, equality and diversity, information governance and safety awareness. The remaining nine modules were just below the target having completion rates between 83.1% and 89.9%.
- The surgical division across both sites had met the trusts target of 90% for nine of the modules for the nursing staff group. The remaining three modules (basic adult resuscitation, conflict resolution and manual handling practical) were just below the target having completion rates between 83.8% and 86.6%.
- We saw evidence that all staff on Dixton ward were up to date with their mandatory training.
- Within the urology wards (Bibury and Snowshill) managers confirmed they were provided with a list of staff every month who had not completed mandatory training and this was used in discussions with staff to ensure mandatory training was completed by deadlines. During our inspection, we saw this system was used effectively with the majority of staff were up to date with their training. Exceptions to this were staff who were on long-term sickness or night staff.
- Staff in theatres told us they had time put aside to undertake mandatory training and this was called audit days. Practical training took place during this time, for example, moving and handling pertinent to theatres. Staff also had mandatory training to complete on the trusts e-learning system.
- Staff told us they had received training on sepsis identification and management.

Assessing and responding to patient risk

- Risks to patients who were undergoing surgical operations/procedures had been assessed and their safety monitored and maintained. Patients for some elective surgery attended a preoperative assessment clinic where all required tests were undertaken, for example, MRSA screening and blood tests. If required, patients could be reviewed by an anaesthetist. When additional tests were ordered, the pre-operative assessment clinic had a process in place to follow these up and inform the surgeon or anaesthetist if any issues were identified.
- We observed the use of the World Health Organisation (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.
- We saw the results of the WHO audit undertaken in theatres dated June 2016. This was mostly rated as green where they met the target and one area rated as red. The audit had identified they were not compliant

with conformation of checking of anaesthetic equipment. As a result, a new process had started in December 2016 but at the time of our inspection, this had not been re-audited.

- Since our last inspection in March 2015, the pain clinic, which undertakes procedures in the Chedworth Suite, had started to use a modified version of the WHO safety checklist for their procedure. This was because of learning from an incident at Gloucester Royal Hospital. This was introduced to prevent any errors with patient procedures.
- We observed surgical safety operating list briefing, which included what operations were taking place on that list and the staffing numbers. We also saw the WHO checklist being completed which included sign in time and sign out time.
- 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. The trust audited their NEWS scores monthly and the figures sent to us for October 2016 showed that they were at 100% completed as per their policy for all surgery wards. The frequency of observations undertaken in line with NEWS procedure audit all showed each surgery ward was at 100% apart from Alstone ward which was 90%.
- During our inspection, we observed a situation where staff had to use their emergency resuscitation call system. All staff attended promptly, in a calm manner and obtained any and all equipment needed. We later observed the patient to have recovered and was being monitored by the staff.
- Staff on the urology ward had looked at ways to help prevent patient falls. Patients were risk assessed on admission and those at a higher risk of falls would be allocated to bays closer to the nurses' station for closer monitoring. Because of this staff felt they were in a better position to observe patients.
- Staff on the wards told us if a patient was assessed or known to have a mental illness; they referred them to the mental health teams, for example, crisis team, alcohol liaison and for older people. However, not all staff felt they were quick to respond. The trust had devised core risk assessments and care plans for a number of mental health illnesses as mentioned under the records heading.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed but there were vacancies for nursing staff in some of the surgery wards and theatres. This resulted in some shifts being under their qualified nurse planned numbers. Staff told us at times they felt this had affected the standard of care patients received. The trust was working hard to address the vacancies. For example, they had several projects in place to support recruitment. These included supporting overseas nurses to achieve the required English language qualification, engagement in role development and working in a strategic partnership with the local university to 'grow their own' nurses.
- The surgical division used 'The Keith Hurst' tool, often referred to as the Safer Nursing Care Tool, which helps determine safe nurse staffing for acute wards based on patients' level of sickness and dependency. This tool has the added benefit of benchmarking staffing as it included data on skill mix, levels of clinical dependency, clinical speciality and quality markers as part of the overall staffing assessment. The trust told us this tool had acuity measurements included and they did not undertake any other acuity reviews.
- At August 2016, of their eight surgery wards/units five were below establishment. Dixton ward and Eyeford, Chedworth and Kemerton (these two units were classed as one unit) were at or above establishment. Overall there was a deficit of 21.65 Whole Time Equivalent (WTE). Prescott ward had the largest deficit at 11.79 WTE. The trust sent us figures following the inspection of their safer staffing summary. For example, Alstone ward from September 2016 to December 2016 showed their planned safer staffing qualified nurses figures for day shifts was higher than the actual figures and the fill rated for covering these shifts ranged 81% to 84% and was rated as green. We saw that extra care staff were on duty as their actual hours for these months was higher than the planned hours. Senior staff on Alstone ward told us they were now mostly filling their qualified nurses shifts using bank and agency staff. Alstone wards bank and agency usage from December 2015 to November 2016 ranged from 2.4% to 13.3%. For Prescott

ward for the safer staffing figures from September 2016 to December 2016 for day shifts also showed that the actual number of qualified staff on duty was below the planned staffing figures. The fill rates ranged from 86% to 89% and was rated as green. Additional care staff were on duty as their actual figures were higher than the planned figures. Their monthly fill rates for bank/agency staff usage between December 2015 to November 2016 ranged from 7.6% to 15.7%.

- Staffing levels were based on the Association for Perioperative Practices (AfPP) guidelines and on the number of theatre sessions per day. Theatre managers told us that they were in the middle of a major push on recruitment, including offering staff to attend an operating department practitioner's course, and holding open days. Manager also told us that they had low levels of staff turnover.
- Sickness levels within theatres was low at 3.0%, and managers told us that this was managed well with support from occupational health when required, although there was a backlog.
- At November 2016, the trust reported a vacancy rate of 16.9% for surgery trust wide, though for Cheltenham General it was below this rate at 15.7%, which was better than the trust figure.
- Turnover rates at November 2016 trust wide for surgery was reported as to be a rate of 12.2%. For Cheltenham General this was 11.4% which was better than the trust figure.
- Sickness rates at November 2016 for surgery trust wide was reported at a rate of 4.6% with Cheltenham General at 4.5% which was also better than the trust figure.
- From December 2015 to November 2016, the trust reported an average monthly bank and agency staff usage of 9% across the surgical division. For Cheltenham General Hospital, this was above at 12% which meant they used more bank and agency staff.

Surgical staffing

- From 1 August 2016 to the 31 August 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior doctors (foundation year 1-2) staff was lower. The surgical division management told us they had a shortage of junior doctors, which had an impact on their services. They had appointed Advanced Nurse Practitioners (ANP) to support junior doctors in undertaking some of their roles so the junior doctors could spend more of their time diagnosing patients. Use of locum doctors in the surgery division was reported by the trust to be average compared to other trusts. Between December 2015 and November 2016, the trust reported an average monthly bank and locum staff usage of 10%.
- We spoke to an anaesthetist who told us they had 50 senior anaesthetic staff across the trust. These included staff grades (who are classed as middle grade doctors but not yet as senior as a registrar or consultant). Twenty of these worked at Cheltenham General. Junior doctors in training were extra to these numbers. There was an on call rota for covering surgery. Anaesthetic cover for the critical care unit was managed separately.
- All surgery specialities had on call consultants and a team of junior doctors, For example, trauma and orthopaedics had a consultant on call from the hours of 8am to 8pm and after this time; one consultant covered both hospital locations.
- Nursing staff we met said they felt well supported by the surgery teams. Consultants and doctors carried out appropriate ward rounds mostly at set times, although on the day surgery unit they reported a variable practice at times. Although, some of the wards did not have doctors based there, they usually came quickly when requested and did spend most of their time on the wards. When we visited the hospital on both the announced and unannounced visits, we observed doctors reviewing patients and coming onto wards when requested by nursing staff. Some of the wards and day surgery unit had reported difficulties at times in getting medical outlying patients reviewed by medical teams.
- At our last inspection, we noted the risk register contained a risk due to the lack of formal out-of-hours interventional radiology rotas for vascular and urology input. We were told this had not changed at this inspection. Vascular consultants told us they had to contact the interventional radiology consultants themselves to find one of them to assist them.

Major incident awareness and training

- Arrangements were in place to respond to emergencies and major incidents. The trust had a major incident plan, which was available to staff on the intranet.
- Staff in theatres told us one of the actions they had to take if a major incident took place was to stop all elective operations.

- If theatres suffered an electrical power cut or loss, they had generators in place to be able to complete operations safely until the power was restored.

Are surgery services effective?

Good

We rated effective as good because:

- The trust had been identified as a 'mortality outlier' in to relation reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions had implemented had made improvements and these were ongoing at the time of our inspection.
- Staff were using national guidance to improve the outcomes for patients.
- Patients were having their pain levels assessed appropriately and overall patients were pain free.
- There was good mutlidisciplinary working across all staff groups to make sure patients care was coordinated.

However:

- Their emergency theatre was only manned on site for 20 hours each day. The remaining four hours were covered by 'on call' staff, which potentially placed patients at risk.
- The trust had introduced a new computer system prior to our inspection. This was causing issues for staff resulting in work arounds to prevent any risks to patients. The trust was working to address these.
- Staff appraisals were not meeting the trust targets.
- Theatre utilisation figures were low however; the trust was looking at ways of improving this.

Evidence-based care and treatment

- Staff on the ward, units and in theatres had access to policies and procedures that were based on national recognised guidance, for example National Institute for Health and Care Excellence (NICE) guidance.
- Standard Operating procedures in theatre were based on national guidance, for example, those set by the Association for Perioperative Practice (AfPP). We were shown several of these as evidence.
- Staff in theatres told us they had some input into policies and procedures that were developed by the education team specifically for them.
- We observed staff in theatres and recovery meeting National Institute for Health and Care Excellent (NICE) guidance, for example, Hypothermia: prevention and management in adults having surgery. In order to maintain a patient's body temperature above 36 degrees centigrade, patient warming devises were seen being used and staff were seen using devices to warm intravenous fluids. Practice was also seen to follow NICE guidance CG74 surgical site infections: prevention and treatment.
- We saw in the patient records we reviewed that the vast majority of patients had a venous thromboembolism (VTE) assessment completed on admission as recommended in the NICE guidance QS3. This also recommends patients be reviewed within 24 hours. In most but not all the patient records we reviewed this had taken place.
- The orthopaedic surgeons followed the Enhanced Recovery programme for some patients who met set criteria. These pathways provided evidence-based protocols to ensure patient recovery was maximised.
- Staff in the pre-admission clinic told us they discussed with patients about how to make sure they were fit for their operation. For example, advice was given about smoking and alcohol intake.

Pain relief

- Patients had their pain assessed and managed. The trust had a consultant led dedicated pain team, supported by senior nurses. Staff in recovery and on the wards told us the pain team were aware of patients who would require epidurals and patient-controlled analgesia machines prior to their surgery. The team provided support and advice to ward staff and patients regarding pain control and for patients with epidurals and patient-controlled analgesia. Out of hours and at weekends an anaesthetist provided this support.
- We saw pain scores recorded on the patients NEWS chart and staff told us they monitored these and provided patients with pain relief as and when required. During our time observing in the recovery area, we witnessed staff asking patients about their pain. For one

patient the member of staff went to get medical assistance to change their pain relief so they became pain free. Staff re-checked their pain score as part of the NEWS.

- A protocol was in place for pain management as part of the care pathway for day case patients, which included types of analgesia and dose range.
- The 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.
- A specialist pain score tool was used for patients with communication difficulties. For example, it had a number of faces showing facial expressions that patients were asked to pick to help identify their pain level.

Nutrition and hydration

- Patients had their nutrition and hydration needs assessed and monitored. The Malnutrition Universal Screening Tool (MUST) was used to monitor patients who were at risk of malnutrition. The tool (an accredited screening tool) screens patients from risks of malnutrition but also for obesity. Where patients were identified, as at risk, nutritional care plans were developed to encourage intake, a food chart was commenced, and there was involvement from a dietician. We saw in one patient record a referral to a dietician based on their clinical need and MUST score.
- Staff at the preadmission clinic told us there was guidance for patients about when they should be 'nil by mouth' from, depending on their operation time. It also mentioned patients should not have sweets or chewing gum. Patients were able to have water up to two hours prior to surgery. Information about fasting was also included on the trust's website.
- In recovery, we saw patients were assessed, monitored for nausea, and vomiting. On the medication administration records we saw anti-emetics were prescribed for patients. We spoke with anaesthetists who told us most patients were given anti-emetic medication whilst undergoing their operations to prevent any nausea and vomiting post operation. They said this was part of their protocol. We spoke with three patients whilst in recovery and all said they had no nausea or vomiting.

Patient outcomes

- Information about the outcomes of patients care and treatment were routinely collected and monitored. In the 2015 bowel cancer audit, overall performance was better than the England average. However, 67% of trust patients undergoing a major resection had a post-operative length of stay greater than five days. This was worse than the national average but an improvement on the 2014 figure of 51%. Mortality rates were better or within the expected limits.
- In the 2016 Oesophago-Gastric Cancer National Audit (OGCNCA), the trust was within the expected limits compared to other trusts.
- In the 2016 Hip Fracture Audit for Cheltenham General Hospital, the risk-adjusted 30-day mortality rate was 8.8%, which falls within the expected range, and the 2015 figure was 8%. However, the proportion of patients having surgery on the day of or day after admission was 71.8%, which does not meet the national standard of 85% though this had shown improvement when compared with the 2015 figure of 55.6%. The perioperative surgical assessment rate was 89.7%, which does not meet the national standard of 100% and was worse than the 2015 figure of 93.3%. However, the proportion of patients not developing pressure ulcers was 99.1%, which falls in the top 25% of trusts.
- In the 2016 National Emergency Laparotomy Audit (NELA), the Cheltenham General hospital achieved a green (more than 80%) rating for the proportion of high-risk cases with a consultant surgeon and anaesthetist present in the theatre. They received an amber (50-69%) rating for the proportion of cases with pre-operative documentation of risk of death, for the proportion of cases with access to theatres within clinically appropriate time frames and for the proportion of highest-risk cases admitted to critical care post-operatively. The risk-adjusted 30-day mortality was within expectations. The trust had actions in place to address the shortfalls.
- In the 2015 National Vascular Registry (NVR) audit, the trust (vascular takes place at CGH only) achieved a risk-adjusted post-operative in-hospital mortality rate of 2.1% for Abdominal Aortic Aneurysms, indicating that the trust performed within expectations. Within Carotid Endarterectomy, the median time from symptom to surgery was 17 days, which was worse than the national standard of 14 days. The 30-day risk-adjusted mortality and stroke rate was within the expected range at 1.2%.

Surgery

- The hospital had mixed performance for Patient Reported Outcome Measures (PROMs) between April 2015 to March 2016. Patients reported their outcome following surgery for groin hernias, hip replacements, knee replacements, and varicose veins. The groin hernia and knee replacement indicators showed that overall the trusts performance was similar to the England average. The hip replacement and varicose vein indicators showed that fewer patients' reported an improvement in health after treatment and more patients' reported a worsening in health after treatment, compared to the England average.
- There had been an increase in surgical site infections in some procedures. At our last inspection, the surgical site infection (SSI) rate for Cheltenham General Hospital from October 2014 to December 2014 for total knee replacement surgery was 1.3% lower (better) than the five year England national average of 2.2%. The rate for hip replacements was 1.3% the same as the five year England national average of 1.3%. However, since then the trust had experienced an increase in SSI in hip replacements at both Gloucestershire and Cheltenham hospitals. The trust was identified by Public Health England as **'**high outliers' in 'inpatient/readmission' SSI at both hospitals for the period of July 2015 to August 2016. This was due to a particular rise identified in July to September 2015. The trust told us their current rate for most up to date quarter does not place them as outliers with Public Health England as improvements have been seen.
  - The latest figures we received from the trust for July 2016 to September 2016 for hip replacements for the trust as a whole showed an overall rate of 2% which was higher than then national average. However, Cheltenham General reported no surgical site infection rates during this period.
  - The latest figure for the trust for knee replacement surgery for July 2016 to September 2016 was 3.4%. (GRH 7.6%, CGH 0.8%). This was higher (worse) than the national average of 1.5%. This figure represents seven cases.
  - The latest data we had for reduction of long bone from January 2016 to March 2016 was 2.4% (GRH 2.1%, CGH 2.9%) which is higher (worse) than the national average of 1.5%**.** This figure represents four cases.
  - For fractured neck of femur for the period January 2016 to April 2016, the rate was 0.5% (GRH 0.8%, CGH 0%) which is lower (better) than the national average of 1.5%. This figure represents one case.
- The surgical division management team told us they had investigated the increase in surgical site infection rates but were not able to identify a specific cause. They were using 'Getting it right first time' (GIRFT) which had been adopted by the Department of Health. This guidance looks at solutions to reducing surgical site infection rates. An action plan had been devised to look at ways of reducing the risks to patients.
- Kemerton and Chedworth Suite were due to take part in an audit the week after our inspection to look at improving patients' hydration levels pre operation to help their post operation recovery. This was to take place across both hospitals.
- The standardised risk of readmission for elective surgery was better than the England average for all specialities except for vascular and urology which was worse than England average. For non-elective (emergency) surgery, all specialities performed better than England average.
- The formation of a Theatre Transformation Board was in progress to look at ways of improving theatre utilisation and session efficiency due to low usage figures For example between June 2016 to August 2016 these ranged across all theatres from 52% to 82%. Cancelled operations would have also had an impact on this.
- The trust had been identified as being a mortality outlier for Reduction of fracture of long bone (Upper/Lower limb)' procedures. The trust had reviewed all deaths between 1 February 2015 and 31 January 2016 to find out why there was an increase in mortality between these dates. Eighteen of the 26 of these patients who died were identified as hip fracture patients. This review identified areas of good practice and areas where improvement was needed. The findings were incorporated into an action plan that also covered the outlier for fractured neck of femur. At our last inspection, the surgical divisional management team told us the trust had commissioned an independent review by the Royal College of Surgeons, as their own investigations had not been able to identify the reason for the increase in mortality rates. This review took place in April 2015. Findings were incorporated into an action plan which we followed up. Changes to the location of the ward had been made and patients were now on ward 2a at Gloucestershire Royal Hospital. Environmental changes

had been made to aid recovery, for example, larger toilet areas and space for storing equipment so it was not in the way when patients were mobilising. We spoke with the advanced nurse practitioner who was appointed to support junior doctors. A practice educator was also in place on this ward focussing on the deteriorating patient. An updated hip fracture admission proforma was also implemented. This contained a management protocol for all staff to follow and included the emergency department as well as surgery wards. It included for example, pain management, nutrition, pressure ulcers and mentioned the possibilities of post operation delirium. A further review by The British Orthopaedic Association had taken place in November 2016 as the trust had agreed to take part in the Health Foundation sponsored (HIP QIP) quality improvement programme. This project involves replicating the learning from other trusts to improve outcomes for patients from trusts who were struggling to provide safe, high quality hip fracture care to patients. The sites were selected based on poor outcomes in the National Hip Fracture Database annual report. The project aims to help these trusts to provide hip fracture care of the highest quality, ensure recent evidence and national standards are systematically implemented, and provide improved patient experience. The report was in draft form during our inspection and therefore we were not able to use information from it. However, it focused on their achievements and areas for improvement.

Competent staff

- Staff had access to training to improve their skills and knowledge. Staff in theatres told us they had competency assessments in place they had to meet. These varied depending on their role and grade. The majority of staff were evaluated for their competence. In recovery, for example, staff followed the guidelines of the Royal College of Anaesthetists. Standard sets of competencies for nurses and operating department practitioners (ODPs) were in place to enable staff to demonstrate competency to the Association for Perioperative Practices and to enhance skills and knowledge within operating departments, associated areas and sterile services departments.
- The surgical division was below the trust target of 90% of appraisals completed for all staff groups, allied health care professionals, health care assistants, medical and dental, nursing and others to include clerical staff. These ranged from 67% to 83%. New staff were required to work a period of supernumerary time on wards, units and theatres/recovery. There was a set period of time, which could be extended based on the needs of the member of staff. They were also required to complete competency tests to assess their skill base.
- On Alstone ward (elective orthopaedics), 60% of registered nurses had completed a post registration qualification in orthopaedic nursing. This meant they had updated specialist skills and knowledge in meeting the needs of their patients.
- Staff on the urology wards confirmed they had all had annual appraisals and had a set of competencies in place. Staff spoke positively about the quality of clinical supervision they received.
- The wards, units and theatres/recovery had link nurses for specific areas, for example pressure ulcers and dementia. These staff could then share their additional knowledge with other staff.
- Medical staff were evaluated for their competence. Medical staff took part in the revalidation programme. This is a General Medical Council requirement for all UK licenced doctors to demonstrate they are up to date and fit to practise. This is tested by doctors participating in a robust annual appraisal leading to revalidation by the GMC every five years.Appraisals of medical staff were carried out each year and they were below the trust target of 90% at 75%
- The anaesthetic team were providing some in-house training to pre assessment staff. For example, they had created an anaemia pack for patients requiring hip replacement, including pre-operative advice to take iron supplements, therefore reducing the risk of a blood transfusion. This had been rolled out after training to staff.
- Staff in the pre-assessment clinic told us they felt the trust did not invest in staff training beyond mandatory training. One nurse told us they had paid for a course on pre assessment, though they had been given time off to complete the course. Most staff told us training was provided 'on the job'.
- Each ward and unit had designated link nurses for a number of areas for example, equipment and dementia. This meant they could provide additional advice, training and support to their colleagues about these areas.
- Staff on the wards and theatres told us they did not have training specifically about mental illness but most had

completed the dementia and learning disability awareness e- learning training. Figures provided by the trust showed that 72% of nurses had completed dementia awareness level one; 86% had completed level two dementia awareness training and 92% in learning disability.
- There was a process in place for identifying and managing poor or variable staff performance. Senior staff described support to improve practice and offered additional training to meet staff needs.

Multidisciplinary working

- All necessary staff, including those in different teams and services, were involved in the assessing, planning and delivery of patients care and treatment. In theatres, they had daily teams meetings for each theatre and then these fed into the daily multidisciplinary operational meetings, which also took place each morning. Representatives included a member of staff from each theatre, theatre management, staff from the day unit, the surgical admissions suite and Central Sterile Stores Department (they were responsible for supplying and cleaning of theatre kits). Staff were able to discuss any issues they might have that day with for example, staffing, equipment etc. so others were aware and resolutions could be found.
- Staff on the urology wards gave good examples of multidisciplinary team working through use of clinical audits, and clinical governance.
- We observed multidisciplinary teamwork in theatre in relation to the use of the World Health Organisation surgical safety checklist. Each member of the team had a recognised role and took part as required.
- We observed physiotherapists and occupational therapists working with patients on the wards and day surgery unit and they liaised with the nursing staff and medical teams who were involved in the patients care.
- To assist the staff on the surgery wards a discharge liaison team was available for patients who had complex needs and required detailed planning before they could be discharged. They provided support for the ward staff, for example, they would liaise with external professionals, including care homes. We observed this team on the surgery wards during our inspection.

Seven-day services

- The hospital provided emergency surgery services mostly around the clock. There was a designated emergency theatre and team on site but only for 20 hours a day with surgeons and support staff on call the remaining four hours. This theatre was available for any surgical speciality. There was system in place for booking patients onto the emergency list which was overseen by a senior member of staff in theatre. The lack of a 24-hour emergency theatre had been recognised by the trust and was on their risk register as a high risk and a control was in place for additional night staff to provide the on call cover. However, the potential risk to patient requiring emergency surgery remained.
- The hospital sterilisation and decontamination services (CSSD) also operated seven days a week to make sure all equipment needed was available.
- Some surgical patients were reviewed daily by a consultant, including weekends. However, consultants did not routinely review elective orthopaedic patients at weekends.
- There was no out-of-hours cover for occupational therapy (OT). However, on the elective orthopaedic ward there was OT support on a Saturday morning as part of the care pathway.
- For physiotherapists, a criterion was in place for weekend visits. This included for elective orthopaedic ward patients, new patients and patients needing to be discharged. A physiotherapist was also on call at nights.
- The dedicated pain team did not work weekends. The on-call anaesthetist provided any support required.
- Dieticians did not provide an out-of-hours, on-call or weekend service. As a result, patients admitted over the weekend in need of dietetic referral had to wait until Monday to be seen
- Staff told us they had access to an out-of-hours pharmacy and imaging. The pharmacy was open at weekends for set hours and a pharmacist was available on call outside of these times.
- We saw the out-of-hours rota for surgery for each specialty. It included junior doctors, registrars and consultants. A consultant was on call at all times for each of the specialties, alongside a registrar and junior doctors.

Access to information

- Information needed to deliver effective care and treatment was not always available for relevant staff in a timely and accessible way. Staff we spoke to at all levels told us of their frustration with the new online theatre

system introduce as part of the upgrade to the patient administration system prior to our inspection. We were shown examples where the procedures that patients were due to have in theatre was not identified in the information provide at the start of the day to theatre staff. Administrative staff were entering this information into the 'comments box' and staff raised concerns that this was a risk as there was an increased risk of wrong site surgery. The expected length of time for the procedure was arbitrary. Theatre lists no longer showed who the attending anaesthetist would be, and the surgeons name was not always accurate. Staff also told us that they were concerned that there was a risk that patients could be missed as the reporting was inaccurate. Theatre managers told us of concerns they had that patients cancelled from theatre lists could be lost from the system. They also told us that theatre scheduling staff were spending on average an extra 30 hours per month to produce theatre lists. Staff also described being unable to get usable reports from the system, such as efficiency target data. Staff we spoke to at all levels told us of their frustration with the new online theatre system introduce as part of the upgrade to the patient administration system in November 2016.

- Staff in the pre-assessment unit told us the training for the new system was generic and not relevant to their role. They expressed concerns about the flow of information and that this had impacted on clinical staff who spent more time using the system. Staff on Eyeford ward also reported issues with the new computer system, for example, urgent and emergency patients were not being automatically entered into the system, which had an impact on their follow up appointments. Staff told us they had work arounds in place to address this. The trust was working hard to address the issues identified by staff.
- When patients were transferred between wards, departments and units all their nursing and medical records were transferred with them. Staff also provided a verbal handover as well as the written records.
- We observed a handover between a recovery nurse and a ward nurse. Important information was given to the ward nurse about the patient and documentation was completed.
- When a patient was discharged to other services, for example, into the care of community nurses, practice nurses and care homes they completed a letter that included details of the patient's needs and what support and treatment was needed.
- We spoke with two junior doctors who told us they completed GP summaries to be sent out. They were unsure what happened to the summary in the computer system once they had completed their section. During our unannounced inspection one ward told us they were having problems with the new computer system and sending out of GP summaries, (they were sent electronically) however they were able to rectify this. On the day surgery unit, not all staff having the correct access to the new computer system As a result, they also experienced issues with sending out GP summaries. This posed a risk to patients as a delay in GP's receiving this information could have an impact on their continued care.
- However, there was good access to intranet-based guidance, policies and protocols. The trust intranet was open and available to all authorised staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the relevant consent and decision making requirements of legislation and guidance. Patients we met said they had been asked to provide consent both verbally and by signing a consent form. The nurses in the clinic or nurse specialists told patients who attended the pre admission clinic about the operation. On the day of their operation, the consultant and anaesthetist saw patients prior to their operation. Patients told us they had been told all the risks and benefits of the operation/procedure and were able to discuss what impact the procedure would have on their wellbeing.
- Staff told us they had 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 were appropriate forms according to the patients' needs were completed in full and had been signed by the doctor and patient. Forms included details about the procedure/operation and any possible risks or side effects.
- Staff on the wards understood about best interest decisions and where these needed to be recorded. At the last inspection, we found a best interest decision

had not been recorded in the patients' notes. We did not witness this at this inspection as all of the patient notes we examined referred to patients who had the capacity to make their own decisions.

- Staff said they knew how to make a Deprivation of Liberty (DOLs) application if it was required and they could access support from a social worker if required when completing DOLS applications. There were no patients on the surgery wards who were under a DOL's during our inspection.
- The trust reported that as of October 2016, Mental Capacity Act (MCA) training had been completed by 90.4% of all staff in within surgery. Deprivation of Liberty training had been completed by 90.3% of all staff. The completion rate for both modules met the trust target of 90%.

Are surgery services caring?

Are surgery services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Due to pressure for beds and the demand on services, some patients had to use facilities and premises that were not always appropriate for inpatients.
- Elective operations were being cancelled due to the pressure on the beds within the trust and medical patients were being cared for on surgical wards to meet the demand.
- Not all patients had their operations re-booked within the 28-day timescale.
- Six patients had been waiting over 52 weeks for treatment, which is not acceptable.
- The average length of stay for both elective and non-elective (emergency) patients was above (worse) than the England average.

However:

- The trust's referral to treatment time (RTT) for admitted pathways for surgical services between January 2016 and November 2016 has been about the same as the England overall performance.
- Staff in theatres and recovery had guidance in place to help reduce the anxiety of patients living with dementia when they using their services.

Service planning and delivery to meet the needs of local people

- Services were planned and delivered to meet the needs of local people and the demands of the service. The surgical division management team told us they had plans to review how surgery services functioned across both hospital sites. A number of surgical specialities had been reconfigured to one of the hospitals, for example, ear, nose and throat surgery was based at Gloucester Royal Hospital and ophthalmology was carried out at Cheltenham General Hospital where vascular services were also situated.
- The trust had witnessed an increase of surgery admissions of over 1000 patients in a year since our last inspection in March 2015, which had affected their services. Plans were in place to improve the elective surgery pathway with the aim to improve patients experience and outcomes. This included, looking at staggered admissions times so patients would not wait for long periods before surgery and a one-stop clinic and pre operation assessment. This work was ongoing during our inspection and changes to practice had yet to be implemented.

Access and flow

- Between January 2016 and November 2016, the trust's referral to treatment time (RTT) for admitted pathways for surgical services has been about the same as the England overall performance. The latest figures for November 2016 showed 72% of this group of patients were treated within 18 weeks versus the England average of 71%.Ophthalmology, ENT and general surgery were above (better than) the England average for admitted referral to treatment times whilst urology and oral surgery were below (worse than) the England average.
- There were 1,172 cancelled operations for the period October 2015 to September 2016, of which 7.8% (91) were not re-booked for surgery within 28 days. A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, they are recorded

as having breached the standard. As a result, the patient should be offered treatment at the time and hospital of their choice. Cancelled operations as a percentage of elective admissions for the period October 2014 to September 2016 at the trust were greater (worse) than the England average. The number of operations where patients were cancelled more than once between January 2016 and November 2016 was 778, with February 2016 being the most at 108.

- The trust told us they had seven patients who had waited over 52 weeks for treatment. One patient has since declined treatment until May and the others were all reviewed in February 2017.
- From April 2015 to September 2016, the trust's bed occupancy has been consistently higher than the England average by between 2 and 8%. This put extra pressure on their services and beds.
- Between April 2015 and March 2016, the average length of stay for surgical elective patients at the trust was 3.3 days, compared to 3.3 days for the England average. For surgical non-elective (emergency) patients, the average length of stay was 5.0 days, compared to 5.1 for the England average.
- At Cheltenham General Hospital, the average length of stay for elective patients was 3.9 days, which was higher (worse) than the England average, and 5.3 for non-elective (emergency) patients, again, higher (worse) than the England average. Elective vascular surgery had the highest average length of stay at 5.2 days for elective versus the England average of 4.5 days.
- Each speciality was responsible for devising theatre lists. The staff we spoke with told us they had been doing this job for a long time and as a result were aware of how long operations took. Patients were added to the waiting list by the clinicians and they were assessed to see if the operations were urgent. Staff liked to have lists compiled well in advance so they could be sent to theatres to make sure equipment was ordered and staffing in place. However, with the new computer system this process was taking longer so operation lists were not compiled so far in advance. There was no reports of any issues for patients
- At our previous inspection in March 2015, Kemerton and Chedworth Suite day surgery units had been opened at night and weekends due to bed pressures. At this inspection senior staff told us they no longer monitored when they were being used as an escalation area, and both had been closed at Christmas and for over week prior to our inspection. They told us the changes they had made since our inspection. They met twice daily with senior staff responsible for the management of the beds and recovery to review all patients within their departments. They discussed any emergency surgery patients they may be able to take from the emergency department to free up their beds whilst a decision was made about their treatment plan. This helped to improve access and flow throughout the surgery department.
- Staff within the pre-assessment clinic expressed concerns about the administrative support for the unit. We were told that patients were often booked into appointments after they had received a date for their operation, but as the pre-assessment had not been completed patients may not be confirmed as well enough for their operation.
- Staff on the urology ward expressed concerns about medical outliers on their wards. We saw evidence that on one 22 bedded ward there were between four and seven medical outliers on there every day during November 2016. This issue had been highlighted to executives on a visit, but the situation was now normalised, with medical patients waiting for discharge and packages of care. Staff told us they could not remember when the ward had been used solely for surgical patients and this had an impact on staff morale and vacancy levels. Staff felt the 'right patient in the right place' was not maintained.

Meeting people's individual needs

- Services were planned to take account of the needs of different people. For example, staff had access to translation services, both in person and by the telephone. A member of staff told us about a patient who had surgery during our inspection who had an interrupter with them.
- A learning disability liaison team supported staff to care for and support patients with complex needs and their carers during their stay in hospital. Carers were able to stay with them and join them in recovery following their operation.
- Patients living with dementia were identified by the 'purple butterfly scheme', which indicated to staff they needed more support. Staff in theatres and recovery had devised guidance for staff to follow. For example, in

recovery, patients were to be admitted into the quiet and calm bays and overhead lighting was kept to a minimum. The patient's family member or carer was also able to be with them in recovery if needed.

- Staff in recovery also had access to 'twiddle- mitts' for patients living with dementia. Twiddle mitts are basic knitted hand muffs with items attached such as large buttons or knitted flowers, which a patient can 'twiddle' in their hands. These were used to reduce patients stress when they were faced with a situation that was unknown to them.
- Staff in the pre-assessment unit could explain how to support patients with complex needs, for example those living with dementia or with a learning disability. Staff told us they would use the 'This is me' hospital passport (contains personal information about how to meet the needs of the patients) to get to know the patient they were caring for and to understand more about how best to support them.
- Staff on Guiting ward were able to tell us how they had cared for and supported a patient with a learning disability. The patient came into the hospital with their hospital passport, which contained personalised information about them and how to meet their needs. The staff were able to communicate with this patient using pictures. Staff from the learning disability liaison team visited the patient and staff to provide support and advice. The patient also had support from their care home each day.
- We spoke with a patient on one of the wards who was using a wheelchair. They told us the ward they were on had wide corridors to enable them get around and the toilets were also large and had handrails in place to assist them.
- Staff told us they had no issues with obtaining food out of hours for patients, for example, they could provide lunch boxes. However, the feedback we received from two patients prior to our inspection was about lack of food provision out of hours.
- When Kemerton and Chedworth Suite day surgery units were being used overnight and at weekends staff told us they had no domestic support to provide patients with refreshments, for example to clean and replace their water jugs. This was left to the staff on the unit but if they were busy, it was often missed or delayed, but patients were not left without access to drinks. A senior member of trust staff told us the unit was able to arrange this but it was clear from talking to staff on the unit they were not aware they did this.

Learning from complaints and concerns

- Patients we spoke with knew how to make a complaint or raise concerns and they were confident to speak up. The majority were happy with the care they had received and did not feel they needed to make a complaint. Patients told us that if they wanted to make a complaint they would speak with a member of the nursing staff. The trust's complaints and comments procedure was displayed on noticeboards around some of the surgery wards, departments and units.
- Patients' concerns and complaints were used to help improve the quality of care. Complaints were discussed at ward and divisional level. Staff told us learning from any complaints was shared with staff.
- We spoke with a senior member of staff on Alstone ward who told us they were involved in the management of complaints. They said they had four complaints in 2016 where required action plans had been devised. Staff had to sign to state they had read these so they were able to ensure all staff were aware of changes to practice following complaints.
- From November 2015 to October 2016, there were 108 complaints about surgical care. The trust took an average of 39 working days to investigate and close complaints, which was not in line with their complaints policy, which states complaints should be responded to in 35 working days. The trust's internal standard states 95% of cases should be responded to within 35 working days.
- Patient care was the most complained about theme with 30 complaints, followed by clinical treatment with 16 complaints. The profession 'nursing' received 51 complaints.
- Cheltenham General Hospital surgical division received 35 complaints, of which patient care received the highest number of complaints at 10 (29%). In contrast Cheltenham General Hospital as a whole received 258 complaints, of which patient care received the highest number of complaints; 47 (18%).

Are surgery services well-led?

End of life care

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

Information about the service

End of life care includes all care given to patients who are approaching the end of their life and following death. This may be provided on any ward or within any service in the trust and is provided by a range of staff. It includes essential nursing care, specialist palliative care, and bereavement support and mortuary services.

The trust's specialist services for end of life care are provided through two teams who were managed through a divisional structure that covers both of the hospitals within the trust. Some staff work at both sites of Gloucestershire Royal Hospital and Cheltenham General Hospital. End of life care follows trust policy at both sites so similarities between the content of the two end of life care location reports occurs in both hospital location reports.

The in-patient team deliver a face to face service from 9am to 5pm, Monday to Friday. There is an out-of-hours telephone advice line available 24/7 for health care professionals.

The two end of life teams provide support and advice for any adult patients throughout the hospital or at the request of clinical staff identified with complex care and/or complex symptom management. Support is also provided to relatives of end of life patients. The in-patient and community teams provide care for patients discharged from both hospitals.

The teams work with two full time doctors one a consultant in palliative medicine and the other a specialty doctor in palliative medicine. Both teams work with a psychologist

The team that provides specialist palliative care for in-patients for the trust is provided by five advanced nurse practitioners and four clinical nurse specialists. Two of the five advanced nurse practitioners are based at Cheltenham General Hospital with one working across both sites.

This was a focused announced follow up inspection. Following the previous inspection in March 2015 end of life services for the trust had been rated as requires improvement for safe, effective and for well-led. The trust had been rated as good for caring and responsive.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed toour aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

End of life care

Summary of findings

We rated this service as Good because:

- End of life care provided at Cheltenham General Hospital was safe, effective caring, responsive and well led because:
- The processes in place to keep people safe for end of life care were good. Staff in the end of life care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong.
- Patient's records demonstrated that nutrition and hydration needs were assessed and appropriate actions were documented as followed in patients' individual care plans.
- Records documented discussions with relatives around what to expect with the dying process.
- Risks to patient's receiving care at end of life were assessed by ward staff with appropriate assessments recorded in medical records for example the prevention and management of pressure ulcers and falls.
- Staff we spoke with on the wards understood that end of life care could cover an extended period for example in the last year of life and also applied to patients with non-cancer diagnoses such as dementia. Staff, teams and services worked together to deliver effective care and treatment.
- Staff we observed on wards delivering end of life care to patients were compliant with key trust policies such as infection control.
- Arrangements in place for managing medicines kept patients safe. Medicines to relieve pain and other symptoms 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.
- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The staffing levels and skill mix of the nurse and medical personnel in the end of life care team were planned and reviewed and supported safe practice. We saw evidence of a yearly education programme of end of life care for medical, nursing and allied health professionals. This included: resuscitation, syringe driver training, quarterly end of life study days and symptom management.
- The end of life care teams responded promptly to referrals, usually within one working day.
- Patients were treated with kindness, dignity, respect and compassion. Staff took the time to interact with people who received end of life care and those close to them in a respectful and considerate manner.
- We saw many written compliments about how caring staff were in the inpatient end of life care teams. We saw that patients' and those people close to them, were involved as partners in their care.
- The end of life care team and wards staff understood the impact a patients' care, treatment or condition had on their wellbeing and on those people close to them.
- Emotional support for patients and relatives was available through the in-patient and community end of life care team, the chaplaincy team and bereavement services. Staff had access to support through their own teams when needed.
- Services were delivered and additional services planned in order to effectively meet patient's needs. Plans and actions included audit to inform future planning so that the end of life team could inform better decision making with patients they cared for.
- There was a clear vision and strategy to deliver care at end of life. The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- Leadership encouraged openness and transparency and promoted good quality care. There were leads on the wards who supported the development and delivery of high quality end of life care.
- Services within specialist palliative and end oflife carehad been continuously improved and sustainability supported since the last inspection March 2015.

However:

- Documenting 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNACPR) decisions had improved since the last inspection however concerns regarding

End of life care

DNACPR remained. For example not all DNACPR having relevant clinical information and not all patients or those close to them being recorded as involved in discussions about resuscitation. These concerns were not identified as a risk and did not feature on a risk register
- There were no centrally held training records for syringe driver training or competency for ward staff.
- There was not a full understanding of performance for all aspects of end of life care. For example the percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not known for all wards or hospital sites.
- There was no risk register specific to end of life care for the trust so oversight of all end of life risk was not easy.
- When we reviewed maintenance records some provided were out of date. The trust told us they were clear that equipment listed was not in use. We saw email communication from directors supporting this.
- There was not a seven day face to face service provided by the in-patient end of life care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals to access.
- Some of the 'white rose' symbols used to locate the mortuary at the hospital were not easy to follow. Signs were not always at eye level for someone walking or in a wheelchair and there were long gaps in signage that led to confusion. Mortuary and bereavement officers told us relatives had commented they were useful. Some relatives had reported they appreciated these signs. However bereavement office staff accompanied relatives when they knew people were attending the mortuary.

Are end of life care services safe?

Good

Overall we have rated safe as good because:

- There were processes in place to keep people safe whilst in receipt of end of life care. Staff in the end of life care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong
- During the inspection we visited three wards where patients were receiving care in their last year of life. Compliance with relevant trust policies was good.
- The maintenance of equipment was compliant with policy and promoted safe patient care.
- Arrangements for managing medicines kept patients safe. Guidance for staff on end of life medicines was included as part of patients' care plans which supported the management of a range of end of life symptoms.
- Potential risks to patients were assessed by ward staff. Identified patient safety risks were monitored and maintained. We saw risk assessments in medical records including early warning scores to identify patients becoming more unwell. Notes also contained skin integrity assessments for the prevention and management of pressure ulcers.
- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- The staffing levels and skill mix of the nursing, medical and other staff in the specialist palliative care team were planned and reviewed which supported safe practice. The nursing complement was complete for inpatient end of life care teams.

However:

- The completion of six do not attempt cardio pulmonary resuscitation (DNACPR) forms we reviewed were of variable quality.
- There were no centrally held training records for syringe driver training or competency for ward staff.
- Some maintenance records provided were out of date although trust directors provided us with assurance via email that the equipment was not in use.

End of life care

- The end of life team were unable to use the results of the safety thermometer specifically in relation to patients receiving end of life care as it was not possible to sort data for all patients who might be in their last year of life.
- There was a trust major incident and business continuity plan. However, the chaplaincy service, mortuary staff, bereavement officers and in-patient and community palliative care teams had not been involved in the major incident plan practice exercises.
- The mortuary was difficult to find and used a system of 'white rose' signs to assist location. Some of the signs were not easy to follow. Signs were not always at eye level for someone walking or in a wheelchair and there were long gaps in signage that led to confusion. Mortuary staff and bereavement officers told us relatives had commented they were useful but that bereaved relatives were accompanied to the mortuary for viewings as the signs were not always relied on.

Incidents

- There were processes in place to keep people safe whilst in receipt of end of life care. Staff in the end of life care team and other areas understood their responsibilities to raise concerns, record safety incidents and report them. Lessons were learned and improvements were made when things went wrong For example: learning from incidents August to October 2016 was incorporated in a recent end of life care presentation which included learning related to medications for patients to take home and improvements in ward care for patients transferred to the mortuary.
- The specialist palliative care team discussed relevant incidents and planned actions during regular meetings. Actions taken were recorded when they had been completed. Information and actions were shared during staff one to one meetings or via email updates. Staff said this ensured feedback and learning was shared and understood by the whole team. Issues were escalated when required to the quality and performance committee.
- Between December 2015 and November 2016, there were no incidents for end of life care reported which were classified as Never Events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. During this same period there were also no serious incidents reported for end of life care. Between November 2015 and October 2016 the trust reported 82 incidents related to end of life care. The two incident categories most commonly reported were medicines not ready for discharge 13 (16%) and pressure ulcers 11 (13%). The trust also reported 28 mortuary incidents from 24 January 2016 to 11 August 2016. Most mortuary incidents were related to not following care of the dying policy. There had been 12 (14.6%) incidents at Cheltenham General Hospital. Actions had been taken to reduce the risk of such incidents reoccurring.

Safety thermometer

- There was no palliative or end of life care ward at the hospital. We visited three wards at Cheltenham General Hospital where patients were receiving care in their last year of life. All wards reported to the national patient safety thermometer. This was used to record the prevalence of patient harm and to monitor ward performance in delivering harm free care for wards where patients were receiving end of life care. Measurement on the wards was intended to focus attention on patient harm and prevention.
- Data collection took place one day each month. Data from the Patient Safety Thermometer showed that the trust reported 123 pressure ulcers, 67 falls with harm and 67 urinary tract infections associated with urinary catheter use between November 2015 and November 2016.
- Results showed a reduction in pressure ulcer prevalence and a decrease in falls.

Cleanliness, infection control and hygiene

- Staff were observed following trust policies. For example, staff were bare below the elbows, used antibacterial hand gel between patient care, wore personal protective equipment and disposed of waste correctly. This ensured that patients receiving end of life care who could be more susceptible to infection were cared for as safely as possible.
- Processes were followed by most staff which ensured that after death the health and safety of everyone that came into contact with the deceased patient's body was protected. However, mortuary staff had recorded and reported occurrences where 'last offices' or the care of

the deceased policy had not been fully followed. This included four instances where an infection risk or last offices policy had not been followed. Actions had been taken to reinforce use of policy. For example reinforcing 'care of the dying policy'.

- Whilst the trust monitored the number of cases of methicillin resistant staphylococcus aureus (MRSA) and Clostridium difficile (C'Diff) and methicillin-sensitive staphylococcus aureus (MSSA) the number of cases attributed to end of life patients could not be identified.

Environment and equipment

- Processes were followed to safely maintain equipment. For example all syringe driver pumps in use were maintained and used in accordance with manufactures recommendation.
- There were adequate numbers of syringe drivers available to meet patient's needs. There were no incidents raised about shortage of syringe drivers.
- The trust used one brand of syringe driver across all wards. This reduced the likelihood of confusion or error by staff, particularly temporary (bank or agency) staff.
- We reviewed the maintenance records for syringe drivers. 17 out of 110 recorded syringe drivers maintenance records provided were out of date. We notified the trust who said that the units showing as out of date were not being used. An alert had already been raised by the medical engineering department. The alert was escalated to the district nursing leads across the county and also the nursing home support team to reinforce servicing of syringe drivers. The alert reinforced the system that supported safe management. All syringe drivers were managed by the medical equipment libraries. Staff removed any syringe driver from use if it was identified as near to or past its service due date.
- The mortuary was difficult to find. The trust had implemented a system of 'white rose' symbols to assist location, however some of the signs were not easy to follow. Signs were not always at eye level for someone walking or in a wheelchair and there were long gaps in signage that led to difficulty in locating the mortuary. When we spoke with mortuary staff and bereavement officers we were told that relatives had commented the signs were useful, however they were accompanied to the mortuary for viewings by staff so the signs were not relied on.
- The mortuary viewing area was visibly tidy and appropriately located and furnished. The bereavement office was easily accessible.
- The chapel, the department of spiritual support, chaplain's office and multi-faith rooms were all easily accessible, visibly clean and tidy.
- The multi faith room at Cheltenham General Hospital was contained within the original chapel. The chapel was able to be converted for use as multi-faith rooms however the ablution area was located some distance away in toilets.

Medicines

- Processes were followed to safely manage medicines. 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.
- Staff on wards said they kept stocks of commonly used end of life medicines so they were available for prompt use. Records we reviewed showed that patients had medication provided when needed.
- In the records we reviewed we saw that patient's needs were met with anticipatory medication being prescribed appropriately. Anticipatory medications are medications prescribed 'just in case' or for when symptoms known to occur at end of life are predicted to occur. There was an anticipatory prescribing medication chart available for use and linked to the trust's shared care record for the expected last days of life. We saw this was used. The medicine chart was prepopulated with four of the most common symptom, and pain-relieving medicines, with guidance for dose and frequency.
- We reviewed four sets of prescribing information at Cheltenham General Hospital from three wards, Rendcomb, Avening and Lilleybrook ward. All records had been completed appropriately.

Records

- Most of the individual care records were written and managed in a way that kept patient's safe. The types of records we reviewed included, 'patients notes' containing all relevant recording and documentation, prescribing information , unwell patient forms or treatment escalation plans that describe what treatments have been agreed when a patient is worsening and 'do not attempt cardio pulmonary resuscitation' forms.

End of life care

- We reviewed 23 sets of notes of patients who had received end of life care. This included a review of four medication prescribing records and six do not attempt cardio pulmonary resuscitation (DNACPR) forms.
- We saw that discussions between clinical staff and patients and relatives were recorded legibly and sensitively.
- Patients' records included advance care planning and detailed conversations. These included explicit records of what patients and relatives understood or wanted to be informed of, their concerns and wishes. Actions for staff to take in accordance with these wishes and advice for ward staff were clearly documented and reviewed by the in-patient specialist palliative care team.
- All clinical staff we spoke with were familiar with the trust's shared care record for the expected last days of life. The shared care record included risk assessments of patients' nutrition, mobility and pressure area care. This document had been 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 and space to record what had been done
- However, we found variable quality of completion of do not attempt cardio pulmonary resuscitation (DNACPR) forms. We looked at six and identified:
  - There was a clearly documented decision with reasoning & clinical information in four out of six records (66%).
  - Records also showed that the patient was not always involved in discussions in four out of 6 records (66%).
  - Discussions or the reasons why decisions had not been discussed had not been recorded on the DNACPR form. Nor had this been recorded in each patient's health record with sufficient detail in in one of the two records (50%).
- However, completion of DNACPR had improved from the last inspection in March 2015. We saw results from the last two audits completed in both hospitals undertaken following this. These showed an improvement in compliance with policy from between 46% and 64% compliance for the first audit. The trust achieved 75% compliance in December 2016.

Safeguarding

- There were reliable systems, processes and practices in place to keep patients safe and safeguarded from abuse. The specialist palliative care team and ward staff we spoke with were knowledgeable regarding processes to follow if they had any vulnerable adult or children's safeguarding concerns. Staff were able to explain what signs 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 had in date mandatory safeguarding vulnerable adults and safeguarding children training.
- The trust had set a target for all staff of 90% for completion of adult and children's safeguarding training. The trust had met its target for medical staff for all four safeguarding modules at October 2016. Records showed that between 93.2% and 90.1% of medical staff had completed safeguarding training.
- The trust had met its target for nursing staff safeguarding training for all but one of the four safeguarding modules. Records showed that between 94.4% and 93.8% of nursing staff had completed safeguarding training. Level two safeguarding children fell just short at 89.8%

Mandatory training

- The trust had set a target for all mandatory training of 90%. The specialist palliative care team, nurses and doctors were not compliant with the trust target of 90%.
- The specialist palliative care team, nurses and doctors were not fully compliant with all of these, however there were now plans in place to address this shortfall now the team were at full establishment. Areas of compliance included Safety Awareness, Equality and Diversity Awareness, Basic Adult Resuscitation, Information Governance, Manual Handling Practical and Conflict Resolution.
- However the team fell short of this target in Blood Transfusion (85%), Code of Conduct (88%), Fire (88%), Infection Control (88%), Manual Handling Theory (85%), Medicines Management (82%) and Prescribing (75%).

Assessing and responding to patient risk

- Risks to patient's receiving care at end of life were assessed by ward staff, and their safety was monitored and maintained.
- We reviewed 23 sets of patient records and saw risk assessments for nutrition, mobility including falls and

pressure area care had been completed and risk management plans had been developed. For example we saw patient's mouth care had been assessed and actions put in place. In addition, medication had been regularly reviewed in response to increased risks and changes recorded.

- Staff identified and responded appropriately to changing risks to patients who used services, including deteriorating health and wellbeing. They used the national early warning score (NEWS) to identify the deteriorating patient and responded with increased treatment when appropriate.

Nursing staffing

- The staffing levels and skill mix of the nurses and other staff in the specialist palliative care team were reviewed and planned to support safe practice. The trust had an in-patient and a community specialist palliative care team. The nursing complement was complete for both inpatient and community teams and no bank or agency staff had been used in the past year.
- Following recent investment the nurse team for the inpatient specialist palliative care team was provided by
  - Five advanced nurse practitioners (band seven) and four clinical nurse specialists (band six). Two advanced nurse practitioners were based at Cheltenham General Hospital with one working across both of the trust hospital sites. Two clinical nurse specialists also worked with the advanced nurse practitioners at the hospital.
  - The team that provided care for community patients discharged from Cheltenham General Hospital was based at Gloucester Royal Hospital with additional work bases at three hospices in the area. There were;
    - Three advanced nurse practitioners (band seven) and twelve clinical nurse specialists (band six).

Medical staffing

- The staffing levels and skill mix of the medical staff in the specialist palliative care team were planned and reviewed to meet patient needs. They did not use agency or locum staff.
- The trust employed one consultant in palliative medicine full time. They covered both hospitals and worked with another full time specialty doctor in palliative medicine. A community consultant in palliative care was due to start 6 February 2017 which was a newly created post of 32 hours over four days (0.8WTE).
- Out of Hours cover was provided via telephone from trust and hospice consultants (weekend and nights)

Other staff

- A social worker and an occupational therapist were part of the multidisciplinary team employed by the trust and worked with the specialist palliative care team.
- Chaplains were appointed by the trust to provide spiritual, pastoral and religious care to the whole hospital whether a patient, a carer, or a member of staff.
- There were 141 chaplaincy volunteers that provided support across the trust in total (93 chaplaincy and 48 Roman Catholic chaplaincy). All volunteers including chaplaincy volunteers were Disclosure and Barring Service compliant and checked. All volunteers had completed a course to ensure they were competent to attend wards and support patients with spiritual and emotional issues.
- The chaplaincy volunteer service had received 12 long service awards in 2016.

Major incident awareness and training

- There was a trust major incident and business continuity plan. However the department for spiritual support, mortuary staff, bereavement officers or in-patient and community specialist palliative care team for the trust had not been involved in a major incident plan practice or exercise.
- However, staff we spoke with were aware of major incident prompt cards to assist with processes and the trusts policy. When we visited the chaplain's office, we saw major incident cards were visible on the walls.
- Risks to the provision of care was anticipated and planned for in advance. The arrangements for the response to emergencies and major incidents by mortuary staff included the ability to transfer temporary mortuary storage between the two hospital sites.

Are end of life care services effective?

Good

We rated effective as good because:

End of life care

- Staff we spoke with understood that end of life care could cover an extended period for example in the last year of life or patients. They were also aware that patients benefited from early discussions and care planning and this extended to patient groups with non-cancer diagnoses such as dementia.
- The end of life care was delivered with the principles of the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's
- There was a 35 point action plan created in response to the trusts performance in the National Care of the Dying audit published March 2016. This included maintaining and where possible increasing education of non-specialist staff and repeating the national voices survey. Some actions had already been completed such as appointing a non-executive to the board to represent end of life, improved symptom control and documentation.
- Medicines to relieve pain and other symptoms 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.
- The patient's records we reviewed demonstrated that patient's nutrition and hydration needs were assessed and appropriate actions followed in patients' individual care plans. The records documented discussions with relatives around what to expect with the dying process.
- The specialist palliative care team had worked towards achieving improvements in patient outcomes and improvements were seen in the 2015/16 National Care of the Dying Audit.
- There was a yearly programme of end of life care education for some medical staff which covered symptom management, levels of care, diagnosing dying, resuscitation and communication skills. There was also some evidence of a programme of non-medical staff education for nursing and allied health professionals for example , covering resuscitation, syringe driver training, quarterly end of life study days and symptom management
- There was evidence of multidisciplinary working to deliver effective care and treatment.

However:

- Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.
- Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation attempts had been made were not always documented.
- There was no organisational oversight of staff competency with regards to syringe driver training as records were not held centrally.
- There was not a seven day face to face service provided by the in-patient specialist palliative care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- Whilst in some cases the possibility of dying had been recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, not all appropriate patients experienced this.
- Most local audit activity had yet to benefit from a thorough analysis of the data produced. Despite that the in-patient and community specialist palliative care team for the trust were acting on initial evidence from audit which supported national guidance and informed improvement projects such as improving discharge planning arrangements

Evidence-based care and treatment

- Patient's needs were assessed and care and treatment was delivered in line with legislation, standards and evidence-based guidance.
- National Institute of Health and Care Excellence guidance includes staff recognition of patients thought to be approaching the last year of life. We saw evidence that staff understanding of this had increased since our last inspection. We saw patients who might be approaching the last few days or hours of life receiving end of life care within the trust.

End of life care

- Staff we spoke with on the wards understood that end of life care could include patients with non-cancer diagnoses such as dementia. Staff understood patients could benefit from discussions about their care and wishes early on in the end of life care pathway.
- The in-patient and community palliative care team in conjunction with the end of life quality group were responsible for leading the development and setting standards of end of life care used. This was achieved through using evidence-based guidance, standards, best practice and legislation to develop how services, care and treatment were delivered.
- End of life care was delivered in line with the principles of the Priorities for Care of the Dying Person (Leadership Alliance for the Care of Dying Patient, date) For example the possibility of dying had been recognised and communicated clearly with the patient and those close to them. Decisions were documented and actions taken in accordance with the patients' needs and wishes. These were regularly reviewed.
- The needs of families and others identified as important to the dying person had been actively explored, respected and met as far as possible.
- Individual plans of care, which included food and drink, symptom control and psychological, social and spiritual support were in place, co-ordinated and delivered with compassion.
- The trust had participated in the National Care of the Dying audit published March 2016 and had created an action plan where improvement was identified as being needed. Some actions had already been completed such as appointing a non-executive to the board to represent end of life, improved symptom control documentation, the development of wards performance monitoring of for example number of patients receiving assessment of spiritual needs and the development of the end of life quality group.
- The trust had an annual audit plan for specialist palliative care and end of life care. However most local audit activity had not yet benefited from a thorough analysis of the data produced. Despite that, the specialist palliative care team had acted on the initial evidence from audit including improving discharge planning arrangements (which included a team member located on a ward to work with staff) and expanding advance care planning.
- We did not see any discrimination on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation. The trust supported patients with potentially life limiting conditions such as dementia and learning disability and employed two nurses to support patients with learning disabilities. We saw evidence that they worked with the specialist palliative care team when necessary.

Pain relief

- Medicines to relieve pain and other symptoms 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.
- If a patient was provided with a syringe driver and was subsequently discharged, the syringe driver was replaced by the district nurse team team, who returned the original syringe driver to the trust. This ensured that any patient's pain and symptoms were managed in a continuous and consistent way.
- 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.
- We saw patient records that showed how patients should take pain relief, likely effectiveness and what to do if there were side effects, plans for further follow-up, and how to get help out of hours.
- We reviewed four end of life patient's medicine records. All patients had appropriate pain relief prescribed including anticipatory medicines.
- The trust had participated in the Cancer Patient Experience Survey 2015. They had been ranked in the top 20% of trusts for two of the 34 questions which included: 'hospital staff did everything to help control pain all of the time'.
- Patients and relatives were offered support with emotional and psychological pain by the end of life care teams. This included a specialist psychology service, chaplaincy service, ward staff and the bereavement offices. Relatives we spoke with confirmed how they had been offered or received support, and we saw this was documented in care records.

Nutrition and hydration

End of life care

- Patient's nutrition and hydration needs were assessed using a Malnutrition Universal Screening Tool (MUST) and was followed by appropriate actions such as referral to dieticians for nutritional support which was documented in patients' individual care plans.
- The records documented discussions with relatives around what to expect with nutrition and hydration as part of the dying process.
- We saw mouth care was provided to patients when required to assist with nutritional and hydration needs.

Patient outcomes

- Staff demonstrated an understanding that the end of life care was for patients diagnosed with any life limiting 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 palliative care team provided a trust-wide service so monitoring systems were set to analyse data combined from both Gloucestershire Royal and Cheltenham General Hospitals.
- The trust took part in the Royal College of Physicians National Care of the Dying Audit in 2014. At this time 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 main end of life patient symptoms for example breathlessness, anxiety.
- Since the audit in 2014 improvement had been seen with some patient care outcomes now being achieved. The trust had participated in the End of Life Care Audit: Dying in Hospital in 2015/2016 which was published March 2016. This scored participating trusts against seven organisational and 10 clinical key performance indicators. Based on the most recent National Care of the Dying Audit the trust, in comparison with other trusts had:
  - Performed better than the England average for one of the five clinical indicators. (Health professionals had discussed recognition that patient may die in hours or days)
  - Performed the same as the England average for one of the clinical indicators (recognition documented that patient may die in hours or days)
  - The trust scored lower for 'Is there documented evidence that the needs of the person(s) important to the patient were asked about?' scoring 30% versus the national average of 56%. This meant that some patients were not being consulted about what was important to them
- The specialist palliative care team had completed two audits of the shared care record (June – July 2014 and August 2015 – February 2016) and concluded that symptom observation charts were very useful, documentation of the reasons for diagnosing a patient as likely to be dying had improved and communication levels were high. However completion rates of the shared care record had fallen. Teaching had been implemented and further audit was planned.

Competent staff

- The learning needs of staff delivering end of life care were not all identified. When we requested the training needs analysis for general staff on wards related to end of life care it had not yet been completed. The trust told us establishing and maintaining records for training needed improvements. The trust planned to improve systems through the newly established trust end of life care quality group who would aim to complete the action by September 2017.
- When we requested evidence of current nursing competency for syringe driver training we were told there were no centrally held records. Records for attainment of competency were held at ward level so there was no organisational oversight of compliance. As a result, we were unable to judge the level of competency for this essential equipment.
- We saw some evidence of a yearly programme of end of life care education for some medical staff. This included: symptom management, levels of care, diagnosing dying, resuscitation and communication skills. For example 44 junior foundation doctors attended a care of the dying session August 2016, and 33 in September 2016. Other sessions were planned to cover symptom control, ethics and legal issues and communication. These were new sessions that had not occurred at the time of the previous inspection.
- Nursing and allied health professionals also had access to additional training covering resuscitation, syringe driver training, quarterly end of life study days and symptom management.
- The specialist palliative care team took opportunities to educate staff in practice by providing micro (short or brief) teaching sessions. This was done when any of the

team attended ward multidisciplinary team meeting or were visiting clinical areas. Ward staff we spoke with said recent micro teaching sessions had included symptom management and setting up syringe drivers. Feedback we saw described staff finding the teaching sessions were helpful

- The specialist palliative care consultants had also delivered 'grand round' case study presentation training in December 2016 and January 2017. This was based on end of life care and the role of the trust wide end of life quality group. The presentations had been to other consultants, junior doctors chaplains, healthcare assistants, professions allied to medicine and nurses at both hospitals. The sessions received a high level of positive feedback.
- Not all staff in the end of life team had received appraisals. 50% of the doctors and 70% of the nurses in the team had received an appraisal; however dates for outstanding staff appraisals were booked.
- The bereavement service staff had training to support bereaved visitors appropriately. This included counselling, bereavement care and conflict resolution training.

Multidisciplinary working

- Staff, teams and services worked together to deliver effective care and treatment. The in-patient end of life care team met every morning to discuss current work and new allocations. Work was allocated based on patients' need and urgency. The team worked closely with the community end of life care team, district nurses and GPs. This supported effective transfer of clinical management and follow-up reviews of patients upon discharge.
- The specialist end of life team held weekly multidisciplinary meeting to discuss patients care in detail and review treatment plans. The consultant completed ward rounds every week to review patients' care with other hospital staff. The in-patient end of life care team worked closely with the community end of life care team. This was done to share key information about older patients with complex discharge planning needs.
- The team worked with staff from other specialties and services. They attended team meetings when available and when required. Staff said this ensured patients received holistic end of life care and support.
- We saw the shared care record (SCR) in use. This had been designed to record the communication and collaboration between multi-professionals team members, patients and their families. The SCR helped a range of staff identify and care for patients at the end of their life
- The chaplaincy service was integrated with the end of life care in patient and community care teams and other services in order to provide and promote good end of life care. The team worked effectively. The team had an established group of volunteers and links with other faith groups.

Seven-day services

- There was not a seven day face to face service provided by the in-patient specialist palliative care team. This was not in line with national guidance. Although the trust provided a face to face service 9-5 Monday to Friday, out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- The chaplaincy service was available seven days a week, 24 hours a day, in order to be responsive to patients' needs. Staff said this ensured most patients' religious or spiritual needs could be met.
- The hospitals 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

- Staff on the wards had all the information they needed to deliver effective end of life care and treatment to patient's, we saw paper records that contained
  - risk assessments,
  - care plans,
  - case notes and
  - Test results.
- There had been a recent implementation of a new type of electronic record. This had caused some difficulties in accessing records. However the specialist palliative care team managed to coordinate information between

different electronic and paper based patient record systems which supported access for staff to patient records. The trust was in the process of implementing a single electronic system to support better access and exchange of information.
- When patients moved between teams and services, including at referral, all the information needed for their ongoing care was shared appropriately and in a timely way. This included for discharge, transfer and transition of care.
- Each patient's GP received a letter which informed them of clinical details of the end of life care provided. This was sent when the patient had been discharged or transferred.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with in specialist palliative care team understood the relevant consent and decision making requirements of the Mental Capacity Act 2005. They also completed documents appropriately. However, we observed some practice by ward based staff that resulted in incomplete records so full information relating to patients consent to care and treatment was not always available in patient records.
- We reviewed six do not attempt cardio pulmonary resuscitation (DNACPR) forms from Cheltenham General Hospital, we found that
  - Where patients were identified as lacking mental capacity or where it was not clear, a mental capacity assessment had not been undertaken and recorded in in two out of four cases (50%).
  - Relatives were not involved in discussions in two out of four cases (50%). This meant that it was not clear which patients lacked the decision making capacity for resuscitation and who needed decisions to be made for them through the 'best interests process' and whether the correct people had been involved.
- While we found variable quality of completion of DNACPR records, there was evidence of improvements from the last inspection March 2015. We saw results from the last two audit of completion in both hospitals since March 2015. The DNACPR forms showed a steady improvement from between 46% and 64% compliance in first audit. The trust had achieved 75% compliance in December 2016. The December 2016 audit of completion stated "…significant improvement but we remain a distance away from 100% compliance" with a recommendation to continue education.
- However, 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.
- 100% of nurse and non-medical staff within end of life care teams had completed Mental Capacity Act (MCA) Awareness training and 90% of medical staff had completed Mental Capacity Act (MCA) and Deprivation of Liberty training.
- Ward staff we spoke with had an understanding regarding processes to follow if a patient's ability to provide informed consent to care and treatment was in doubt. General decisions about care were made by clinical staff and often involved the patients' relatives when the patient was no longer able to give informed consent. Staff demonstrated that they understood that more complex decisions needed to include best interests' discussions and meetings in accordance with the Mental Capacity Act 2005.

Are end of life care services caring?

Good

We rated caring as good because:

- Patients and their relatives were treated with kindness dignity respect and compassion while they received care and treatment. We saw many written compliments about how kind and caring staff were
- Staff took the time to interact with people who received end of life care and those people close to them in a respectful and considerate manner.
- Staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and respectful of cultural and religious differences in end of life care.
- Patients and those people close to them were involved as partners in the care and this was clearly documented in patient notes.

End of life care

- Staff we spoke with understood the impact that a patients' care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially.
- Emotional support for patients and relatives was available through the in-patient and community end of life care team, through clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services

Compassionate care

- We spoke with a patient receiving end of life care at the hospital and one in the community. We also spoke with relatives of patients who were receiving end of life care. All described being treated with kindness dignity respect and compassion while they received care and treatment.
- Staff took time to interact with people who received end of life care and those close to them in a respectful and considerate manner. We observed sensitive communication taking place between staff and the dying person, and those identified as important to them.
- We saw many written compliments about how kind and caring staff were on the wards and how the trust in-patient and community palliative care team worked so well for patients and their relatives.
- Where possible, patients receiving end of life care were accommodated in side rooms to increase dignity and privacy for them and those visiting.
- Whilst the hospital had very limited accommodation for relatives staff supported the needs of relatives as much as they could when visiting for long periods. For example, relatives were offered a pillow and a blanket when staying in chairs.
- We were told that bereaved 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. Some relatives had reported they appreciated these signs. However bereavement office staff accompanied relatives when they knew people were attending the mortuary. Alternatively they arranged for others to accompany relatives as the signs were not easy for all to follow.
- Staff on wards, staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and acted accordingly on cultural and religious differences in end of life care. For example: bereavement office staff were aware of the importance of being able to provide a death certificate in timely manner. Mortuary staff understood the need to be able to release recently deceased patients quickly. This supported the spiritual and cultural wishes of the deceased person and their family and carers whilst making sure legal obligations were met.

Understanding and involvement of patients and those close to them

- We saw that patients who received end of life care services were involved as partners in their care. We reviewed care records and saw that staff delivering end of life care had recorded some discussions with patients and relatives. These included discussions about care and treatments and their implications. We also saw records of actions staff should take in response to patients' and relatives' wishes. These included requests to speak with a member of the chaplaincy.
- Ward staff communicated sensitively with patients and those people close to them so that they understood their care, treatment and condition.
- Patients approaching the end of life were given the opportunity to create a shared care record and an advance care plan. This included wishes and any advanced directives they wished care staff to take on their behalf.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for two of the 34 questions, in the middle 60% for 28 questions and in the bottom 20% for four questions. One of the two questions where the trust was in the top 20% was 'all staff asked patient what name they preferred to be called by'

Emotional support

- Staff we spoke with understood the impact that a patients' care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. Although some staff told us they found it

difficult to start a conversation with a patient when the ward was full and staff were busy. Despite this we saw many staff engaging with patients and those close to them.

- Emotional support for patients and relatives was available through the in-patient and community end of life care team, through a clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services.
- Patients who received end of life care and those people close to them received the support they needed to cope emotionally with their care, treatment or condition. Patients were enabled to have contact with those close to them and to link with their social networks or communities although there was limited space for relatives to stay. Chaplaincy volunteers were clear that their role was to provide non-religious as well as religious support. Often offering time for the patient to 'just' talk with no other purpose than to listen. Staff knew how to contact chaplaincy volunteers and the department for spiritual support at any time.
- Patients were empowered and supported to manage their own health, care and wellbeing and to maximise their independence

Are end of life care services responsive?

Good

We rated responsive as good because:

- Services were being planned and delivered in order to respond more effectively to the needs of patient's. Audit was used to inform future planning of the service.
- Systems and processes were being reviewed so that the specialist palliative care team could better understand and respond to service development plans created for 2017.
- We saw that patients and relatives had been consulted about care and their individual wishes had been clearly recorded in care plans.
- The in-patient specialist palliative care team was available to ward staff to provide advice and training regarding communication and end of life care; this included communicating with patients and carers.
- The specialist palliative care team responded promptly to referrals, usually within one working day.
- Lessons were learned and improvements were made from complaints. This learning was used to improve the quality of care.

However:

- There were no designated beds for people receiving care at end of life. Side rooms were used when available but could not be guaranteed.
- The percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not all known for all wards or hospital sites.
- The trust did not have systems in place to identify all patients in the hospital who had been identified as approaching end of life.
- End of life complaints were not always handled promptly and in accordance with trust policy. The trust took an average of 53 working days to investigate and close complaints, which was not in line with their complaints policy of 35 working days.

Service planning and delivery to meet the needs of local patient's

- Services were being planned and delivered in order to respond more effectively to the needs of patient's. Plans were underway to:
  - Accurately identify all patients at end of life in the trust.
  - Audit to inform future planning such as discharge planning projects; advance care planning and data collection so that the end of life team could inform better decision making with older, frail patients.
  - Establish a baseline for key performance indicators which would involve information at ward level
  - Improve coding for the new electronic system so that the trust and the specialist palliative care team could understand incident reporting and complaints relating to their service better.
- Senior staff attended a countywide group attended by commissioners, other providers and relevant stakeholders. The aim was to share good end of life practice and consistency in services through the development of a county plan for end of life care for 2016 - 2019. Other professionals who attended these meetings included staff from three local hospices and staff from other health and social care - services.

Outputs from the steering group included the development of the shared care record for the expected last days of life. This was produced and piloted in partnership with the community palliative care services, the clinical commissioning group and the local hospice.

- Where possible, senior end of life care staff attended the clinical governance meetings at the local hospice. They also took part in a number of working groups which stemmed from the countywide end of life group. Consultants in specialist palliative care also met twice a year with the end of life care teams in surrounding areas to inform care pathways and improved communication.
- The trust recorded the number of patients at any one time who had a learning disability or dementia in order to help plan what services might be needed in future.

Meeting patient's individual needs

- We saw that patients and relatives had been consulted and their individual wishes had been clearly recorded in care plans.
- The specialist palliative care team was available to ward staff to provide advice and training regarding end of life care. This included communicating and breaking bad news to patients and carers. This information was also available on the trust's website. This ensured staff had access to support when required to provide sensitive patient information.
- Services took account of the needs of different patient's with life limiting conditions as well as those patients in vulnerable circumstances. For example the trust recorded 2125 patients who had 'complex needs' who had been in-patients in 2015/16. The trust also recorded 540 people with a learning disability had received in-patient care in the last year. In order to support staff to meet the needs of this group of patients, the trust employed two learning disability nurse specialists who worked with the specialist palliative care team.
- The trust had a policy to support staff to effectively process patient deaths from different faiths and cultures. Staff we spoke with on wards and in the mortuary service were aware of this.
- 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 chapel which was also used as a multi faith room had a broad range of religious texts including Christian bibles, Hindu Bhagavad Gitas, Muslim Qurans and other literature relating to spiritual and non-religious support.
- There were limited family rooms and some overnight accommodation available for relatives, information was available from the hospital switchboard. This had been discussed at the end of life care quality group meeting in January 2017. The action recorded was to remind the trust's 69 end of life champions on wards to share knowledge of what was available and help relatives to know what they could expect of the limited availability. Staff were able to direct relatives of patients receiving end of life care to areas where they could wash if needed during prolonged stays.
- The inpatient specialist palliative care team won an annual Staff Award 'the trust patient's choice award 2016,' where patients and others recognised the NHS staff who had made a difference to their lives.

Access and flow

- Whilst referral into the service was dependant on staff identifying appropriate patients, the end of life team responded promptly to referrals, usually within one working day. Ward staff demonstrated they understood how to make a referral to the specialist team and consistently reported that the team responded promptly. This information was documented in the main medical notes. The service undertook an audit of 44 patients referred during a 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.
- However the trust was unable to identify the total number of patients in the hospital within a central record receiving end of life care. The trust was planning to adopt a new electronic patient record with the ability to identify patients who had an advance care planning document or to be able to search for patients being cared for at end of life or identify specific needs around end of life care had been built in. The system was not yet in use as it had been delayed.
- Access to the spiritual support provided by the chaplaincy service was audited. This was done in order to identify areas of high demand and low use and to understand if staff needed to be made more aware off the support available, including future planning of the spiritual support department.

End of life care

- Cheltenham General hospital chaplaincy call-outs(2016)
- Six wards had not called on call chaplaincy
- 12 wards had called out on call chaplaincy
- Ward and other staff had called on call chaplaincy on a total of 29 occasions
- 144 out of Hours call-outs across trust
- A review of preferred place of care for patients was undertaken between July and August 2016. In 21 cases 65.6% successfully achieved a preferred place of care or death (PPD) where information was recorded. This review highlighted potential difficulties with the planned electronic patient record and recording of the data. As a result, the importance of clearly documenting PPD was raised and where discussion was not appropriate or not wanted by the patient, to ensure this was known by the team. The specialist palliative care team also planned to liaise with team developing the new electronic patients record so that information was able to be identified trust wide
- The trust planned for discharges for patients at end of life to be completed within two hours of booking. Discharges could be booked the day prior to discharge to ensure a planned approach. Ambulance services recognised the Do Not Attempt Cardio Pulmonary resuscitation (DNACPR) documentation and this was provided to them at the point of patient transfer. Ward staff and the rapid discharge team said that most end of life discharges were achieved within 24 to 48 hours, although there were sometimes delays for patients who lived in rural areas.
- Discharge for patients at end of life took place at an appropriate time of day. All relevant teams and services were informed and discharge took place only when any ongoing care was in place. Most delays experienced for end of life care were attributed to the lack of availability of care in the community.
- Between October 2015 and September 2016, the main reasons recorded for delayed transfer of care for all patients from the trust were 'waiting further NHS non-acute care' (35.1%), followed by 'completion of assessment' (29.8%). The trust's percentage share for 'waiting further NHS non-acute care' was almost double the percentage share for the England average. There were no specific figures available for end of life discharge delays.
- There were 1693 referrals to the specialist palliative care team between April 2014 March 2015. Cancer related referral accounted for 1175 (69%) and non-cancer 518 (31%). There were 2067 referrals between April 2015 and March 2016 pf which Cancer referrals numbered 1587 (77%) and non-cancer 480 (23%).
- A policy was in place for the rapid release of a deceased patient from the mortuary which supported the respect of cultural wishes of deceased patients. Medical and mortuary staff demonstrated an understanding of the processes to follow, and we saw documentation confirming this.

Learning from complaints and concerns

- Lessons were learned and improvements were made when care provided was not as good as expected. Significant learning was focussed on improving bereaved relatives experiences in the mortuary and care of those who had recently died.
- Patients who used the service and those close to them knew how to make a complaint or raise a concern and were encouraged to do so. Between November 2015 and October 2016 there were a total of 18 complaints about end of life care.
- A formal complaint record was maintained. This showed complaints were handled confidentially, with a regular update provided for the complainant.
- However complaints were not always handled effectively. The trust took an average of 53 working days to investigate and close complaints, which was not in line with their complaints policy, which stated complaints should be responded to in 35 working days.

Patient care was the most complained about theme with 13 complaints, followed by admission and discharges with two complaints.

- There were three complaints for Cheltenham General Hospital, of which two related to patient care.
- Processes were in place for the learning from complaints to be visible at board level.

Are end of life care services well-led?

Good

We rated well-led as good because:

End of life care

- The leadership and culture of the specialist palliative care team in the trust reflected the vision and values of the trust.
- The trust had a clear vision and strategy to deliver care at end of life linked to national best practice including Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's.
- The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- Priorities were identified at the specialist palliative care team meetings for consideration at the trust's quality committee meetings.
- Systems were in place to learn from incidents that occurred in end of life care.
- Leadership, encouraged openness and transparency and promoted good quality care. There were leads on the wards for delivery of end of life care which supported the development of high quality end of life care.
- Staff felt respected and valued. There was a strong emphasis on promoting the safety and wellbeing of staff delivering end of life care in the community.
- Services within specialist palliative and end of life care had been continuously improved and sustainability supported since the last inspection March 2015.
- We saw examples where leaders and staff took part in contributing to their own and others continuous learning, improvement and innovation

However:

- There was no risk register specific to end of life care for the trust so there was no easy trust wide oversight of risk relating to the service.
- There was a program of internal and national audits for end of life care, which were on time. However most local audit activity had not yet benefited from a thorough analysis of the data produced.

Vision and strategy for this service

- The trust had a clear vision and strategy to deliver care at the end of life. The vision was developed by the end of life quality group and was presented to the quality and performance committee in December 2016. The vision was to embed pride in end of life care delivery across the trust to ensure that end of life care was good as it can be for every individual and those important to them, every time. Following the previous inspection, work had been completed by members of end of life care team on the vision and strategy. We saw a realistic action plan to achieve the 10 actions considered most important by the team for the Board. Compliance was monitored by the executive and non-executive leads for end of life care through an action plan with set deadlines.
- The end of life vision also included improving patient experience, clinical effectiveness, the establishment of the end of life care group and patient safety. The strategy and vision was presented to the quality and performance committee. Following the presentation the committee agreed that end of life care should form part of the essential training for the trust. We saw three different levels of training proposed during inspection with end of life champions being in the first wave and staff of the trust all completing an end of life module. The recommendation was referred to the education and learning development unit. The trust charter for end of life care (an explicit statement of what various parts of the trust would do to support end of life care) was underway. The charter, once finalised, was to be presented to the Board.

- The specialist palliative care team understood what the vision and values were. Some general staff on wards were aware of it, most usually end of life champions and ward sisters. The specialist palliative care team and the trust were at an early stage of development and the written strategy for the hospital with defined work plan priorities for the present and future recently completed.
- The strategy reflected the learning and development within the specialist palliative care team and findings of previous inspection reports. It reflected the current challenges the trust faced in relation to end of life care services. Which were
  - Continuing and improving education
  - Understanding of performance and safety
- The trust had included a quality priority in the 2016/17 quality account which was to improve end of life care.

Governance, risk management and quality measurement

- The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed. The strategic end of life group reported directly into the trust quality and performance committee, chaired by

the Chief Executive. The membership of the end of life quality group included the medical director, the specialist palliative care team consultant and a range of other staff including the non-executive director, senior ward nurses, chaplain and patient experience manager.

- Processes were followed to provide assurance to the board regarding safety issues. The end of life care quality group and medical director provided regular reports to the board.
- Although there was no specific risk register for end of life care, risk management processes were followed. However oversight of all end of life risk was not easy. Priorities were identified at the specialist palliative care team meetings for governance and fed into divisional meetings and on through to the trust's quality committee.
- Systems were in place to learn from incidents that occurred in end of life care for example mortuary incidents and discharge planning for patients at end of life.
- There was a program of internal and national audits for end of life care, which were on time. However most local audit activity had not yet benefited from a thorough analysis of the data produced. This was due to some deadlines and projects only being implemented recently due to recent reduction in staff shortages within the specialist palliative care team. Staff shortages had not affected other aspects of end of life care practice.
- However the trust had a programme and strategy to understand and improve on hospital based mortality indicators related to end of life patients. In January 2017 the known challenges were listed as;
  - The coding of palliative care input (or end of life care) was low by national comparison. As a cancer centre a higher level of patients falling into a palliative category had been expected. This was currently under review between the specialist palliative care team and the coding team. Better coding was hoped to lead to better information about numbers of patients and any delays they experienced.
  - The trust was aware of the delayed discharge of patients. Some patients then became too unwell for transfer due to the delay. The improved discharge of those patients choosing to receive their end of life care at home would give a key indication of a system driven by high quality care.
  - Work was currently underway to review admission pathways as part of the emergency pathway review. This was planned to allow more specialist input into patient care prior to admission. This would improve accuracy of initial diagnosis and ensure more appropriate admissions and avoid inappropriate end of life admissions.

Leadership of service

- The leadership and culture of specialist palliative care team in the trust reflected the vision and values of the trust. Leadership, encouraged openness and transparency in decision making.
- The medical director was the executive lead for end of life care responsibilities. The non-executive lead contributed by challenging timescales and decisions regarding end of life care planning and delivery. Staff described them as understanding the issues within the hospital and being active, visible and supportive.
- The specialist palliative care team were led by the specialist consultant with support through five in patient advanced nurse practitioners. Two of the five advanced nurse practitioners were based at Cheltenham General Hospital; two were based at Gloucestershire Royal Hospital with one working across both sites.
- There were 69 end of life champions in the trust based on wards The 'champions' provided additional local ward leadership with senior ward nurses for the delivery and development of high quality end of life care.

Culture within the service

- There was an open culture within the service where staff were able to raise concerns. Staff felt respected and valued and there was a strong emphasis on promoting the safety and wellbeing of staff delivering end of life care.
- The culture was centred on the needs and experience of people who received end of life care. Ward staff felt end of life care was an important part of their work. However when busy felt it was something that was difficult to ensure was a priority.
- Staff and teams worked collaboratively, to deliver good quality care.

Public engagement

- Patients and those close to them who used the end of life care were engaged and involved. Patients and those

close to them shared their experiences with both the in-patient and community specialist palliative care team. Some experiences were used anonymously to inform staff training and to improve process such as enabling better discharge planning.

- While there was no specific Friends and Family Test for those in receipt of end of life care, the overall hospital response was generally worse than the England average between November 2015 and October 2016. In the latest period, November 2016 trust performance was 95.2% which is the same as the England average of 95.2%. The trust's performance had stayed consistently between 93% and 97%.
- In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for two of the 34 questions, in the middle 60% for 28 questions and in the bottom 20% for four questions

Staff engagement

- Staff we spoke with in specialist palliative care teams felt actively engaged and that their views were reflected in the planning and delivery of services and in shaping the culture.
- Leaders and staff understood the value of raising concerns and appropriate action was taken as a result of concerns raised. For example we saw that concerns over team resources had been responded to with increased recruitment.
- There was a trust wide end of life care steering group or committee, which was representative of the breadth of staff involved in end of life care which ensured decisions where informed by a range of staff involved.
- We saw records which showed that the majority of staff who attended training courses facilitated by the end of life care team gave positive feedback. Staff said this was used to plan and improve future training sessions.

Innovation, improvement and sustainability

- Improvements had been made to the service since the last inspection. Staff had considered developments to services and, the impact on quality and sustainability was assessed and monitored which had led to an increase in nurse and doctor provision.
- End of life care performance measurements were being developed and implemented
- There was a trust wide end of life care quality group, established during September 2016. The group had a membership of medical nursing, allied health professionals, non-executive, chaplaincy and hospital site management. This group were aiming to implement the countywide and local end of life care strategy.
- Think '333' was a prompt for improved discharge planning which required prescriptions, communication and documentation needed from wards to facilitate smooth discharge for patients receiving end of life care. The tool was beginning to be widely used by the hospital wards, having been developed by nurses in the specialist palliative care team and medical staff following responses to incidents recorded.
- There were a team of end of life champions, based across the inpatient wards. They supported the delivery of end of life care on wards. They attended regular trust meetings and were developing an end of life care work programme.

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	
Responsive	Requires improvement
Well-led	
Overall	

Information about the service

This report focuses on our inspection of the outpatient and diagnostic imaging departments located at Cheltenham General Hospital.

Gloucestershire Hospitals NHS Foundation Trust provides outpatient and diagnostic imaging services to a population of over 600,000 people. These services are provided in outpatient and diagnostic imaging departments at the Cheltenham General Hospital and the Gloucestershire Royal Hospital. The same team of senior staff, who work between both sites, manage the general outpatient and diagnostic imaging departments at both hospitals. Some outpatient departments are managed by the specialties themselves, for example the trauma and orthopaedic department.

Across all Gloucestershire Hospitals NHS Foundation Trust sites, between April 2015 and March 2016, there were 815,638 new and follow-up outpatient appointments of which 350,168 were held at Cheltenham General Hospital. During the inspection, we visited a range of outpatient clinics on the Cheltenham General Hospital site including physiotherapy, oncology, dermatology, ophthalmology, respiratory medicine, general medicine, general surgery, ear nose and throat, urology, audiology, rheumatology, trauma and orthopaedics, gynaecology, pain clinic and clinical psychology.

We also visited the radiology department, including plain film imaging, magnetic resonance imaging, computed tomography, ultrasound, nuclear medicine, screening and medical physics.

Between January 2016 and October 2016 the diagnostic imaging department at Cheltenham General hospital reported on 69,919 examinations.

On our last inspection in March 2015, the diagnostic imaging and outpatient departments were rated as requires improvement for both safe and responsive domains. There were five areas requiring improvement which included storage and administration of medicines, consent and access to tests.

During this inspection a team of inspectors and specialist advisors spoke with 44 members of staff, including managers, sisters, nurses, healthcare assistants, consultants, radiographers, physiotherapists, receptionists, secretaries and bookings staff.

We reviewed seven sets of patient records, and spoke with seven patients and their relatives to seek their views of the services provided.

As part of this inspection, CQC piloted an enhanced methodology relating to the assessment of mental health care delivered in acute hospitals; the evidence gathered using the additional questions, tested as part of this pilot, has not contributed to our aggregation of judgements for any rating within this inspection process. Whilst the evidence is not contributing to the ratings, we have reported on our findings in the report.

Outpatients and diagnostic imaging

Summary of findings

We found;

- There were good infection control measures in place to help keep people safe, including hand hygiene practices, and the outpatient and diagnostic imaging departments had 100% compliance.
- Patients who were vulnerable were protected from avoidable harm through comprehensive safeguarding procedures, and staff showed good understanding of these procedures and shared learning from safeguarding incidents.
- Staff were given the right skills and training to do their jobs, and in ophthalmology a competency based training package had been developed for healthcare assistants.
- Patients had access to specialist services, and the urology department had developed a dedicated consent form for cystoscopies and was expanding its one stop clinic service.
- A new waiting list validation process had allowed some patients to be discharged back to primary medical care facilities for their on-going care and follow up treatment.
- Visually impaired patients were able to access services on an equal basis to others in ophthalmology through the use of colour coded signs, which made navigation of the department easier.
- The oncology department provided an information presentation for all newly diagnosed patients which included opportunities to ask questions on a one to one basis.

However;

- The service did not have sufficient arrangements to keep clinical and patient areas clean. Some treatment rooms in ophthalmology had carpet flooring and contained visibly dusty equipment, and the trust had not met its infection prevention and control training target.
- The environment in the phlebotomy clinic was small and did not allow staff to respond to patients effectively if they became unwell.
- The trust did not make sure staff had access to the most up to date policies and guidance, and had several versions of one Patient Group Directive (PGD) in circulation in ophthalmology.
- The hospital was not meeting the 62 day waiting list target for cancer patients, and the trust was not meeting referral to treatment target in all specialities.
- Patients were experiencing delays in diagnosis and treatment because the diagnostic imaging department had a reporting backlog of 19,500 films, and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety, diagnosis and on-going treatment.
- Implementation of new IT systems had impacted on waiting lists as some specialties could not see their live waiting lists.
- Patients were not able to access the top floor clinics easily due to the lift being out of order.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as Good because;

- The outpatient and diagnostic imaging departments had 100% hand hygiene compliance.
- Staff had a good understanding of safeguarding procedures and we saw learning shared as a result of an incident.
- Healthcare assistants in ophthalmology had received competency based training so they could administer eye-drops.
- The diagnostic imaging department escalated safety concerns around equipment and made changes as a result.
- Urology had developed a dedicated consent form for cystoscopies and was expanding the one stop urology clinic service.

However;

- A number of patient treatment rooms in ophthalmology had carpet flooring and contained visibly dusty equipment, and the trust had not met its infection prevention and control training target.
- The phlebotomy clinic environment was small and did not allow staff to respond to patients effectively if they became unwell.
- Staff did not always have access to the most up to date policies and procedures, and there were several versions one Patient Group Directive (PGD) in circulation in ophthalmology.

Incidents

- Staff consistently reported incidents and understood their responsibilities to raise concerns using the electronic reporting system. Staff understood why it was important to record safety incidents, concerns and near misses both internally and externally. An example of this was in the general outpatient department where a senior nurse had raised concerns about carrying out a particular type of urology test in the outpatient department. Patients undergoing that test sometimes bled after the procedure, so the sister had managed to get the tests performed on an inpatient ward to allow patients time to recover after the procedure.
- Staff told us they were encouraged to report incidents and near misses, and all staff we spoke with were confident using the trust's electronic incidents reporting system. One member of staff told us of a change in practice as a result of an incident form they submitted, however, not all staff told us they consistently received feedback from incidents they reported. A senior member of staff with responsibility for investigating incidents told us they verbally discussed the outcomes of incidents with staff, but did not email feedback routinely. This was similar to what we found on our previous inspection.
- Since our last inspection, incident reporting had increased when compared to other similar services and England averages. Between November 2015 and October 2016 the outpatient department reported 935 incidents. 827 were graded as no harm, 86 as minor harm, 6 as moderate harm, 2 as major harm and 1 as death. Staff told us they understood how incident reporting helped the trust identify and monitor patient safety.
- When things went wrong in the outpatient and diagnostic imaging departments, thorough and robust reviews or investigations including all staff involved, were carried out. An example of this was an investigation into a serious incident which was reported to NHS England in accordance with the Serious Incident Framework 2015. The trust reported one serious incident (SI) in outpatients which met the reporting criteria set by NHS England between December 2015 and November 2016. The incident surrounded an incidental finding of an abdominal aortic aneurysm (AAA) in 2010, which had not been confirmed through a screening programme in 2011. A review of the screening process during the investigation had shown all procedures had been followed correctly.
- People who used services were told when they were affected by an incident and they were given an apology. An example of this was when a patient attended for a procedure, which had to be cancelled due to an unexpected finding, which had altered their care plan.
- When things went wrong in the outpatients and diagnostics service, lessons were learned and action

was taken a result of investigations. Lessons were shared to ensure action was taken to improve safety beyond the affected team or service. An example of this was when a patient developed blistering following the injection of iodinated contrast through a cannula in the patient's hand at the Gloucester Royal Hospital. The incident was reported, and an investigation showed the cannulas had been blowing in examinations where contrast was required to be injected under pressure. As a result, a safety alert was risen with the manufacturer, and the cannulas were removed from use across all diagnostic imaging departments in the trust.

- Staff in the oncology outpatients department told us how incidents of extravasation were discussed at the chemotherapy sub group meetings. Extravasation refers to the inadvertent infiltration of chemotherapy into the tissues surrounding the intravenous or intra-arterial administration site. One specific drug presented with a late on set extravasation. Investigations into this informed future practice and staff now diluted the drug further, flushed the intravenous device more thoroughly and applied a heat pad during the infusion.

Duty of candour

- Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 is a regulation, which requires the organisation to be open and transparent with patients when things go wrong in relation to their care and the patient suffers harm or could suffer harm, which falls into defined thresholds. Staff we spoke with were aware of this legislation and demonstrated good understanding of their responsibilities under it.

Cleanliness, infection control and hygiene

- Reliable systems were in place to prevent and protect people from a healthcare-associated infection. For example the outpatient and diagnostic imaging departments collected monthly data about hand hygiene and the most recent data available showed 99% compliance in July and 100% compliance in August and September 2016 across both hospital sites.
- Standards of cleanliness and hygiene were maintained in all clinical areas we visited, and staff could explain how this was consistently achieved. For example we saw evidence that cleanliness and hygiene checks were regularly carried out and in the outpatient department and had been improved to give staff daily tasks to carry out in each room. We saw completed, up to date documents to show this was being done.
- Most areas we visited were visibly clean and clutter free, however; in the ophthalmology department, we saw several patient treatment rooms which had carpet tile flooring, which was not in line with best infection prevention control guidance set out by HBN 00/10 part A. We also saw the laser treatment room had shelving and equipment including a fan, which was visibly dusty and we saw the fan in use during treatment.
- On our previous inspection we saw there was no visible system to enable staff to identify if a piece of equipment was clean prior to use. On this inspection staff told us there was still no such system in place, and if equipment was in a store cupboard, it was assumed to be clean as it was part of the cleaning of that store cupboard. Cleaning took place in the mornings before clinics started, and was carried out by the clinic staff. We saw cleaning checklists were complete and up to date, and mentioned pieces of equipment by name in the tasks outlined on the checklist.
- The trust had set a target for 100% of staff to undertake infection prevention and control training. The most recent data available showed this had not been met in July 2016 (94% compliance) and August 2016 (93% compliance).
- Staff we spoke with could explain the importance of hand washing, and understood when to use soap and water or antibacterial hand gel. We saw staff were either washing their hands before and after patient contact or using alcohol gel which was in line with National Institute for Health and Care Excellence (NICE) guidance quality statement 61. We also saw all clinical staff were bare below the elbow, in line with trust policy.
- We saw antibacterial gel dispensers in all consulting rooms and patient waiting areas. Staff were able to access hand wash basins throughout the clinics and departments and posters displaying best practice for hand hygiene technique were displayed.
- Staff took appropriate precautions when seeing patients with suspected communicable diseases or infections. For example, patients with suspected or confirmed

communicable diseases were placed at the end of appointment lists to allow thorough cleaning to take place after the scan or investigation, and to help minimise contact between patients.
- Personal protective equipment, such as aprons and gloves were readily available in all areas and staff could describe how and when to use this equipment. Staff could explain how this equipment protected both patients and staff from the possible spread of healthcare associated infections, but also explained how it was not a replacement for good hand hygiene.
- Staff in ophthalmology told us of changes they had made to their cleaning procedures as a result of learning from a review of infections in patients receiving intravitreal eye injections at the Cheltenham General Hospital clinic. Changes were made to cleaning procedures across all ophthalmology clinics. Staff were awaiting audit data to assess if the infection rate had reduced as a result.

Environment and equipment

- Facilities and premises were designed in a way that did not always keep people safe. For example, the outpatient departments were located in an older part of the hospital, and we saw some patients waiting in small sub-waiting areas which were not always in sight of clinical or reception areas. The main west block outpatient department was arranged around a large waiting area with clinics located off each corner. Staff and patients told us this area could often become very crowded.
- Phlebotomy services were located in the West outpatient department and consisted of two bays and a store cupboard which was also being used as the office to coordinate phlebotomy services throughout the hospital. Staff told us the bays were cramped, and we saw a patient with a pushchair struggle to get access to one of the bays. The bays contained a small equipment trolley and a specialist chair, however, staff told us of an incident where a patient had become faint after their test, and the staff had nowhere to lie the patient down.
- In diagnostic imaging we saw Staff inserting cannulas in patients in a disused x-ray room. We saw patients having cannulas inserted, sat in a chair in the centre of the room, in front of other patients in the room.
- Equipment was regularly and adequately maintained by the medical electronics department and through a number of external maintenance contracts in diagnostic imaging. Staff used equipment safely and we were shown standard operating procedures for equipment, where there were operational differences to ensure all staff knew how to use the equipment safely. We saw electrical safety test stickers on all equipment we looked at which were within their service date.
- There were systems for managing waste and clinical specimens including sharps bins, however, we saw three sharps bins in ophthalmology which were not temporarily (partially) closed in-between use as recommended by the Department of Health management of healthcare waste HTM 07-01 (2013). The sharps bins were temporarily closed as soon as this was raised.
- Staff in diagnostic imaging told us of a problem they had with the introduction of a new safety cannula. When intravenous contrast was injected under pressure (as required for certain types of venous scans), the cannulas were blowing under the pressure. The senior staff escalated the problem to the health and safety committee and back to the manufacturer. As a result a different type of cannula was sourced for use in these types of investigations.
- Resuscitation equipment was readily available on each floor and this equipment was stored and checked in line with Resuscitation Council best practice guidance, and we saw completed checklists confirming this.
- Not all outpatient resuscitation trolleys had defibrillators, and in one area we saw a sticker on the trolley informing the user where the nearest defibrillator could be found, however, this area was on a different floor and this information was not on the sticker. Staff we spoke with all knew where to locate their nearest resuscitation trolley and defibrillator.
- Resuscitation equipment was available on each floor of the general outpatient department. Trolleys were located in accessible areas to staff. In addition to the checks carried out by staff on the equipment and medicines, the resuscitation department also carried out an audit of resuscitation trolleys to check they were being maintained in line with trust policy. Data submitted in August 2016, showed there was 97.95% compliance with the trust's resuscitation policy across the whole Cheltenham hospital site.
- The imaging service ensured that non-ionising radiation premises in particular magnetic resonance imaging

(MRI) scanners had arrangements in place to control the area and restrict access. All MRI scanners had coded locked doors, to prevent people accessing the scanner accidentally and being exposed to its magnetic field.

Medicines

- There were reliable systems for the recording and storage of medicines, medical gases and contrast media. The outpatient and diagnostic imaging departments monitored minimum and maximum temperatures of the refrigerators and rooms where medicines were stored and we saw records of this which were complete and up to date. Staff could explain what to do if temperatures had exceeded certain thresholds and had an understanding about the effects temperature fluctuations could have on the medicines they held stock of.
- The trust provided staff with medications management training, and staff showed us policies relating to medications management were available to them on line. However, the trust had set a target for 90% of staff to have completed medication management training, and in the outpatient department this target had not been met, with 84% of staff receiving this training.
- In ophthalmology, healthcare assistants (HCA) were administering eye drops to patients under direct supervision from a non-medical prescriber. On our previous inspection, we found healthcare assistants administering eye drops under a patient specific directive (PSD) which had been derived from existing patient protocols. This practice had been reviewed, and a new patient group directive (PGD) had been drawn up. HCAs were now checking drops with a registered nurse before administration and documenting this in the patient notes. The ophthalmology department had also worked with pharmacy to develop a competency based training package for all HCAs administering eye drops, and held a list of those trained. We reviewed the new PGD, however, we also saw the old PSD still in circulation on the trust's intranet.
- There were systems in place to ensure the safety of controlled drugs administered in outpatients. All controlled drugs were stored securely in locked cupboards. We carried out random checks of a number of controlled drug record books which showed all entries were complete and up to date.
- Prescription pads (known as FP10 forms) were stored securely and were signed in and out of each clinic at the start and end of each clinic session. We saw FP10's stored in plastic wallets, with a record sheet containing each FP10 reference number, the patient's hospital number and the signing doctor's name and date. Staff told us they cross checked the sheet with the remaining prescriptions to check all of the prescriptions were accounted for. Staff could describe what to do if a prescription has gone missing, but could not recall an occasion when this had happened. We saw all FP10s were locked in secure cupboards in unattended clinic rooms.
- The imaging service did not take account of The Medicines (Administration of Radioactive Substances) Regulations 1978 (MARS), as we did not see an up to date list of practitioners who could approve nuclear medicine procedures.
- An outpatient survey had been completed in August 2016 and 32% of patients who took part in the satisfaction survey reported that they were not fully involved in decisions over best medication, 12 % of patients said they had not been told how to take their current medications, 13% had not been told how to take their medications, 17% had not had the reason for a change to medications explained and 40% were not told of side effects. These results showed the trust was doing better with regard to medications satisfaction when compared to some other trusts. The trust had an action plan which focussed on 13 areas for improvement identified within the survey, including improvements around better communications with patients before and during appointments, and continuity of care.

Records

- Patient care records were accurate, legible, compete and up to date, and we found this to be true of the six sets of records we looked at. There were systems in place for managing records which were communicated to staff, which included a delivery and collection service. However; we saw several unattended open trolleys of patient records outside clinic rooms in the oncology unit.
- In the west block outpatient department and the trauma and orthopaedic outpatient department, patient notes were obtained in advance of the clinics, and sorted into the appropriate area. We saw locked filing cabinets in each area where patient notes were stored until their appointment time. They were then

transferred to the work surface and covered with a 'confidential' sign to prevent people passing through the area from seeing any information on the outside of the notes.

- There was a reliable system for ensuring medical records availability for clinics which was audited regularly. The trust reported that between January 2016 to November 2016, 1.5% of patients were seen without their full medical record being available. Any records that were not available were substituted with a set of temporary records and joined up with the patient's full record when returned to the medical records department. These temporary records contained a copy of the referral, discharge summary or letter from a previous appointment depending on the patient pathway. Clinicians also had access to pathology results, diagnostic imaging results and clinic letters electronically within the outpatient department via other hospital internal IT systems.
- Staff in the outpatient departments told us missing notes were reported as incidents. Since the introduction of the new IT care system in December, staff said the instances of temporary and missing notes had increased, however, no data had been collected to show this. The new IT system was used to track patient notes, schedule appointments and hold electronic copies of patient care records.
- Medical records staff told us that since the introduction of the new IT system care, staff were not booking notes in and out correctly, which made tracking the notes difficult leading to an increase in the numbers of temporary files being made up. We requested data collected after the introduction of the new IT system for numbers of temporary notes but none was provided.
- There were systems in place to record which patients had mental health, learning disabilities or dementia in order to aid their care and treatment. We were told that at this stage of implementation, the new IT care system did not alert staff to patients who had a mental health needs, learning disabilities or dementia. If patients were known to be living with a diagnosis of dementia then a purple butterfly was attached to their records.
- Staff told us that a yellow sticker was placed on the front of notes to let clinic staff know if a patient was living with a mental health diagnosis. Staff in the trauma and orthopaedic outpatients department told us that the mental health liaison team would pre alert staff when they knew a patient living with a mental health issue would be attending clinic.

Safeguarding

- There were systems, processes and practices in place to protect people from harm and these systems and processes were communicated to staff. The trust had set a target for 90% of clinical staff to have completed safeguarding level two training for both adults and children. The trust had met this target for medical staff; however 83.9% of nursing staff had completed safeguarding level two training for children.
- In the diagnostic imaging department, two members of staff acted as safeguarding champions, and had been trained to level three in both adult and child safeguarding. We were shown a spread sheet which the staff used to monitor the diagnostic imaging departments compliance with safeguarding training against the 90% trust target, which the department had met.
- There were arrangements in place to safeguard adults and children from abuse that reflected the relevant legislation and local requirements and staff understood their responsibilities. For example, staff told us of an incident in one outpatient clinic where a young person had been treated as having adult capacity when they attended alone for an appointment. Staff had identified this before any treatment had commenced, and the incident was escalated to board level. We saw evidence of learning from this incident shared across the whole trust.
- Staff in the trauma and orthopaedic outpatient department told us they had regular safeguarding updates and had a talk scheduled on domestic abuse. Staff showed us leaflets that they gave out discreetly should they suspected a patient was suffering from domestic abuse.
- We saw staff carried pocket prompt cards with information about safeguarding procedures and contact information for the lead safeguarding nurses. These cards had been developed by a lead HCA in Gloucester Royal Hospital outpatient department and shared with all outpatient departments throughout the Trust via the outpatient nurses forum.
- There were processes in place to ensure the right person received the right radiological scan at the right time, and

we saw posters reminding staff to carry out three point checks of identification before an X-ray examination. Between February 2016 and January 2017, the diagnostic imaging department notified CQC of eight incidents across all sites involving referral or patient identification errors, resulting in unnecessary scans taking place.

- In the radiotherapy department, staff used the Society of Radiographers pause check guidance alongside a digital photograph of each patient to ensure correct patient identification prior to any treatments. Photographs were taken at the start of patient treatment and only with their permission and were stored on secure computers used in the treatment control rooms.

Mandatory training

- Staff received regular mandatory training updates, and the trust had set a target for 90% of relevant staff across all sites to have competed all 12 mandatory training modules. Subjects covered included manual handling, information governance, infection control and equality and diversity awareness for all staff, with the additional of some specialist modules for medical staff which included blood transfusion and prescribing. The trust met its 90% target in three of the 12 modules for medical staffing, and eight of the 12 modules for nursing staff.
- Staff understood the difference between lawful and unlawful restraint practices and staff were aware how to seek authorisation for a deprivation of liberty. Deprivation of Liberty training had been completed by 94.3% of staff in the outpatient departments.
- The trust had set a target for 90% of all staff to have had an annual appraisal. At the time of our inspection, this had been met for healthcare assistants, but not for allied healthcare professionals, medical and dental staff, nursing and midwifery staff and clerical and administrative staff. Overall, 87% of all staff had received an annual appraisal.
- All staff were offered 'awareness' training to help them identify and respond to patients with mental health needs, learning disabilities, autism or dementia. The trust reported that at 31st October 2016 Mental Capacity Act (MCA) Awareness Act training had been completed by 100% of staff within outpatients.

Assessing and responding to patient risk

- The Radiation Protection Advisor (RPA) was easily accessible for providing radiation advice and covered all Cheltenham and Gloucester hospital sites.
- The imaging services had appointed Radiation Protection Supervisors in each clinical area. The imaging service ensured that the 'requesting' of an X-ray or other radiation diagnostic test was only made by staff or persons in accordance with IR(ME)R, and held lists of approved referrers for staff to check requests against. Staff told us this list was regularly reviewed and updated, and we saw the current list.
- There were adequate signs and information displayed in the diagnostic imaging department waiting area informing people about areas where radiation exposure took place.
- The imaging service ensured that women who were or may be pregnant always informed a member of staff before they were exposed to any radiation. For example we saw radiographers using the 28 day rule to confirm pregnancy (if a patient is unsure if they are pregnant and their last menstrual period is overdue, the radiographer or radiologist may consider postponing the examination until pregnancy can be confirmed or ruled out). This is in line with Royal College of Radiologists (RCR) best practice guidance.
- There were local policies for the risk assessment and prevention of contrast induced nephropathy, and staff were aware of these policies. Staff told us clear information was given to patients about hydration before and after contrast examinations, and we saw a radiologist vetting computed tomography scans where a patient's renal function was too poor to allow the use of contrast. In this case, the radiologist used a set of pre-defined codes for the type of scan they wanted, which clearly said contrast was not to be given. These policies were in keeping with NICE guidelines and the RCR standards for intravascular contrast agent administration.
- The trauma and orthopaedic outpatients department had recently had training in focus rigidity casting as a new technique in the application of plaster casts. Staff were using this technique to reduce the risk of muscle wastage and the development of pressure ulcers under their casts.
- There were clear pathways and processes for the assessment of people within outpatient clinics or radiology departments who were clinically unwell and required hospital admission. Staff were aware of these

pathways. For example, a HCA told us of an incident where a patient had become unwell in a waiting area, and they were able to call 2222 for help. The HCA had started basic observations including blood pressure and blood sugar monitoring, and had also accompanied the patient to accident and emergency to give a handover to staff.

- Staff in the trauma and orthopaedic outpatients told us they were provided with conflict resolution training. Staff told us that they had processes in place to protect themselves and the public from violence and aggression, and could call 2222 and ask for support from the violence and aggression team.
- Most staff demonstrated understanding of consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. The process for seeking consent was monitored in the outpatient department by an audit programme which showed that, 82% of notes audited had documented evidence of consent.
- In the Urology department, since our last inspection, a new dedicated consent form had been developed for cystoscopy procedures. We reviewed three sets of patient notes and saw this form was filled out in two sets, and a standard written consent form was filled out in the third. Staff told us an audit of the new forms was being undertaken. On our previous inspection, we saw several sets of records with no written evidence of consent being obtained for the procedure.
- There were systems in place to maintain up to date records and alerts on the Control of Substances Hazardous to Health (COSHH). We saw evidence in the trauma and orthopaedic outpatients departments of folders with up to date information.
- Staff in the oncology department had access to clinical psychologist if they were concerned about risks associated with a patient's mental health, and staff knew how to access them.

Nursing staffing

- Staffing levels and skill mix were planned and reviewed so that people were protected from harm. At Cheltenham General Hospital, the outpatient department was staffed by 10.2 (60%) unqualified staff, and 6.8 (40%) qualified staff, which was better than the trust's target staffing ratio of 70% unqualified to 30% qualified.
- Staff worked across all areas of the outpatient department, and covered additional hours through the hospital bank staff system. We saw that no agency staff were used on the rotas we reviewed.
- Across both hospital sites, the outpatient departments had a sickness level of 4.9% in September 2016, which was above the trust target of 3%.
- The highest level of sickness across both hospital sites was in the orthodontics departments which was 8.2%.

Allied healthcare professional staffing

- Staffing levels and skill mix were planned and reviewed so that people received safe care and treatment at all times. Planned staffing levels for the department showed between 40 to 41 planned qualified staff (radiographers) and six planned non-qualified (radiography assistants)on a week day and 18 qualified and four non-qualified on a weekend. Actual staffing levels for the department showed the planned staffing levels were frequently not met by between one to six staff for qualified staff, and one to two for non-qualified staff. Over a period of 16 weeks, staffing levels were monitored by the diagnostic imaging department. Out of 112 days covered, 82 showed a shortfall of qualified staff and 98 showed a shortfall of unqualified staff.
- On one week day, data showed there were 27 qualified staff against a planned establishment of 41 staff. Another weekend day showed a shortfall of five staff against a planned establishment of 18 qualified staff. Staff told us when weekend shifts were understaffed, they reported this as an incident on the electronic reporting system.
- At the time of our inspection, the diagnostic imaging department across both sites, had seven band 5 radiographer vacancies, and seven band 6 radiographer vacancies, and staff said some shifts were often down a member of staff. Managers told us of an on-going recruitment plan to engage with universities to encourage newly qualified staff to apply to the hospital to help fill the band 5 positions.
- There were no radiographer vacancies in the radiotherapy department, and at the last recruitment drive, the department had received over 40 applications for one job.
- Data supplied for both hospital sites showed diagnostic imaging had a sickness rate of 3.6% in September 2016, which was above the trust target of 3%, and a staff turnover rate of 1.7%.

Outpatients and diagnostic imaging

Medical staffing

- The diagnostic imaging department currently had 5.5 whole time equivalent vacancies for radiologists, with an advert currently live. Staff told us radiographers had been used to help clear the reporting backlog, as the existing radiologists did not have capacity to clear it, and meet current reporting targets.
- In Rheumatology, the recruitment of an additional substantive consultant was a key element of the specialities' referral to treatment recovery plan. The new post was to focus on clearing the backlog in rheumatology for patients by creating additional capacity for follow up appointments, but had not yet been filled.

Major incident awareness and training

- There were reliable arrangements in place to respond to emergencies and major incidents, and the trust had a major incident plan which was available to staff on the intranet. In the trauma and orthopaedic outpatient department, staff had access to in date lockdown action cards outlining what to do in a lockdown situation.
- There were effective arrangements in place in case of a radiation or radioactive incident occurring and staff could explain how they would contain a spillage of a radiopharmaceutical, and knew who to contact and how to report the incident.

Are outpatient and diagnostic imaging services effective?

Are outpatient and diagnostic imaging services caring?

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because;

- The hospital was not meeting the 62 day target for cancer patients, and the trust was not meeting referral to treatment target in all specialities.
- Patients were experiencing delays in diagnosis and treatment because the diagnostic imaging department had a reporting backlog of 19,500 films, and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety, diagnosis and on-going treatment.
- Implementation of new IT systems had impacted on waiting lists as some specialties could not see their live waiting lists.
- Patients were not able to access the top floor clinics easily due to the lift being out of order.

However;

- The hospital had introduced a new waiting list validation process to discharge some patients back to primary medical care facilities.
- Visually impaired patients were able to access services in ophthalmology through the use of colour coded signs, which made navigation of the department easier.
- The oncology department provided an information presentation for all newly diagnosed patients which included opportunities to ask questions on a one to one basis.

Service planning and delivery to meet the needs of local people

- It had previously been identified that some services were not planned in a way which met people's needs, and some patients were remaining on follow up lists for too long after their treatment. This in turn was preventing the services from seeing new patients.
- Information about the needs of the local population was used to inform how services were planned and delivered. Commissioners and local GPs had been involved in developing a process for reviewing all pending and follow up patients. In June 2016, local GPs had begun to identify patients who were currently under the care of the hospital, who could be discharged back to community services such as community hospitals and GP surgeries for their on-going care and follow up. This had begun to free up more capacity in the hospital clinics to accept new patients.
- The services provided reflected the needs of the population served. There were specialist clinics such as the urology multi-disciplinary clinic or 'MAD' clinic. Staff

told us this clinic was a direct referral clinic for any type of urological problem including suspected cancer. The aim of the clinic was to see patients within two weeks and provide a one stop clinic where patients received most of tests they needed. If a test could not be performed in the clinic, patients were referred on to other facilities. Data submitted showed 70% of patients received all of their tests the same day. Senior staff told us the frequency of these clinics was being increased from once to twice a week to help meet the demand for appointments, however, staff told this had not happened yet due to a delay in purchasing additional equipment for the clinic

- Some types of test such as urodynamics were only available for male patients.. Female patients were referred to another facility as the room used for male urodynamic studies was small and not easily adaptable for female patients. There had been no change to this situation since our last inspection, and no plans to change this arrangement.
- The diagnostic imaging service offered a seven day appointment service across most specialities including computed tomography (CT), ultrasound, Magnetic resonance imaging (MRI) and plain film x-rays.
- A new initiative had been developed in the oncology outpatient department where nurses were trained to give a group presentation to new patients. The presentation covered information such as car parking, dietary tips and financial advice. One to one sessions were also provided with specialist nurses during the group time. Staff told us the service had been nominated for a national award.
- The facilities and premises were not appropriate in some areas for the services that were planned and delivered. For example the west block cardiology and rheumatology clinics were held on the second floor, and patients did not have access to a lift. Staff told us of a bariatric patient who attended for a cardiac appointment, who had to be placed in a wheelchair and taken through the hospital to the nearest working lift in order to access the clinic because they could not manage the stairs.
- The environment of the other outpatient clinics and diagnostic imaging department were appropriate and patient centred and there was a selection of magazines and patient information available in the waiting areas we visited.
- Patients were able to locate the outpatient and diagnostic imaging departments because they were clearly signposted within the hospital and there were volunteers available to help.
- Patients told us information was provided to them before their appointments which included a hospital map, directions, their consultant's name and parking and travel information.
- There were quiet areas where patients could wait without being forgotten if they found busy environments distressing. In the trauma and orthopaedic outpatient department staff told us that if patients attended the department and were unable to sit in the waiting room provision would be made for them to wait in a quieter area.
- Staff in the oncology outpatient department told us how they made special provisions for needle phobic patients, by making sure every session of chemotherapy was administered in a private room.

Access and flow

- Care and treatment was prioritised for people with the most urgent needs, although not all people were seen in a timely way for example, the emergency eye casualty department provided same day appointments to help reduce unnecessary admission through accident and emergency, and provided an emergency telephone line, manned by a nurse practitioner. The line was open Monday to Thursday between 9.00-17.300 and 09.00-13.00 on a Friday.
- Between April 2015 and March 2016, the follow-up to new rate for Cheltenham General Hospital was higher than the England average. This meant the trust were seeing fewer new patients when compared with the rest of the hospitals across England.
- Between November 2015 and October 2016 the trust's referral to treatment time (RTT) for non-admitted pathways has been worse than the England overall performance. The latest figures for October 2016, showed 82.5% of this group of patients were treated within 18 weeks versus the England average of 89.4%. Whilst the trust was following the national trend of decline in this measure, it was declining at a faster rate than the England average. Out of the 16 specialties reported, 13 were falling below the England average for RTT. These included urology (81.3%), oral surgery (68.1%) and rheumatology (66.5%).

Outpatients and diagnostic imaging

- Between November 2015 and October 2016 the trust referral to treatment time (RTT) for incomplete pathways had been overall better than the England overall performance but worse than the operational standard of 92%. The latest figures for October 2016 showed 89.9% of this group of patients were treated within 18 weeks versus the England average of 90.1%. The trust's performance had followed the England average until May 2016 when performance started to decline over time. However, despite this decline the trust's performance was better than the England average in September and October 2016. Of the 17 specialities reported, 11 were meeting or exceeding the RTT. These included, ophthalmology, dermatology, gastroenterology, trauma and orthopaedics and general surgery. However, six were falling below the England average and operational targets for RTT. These included urology (84.3%), oral surgery (81.5%) and rheumatology (88.9%).
- The waiting times for patients needing cancer treatment were described in relation to the 'cancer wait' targets set by NHS England. The trust was performing worse than the 93% operational standard for people being seen within two weeks of an urgent GP referral between October 2015 and September 2016. However, since April 2016, this had begun to improve, and during our inspection, we saw data which showed the trust had met the 93% target in October and November 2016, but had declined slightly in December to 92.5%. The overall situation had improved since our last inspection.
- Between October 2015 and September 2016 the trust was consistently performing better than the 96% operational standard for patients waiting less than 31 days before receiving their first treatment following a cancer diagnosis (decision to treat). However, the trust was performing worse than the 85% operational standard for patients receiving their first treatment within 62 days of an urgent GP referral. This was similar to what was found on the previous inspection.
- As part of the trust's cancer performance recovery plan, each speciality was given a red, amber or green rating depending on the numbers of patients waiting past the two week wait or 62 day wait target. Two specialities were rated green, six amber and one red. The speciality rated red was urology, and in November 2016, had seen 87% of its two week wait patients, and 53% of its 62 day pathway patients. Actions recorded in the recovery plan included expanding the multidisciplinary (MAD) clinics from one to two a week, using more routine slots to see two week wait patients and securing short term funding for additional Magnetic Resonance Imaging (MRI) scans.
- The urology department had a typing backlog of 1014 letters in December 2016. Staff told us bank medical secretaries were being used to support the permanent secretaries, but staff were spending an increasing amount of their time speaking with patients and GPs over the phone, who were chasing clinic letters which was in turn affecting their ability to work through the typing backlog. Staff told us letters often contained instructions to GP's and other consultants about patient on-going care, which was being delayed by the typing backlog.
- Bookings for most outpatient clinics were made through the offsite central bookings office, with the exception of some specialist clinics which were booked by the consultants. The trust had recently introduced a new IT system to oversee all aspects of patient care including bookings. Staff told us the system had left them unable to view some waiting lists, and staff were using data from the end of November to book appointments. Senior staff told us the next roll out of the system would rectify some of these issues. Staff also told us the e-learning training package for the new system had been difficult to understand and some outpatient areas at Cheltenham General Hospital had not received the face to face support which was promised during the first week of roll out.
- For diagnostic and imaging, between November 2015 and October 2016 the percentage of patients waiting more than six weeks for their test or scan was higher than the England average for five of the twelve months.
- The diagnostic imaging department across all sites, had a reporting backlog of 19,500 plain films, which it was working to reduce, and provided weekly updates to the board. We were told the department had employed a number of reporting radiographers to reduce the backlog, which had been over 40,000 films in September 2016. The department had prioritised outstanding CT and MRI scans, which had allowed the plain film backlog to rise. At the time of our inspection there were 250 CT scans outstanding, and 270 MRI scans. The clinical lead for diagnostic imaging had a proposal to clear all of the outstanding reporting, which required funding approval from the board. If this was unsuccessful, the department

was planning to audit patient notes to assess if referrers were documenting their findings, which is a requirement of IR(ME)R 2000 and an extra assurance of patient safety.

- Clinicians in the diagnostic imaging department reminded referring medical staff of their responsibilities for reviewing and documenting findings from X-rays ,which insured no images were going un-reviewed by a clinician.
- The diagnostic imaging department had set a target for all examinations to be reported within five days. Data submitted for October 2016 showed that 63% of examinations were reported within five days and 37% over five days. Accident and emergency examinations had a three day target for report turnaround, which the department was meeting for CT, MRI, Nuclear medicine, ultrasound and fluoroscopy examinations, however, 72.6% of plain film X-rays were waiting over five days for a report.
- Action was taken to minimise the time people have to wait for treatment or care. For example in diagnostic imaging in October 2016, 54% of outpatients attended for their examinations within two weeks of a referral being accepted and radiologists worked to verify reports within 24 hours to minimise delays in sending out results. In October 2016, 94.7% of were verified within 24 hours.
- Care and treatment was only cancelled or delayed when absolutely necessary. Between June 2016 and September 2016, the trust cancelled between 3 - 3.2% of all outpatient appointments across all sites with less than six weeks notice, and between 4.9 – 6.4% of clinics with over six weeks notice. The most frequently recorded reasons for these cancellations were clinicians' annual leave and the junior doctor strike.
- Patients told us that cancellations were not always explained to them, and some patients told us of multiple cancelled appointments. Another patient had attended for their procedure to be told it was cancelled when they arrived at the hospital.
- We saw that clinics did not always run on time, however, we saw delays displayed on whiteboards in each clinic waiting area, and heard staff updating patients verbally while they waited.
- Patients told us that the waiting times for appointments were always communicated, and this was echoed on the trust website in its information about the outpatient department.
- The diagnostic imaging department recorded the time that patients were kept waiting once they arrived in the department. This data was collected across all sites and indicated that patients for plain film imaging were being seen on average within one to two minutes of booking into the department. Patient for Computed tomography (CT) waited on average between 36-41 minute and nuclear medicine patients between 47-96 minutes, however, this was due to the complexity of the scans which often required patients to wait for a set period of time prior to their scan.
- Between April 2015 and March 2016 the rate for non-attendance for appointments was below the England average at Cheltenham General Hospital. Action had been taken to reduce this rate by using text messages to remind patients of their upcoming appointments.

Meeting people's individual needs

- Services were not always planned and delivered to take account of the needs of people. For example, a patient told us they had attended for a procedure, and had been told to leave their mobile phone at home, as the hospital had contact details for their spouse on the computer system. After the patient's spouse left the hospital, the patient was told their procedure was cancelled. The hospital did not have a phone number recorded for the patient's spouse, and this had not been checked before the patient's spouse had left the hospital. As a result, the patient had to stay in the hospital until they returned several hours later.
- Services were planned, delivered and coordinated to take account of people with complex needs, such as a learning difficulties or those patients living with dementia. For example, the trust used a document for people with complex needs called 'tell us about you'. These documents were kept by the patient, and brought to clinic appointments to help staff understand their individual needs, and we saw them in use in one of the outpatient clinics we visited.
- Staff told us about occasions when reasonable adjustments were made so that people with a disability could access and use the outpatient services on an equal basis to others. In one ophthalmology clinic we saw colour coordinated signage and a coloured floor pathway for visually impaired people, which patient's told us made navigating the unit a lot easier.

Outpatients and diagnostic imaging

- Translation services were readily available if required via a telephone system, or through pre-bookable translators. Staff we spoke with were all aware of these systems and we saw information displayed for patients regarding this service as well. For example, the oncology outpatients department provided hour-long sessions with translators who were booked in advance by booking staff. During these sessions, patients and their relatives had the opportunity to discuss consent for their treatment alongside general questions they had about their care.
- Staff used a visual system to identify patients with cognitive impairments and attached eye or ear signs to the front of the patient's notes.
- Appropriate support was available for bariatric patients such as wheelchairs, however staff showed us that due to limited space in some clinic rooms in west block outpatients, not all types of wheelchairs, could be accommodated.
- The outpatient department did not always arrange appointments so that new patients were allowed time to ask questions, and clinics were sometimes up to an hour behind. We were told this was due to doctors wanting to accommodate patient questions in the clinic appointment. However, the multi-disciplinary clinics in urology were arranged to allow patients extra time to ask questions and attend tests at their first appointment. Patients told us they were made aware of possible waits before they attended but were pleased they had access to diagnostic testing as part of the clinic.
- The outpatient department in the West block was arranged over three floors, with a lift to allow patients to access clinics on the top two floors. Staff told us the lift had been out of order since November 2016, and patients were finding it difficult to access the top floor clinics via the stairs, which included cardiology and rheumatology. We saw healthcare assistants helping patients up and down the stairs. Senior staff told us the lift engineers were hoping to have the lift working very soon, but expressed concern at the length of time it had taken.

Learning from complaints and concerns

- Not all patients we spoke to knew how to make a complaint or raise concerns but felt confident to speak up about concerns if necessary. We saw leaflets displayed in most clinical areas about the complaints process and these were available in different languages and easy read formats. Patients also told us they were given written information about the complaints process and the patient advice and liaison service (PALS) when they attended for their appointment.
- Patients who had raised a concern were treated with compassion and we saw that clinicians encouraged patients to make complaints or raise concerns.
- Between November 2015 and October 2016 there were 390 complaints about the outpatient departments across all sites. The trust took an average of 36 working days to investigate and close complaints, which was not in line with their complaints policy, which stated 95% of cases should be responded to within 35 working days.
- Across all sites the most complained about areas were appointments with 99 (25.3%) complaints, and clinical treatment with 77 (19.7%) complaints.
- Cheltenham General Hospital received 134 complaints between November 2015 and October 2016 about the outpatient departments. The most complained about area was appointments, which accounted for 32 complaints (24%) of all complaints received.

Are outpatient and diagnostic imaging services well-led?

Outstanding practice and areas for improvement

Outstanding practice

- Direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- The expansion of the 'MAD' multi-disciplinary clinics in urology allowed more patients to access the one stop services and receive same day tests and results for the majority of cases.
- A new initiative had been developed in the oncology outpatient department where nurses were trained to give a group presentation to new patients. The presentation covered information such as car parking, dietary tips and financial advice. During the session, one to one sessions were also provided with specialist nurses.

Areas for improvement

Action the hospital MUST take to improve

- Ensure that all information related to patients' mental capacity and consent for 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) is available in patient records.
- Ensure trust staff comply with all the requirements of the Mental Capacity Act (2005).
- When using Kemerton and Chedworth Suite for inpatients, provision must be made for the cleaning of the units at weekends and to provide patients with clean water jugs and drinks.
- Review processes to monitor the acuity of patients to ensure safe staffing levels.
- Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health (COSSH).
- Ensure machines used for near patient testing of patient's blood sugar, are calibrated daily and this is recorded or ensure all staff are trained in how to use the new machine so the old machines can be removed.
- Ensure effective cleaning of ward areas and equipment.
- Review the governance and effectiveness of care and treatment through participation in national audits.
- Ensure patient records are kept securely at all times.
- Ensure steps are taken to reduce the current typing backlog in some specialities
- Ensure specialities have oversight of all of their waiting lists.
- Ensure that all staff are up-to-date with mandatory training and receive yearly appraisals in line with trust policy
- Ensure that patients arriving in the emergency department receive a prompt face-to-face assessment by a suitably qualified clinician.
- Ensure that a suitable space is identified for the assessment and observation of patients presenting at the emergency department with mental health problems.

Action the hospital SHOULD take to improve

- Ensure all complaints are handled within trust policy timescales
- Ensure all risk identified relating to the provision of end of life care is included on a risk register.
- Ensure the training needs analysis for general staff on wards related to end of life care is completed by the trust end of life care strategic group.
- Consider involving the specialist palliative care team and support teams in major incident plan practices or exercises.
- Review the signage and consider if the system of using 'white rose' symbols to assist location of trust mortuaries is effective

Outstanding practice and areas for improvement

- Consider the availability of family rooms associated with wards for overnight accommodation for those close to patients at end of life.
- Ensure staff in specialist palliative care team are able to use the results of the safety thermometer information in relation to patients receiving end of life care.
- Ensure all staff within the surgical specialities is aware of Never Events and the learning needed to prevent a reoccurrence.
- Continue to make improvements with the reduction of surgical site infection rates.
- Consider a system to recognise and respond to blank boxes on prescription charts to make sure patients receive medicines as prescribed.
- Ensure emergency trolleys should be checked in line with trust policy and best practice guidance.
- Review the pre admission clinic area including appropriate seating.
- Provide resuscitation equipment for the pre admission unit to ensure if a patient collapsed, they receive the correct care in a timely manner.
- Review the equipment in the pre-admission unit to ensure it meets the needs of the service.
- Ensure the safe management of medicines at all times and including the checking and signed for controlled drugs administration. Ensure all patient group directions (PGDs) are reviewed and in date. Review processes to recognise and respond to blank boxes on prescription charts to make sure patients receive medicines as prescribed.
- Review the lack of 24-hour emergency theatre to ensure no patients will be put at risk.
- Reduce the number of patients who have their operation cancelled on the day of surgery, and reduce the number of patients not rebooked within 28 days.
- Ensure oversight of mortality and morbidity (M&M) meetings across all services.
- Ensure staff can decontaminate hands on entering and leaving clinical areas where care is delivered.
- Ensure staff follow best practice when patients are admitted with potentially transmittable viruses such as diarrhoea and vomiting.
- Ensure replacement of equipment to ensure safe diagnosis of medical conditions.
- Ensure medicines are stored, used and disposed of in line with manufacturers specifications and trust policy.
- Ensure fire doors are secured in line with fire risk assessments.
- Ensure treatment pathways are reviewed and update to ensure best evidence-based treatment.
- Ensure effective monitoring of clinical improvement and audits, including compliance with accurate and timely NEWS assessments
- Review processes to ensure compliance with the accessible information standards.
- Continue to work in collaboration with partners and stakeholders in its catchment area to improve patient flow within the whole system, thereby taking pressure off the emergency department, reducing crowding and the length of time that patients spend in the department.
- Consider ways to ensure the emergency department is supported by the wider hospital and that there is more engagement from specialties in addressing the risks associated with patient flow.
- Ensure steps are taken to reduce the current typing backlog in some specialities
- Ensure effective cleaning systems are in place in clinical areas of both the environment and equipment.
- Ensure specialities have oversight of all of their waiting lists.
- Ensure patient records are stored securely at all times.
- Maintain an up to date list of all practitioners under IR(ME)R.
- Take steps to ensure all patients' referral to treatment times do not exceed national targets including cancer wait targets.
- Continue to reduce the current reporting backlog.
- Take action to monitor and reduce the numbers of temporary notes in use.
- Ensure reporting of plain film x-rays for the accident and emergency department meet the three day turnaround.
- Ensure flooring in treatment rooms conforms to infection prevention and control standards.
- Review the phlebotomy clinic environment so it is fit for purpose and accessible to all patients.
- Ensure patient privacy and dignity is respected at all times when giving care or treatment.
- Ensure steps are taken to allow patients with limited mobility to access all services on an equal basis to others by fixing lifts.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent (1) Care and treatment of service users must only be provided with the consent of the relevant person. (3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act*. Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation attempts were not discussed or were not documented.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance (1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this part. (2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

This section is primarily information for the provider

Requirement notices

(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and

treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.

The processes and systems used to monitor and process the number of outstanding clinic letters were not effective, and several specialities had significant backlogs of typing.

The processes and systems in place to identify and assess risks to the health and safety of people who used the services were not effective. The lack of oversight of the backlog of pending and follow up waiting lists placed patients at risk of harm due to increased delays in treatment and assessment.

People who used the services were not protected from the risk associated with unauthorised access to confidential patient records. Patient records were not securely kept at all times.

The medical service did not consistently participate in and review the effectiveness of care and treatment through national audits.

Trolleys with patients' medical records were not always secured and stored in an appropriate area that ensured the safe keeping of medical records. When we returned unannounced, we saw many patient records that were placed on desks and in unlocked trolleys on the wards, we visited

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, (c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role. Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day. The trust did not use a recognised tool to assess the acuity of patients daily and ensure safe staffing levels were in place on each shift and particularly at night. There was no formal out of hour's interventional radiology consultant rota and surgeons had to spend time trying to find one in an emergency situation.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

(1) (a) All premises and equipment used by the service provider must be clean.

The fabric of the building did not always ensure efficient cleaning could be carried out. The premises used for the delivery of services in ophthalmology outpatients were visibly unclean, with dirty fans in use in clinical procedure rooms.

The fabric of the building did not always ensure efficient cleaning could be carried out. For example, there was cracks in the flooring in the acute assessment unit.

When Kemerton and Chedworth Suite were opened at weekends, there was no provision for cleaning of the unit during this time.

(1) (c) All premises and equipment used by the service provider must be suitable for the purpose for which they are used

Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).

The mental health assessment room did not comply with safety standards recommended by the Royal College of Psychiatrists

(1) (d)(e) All premises and equipment used by the service provider must be properly used and maintained.

There were new machines for checking of patients' blood sugar however, not all staff had had training so the old machines were also still in use. Staff did not always calibrate these daily in line with manufacturer's guidance.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Safe care and treatment. 12 (1) The provider did not provide care and treatment in a safe way: Patients arriving in the emergency department did not always receive prompt, face to face initial assessment by a clinician. 12 (2) (a). The emergency department did not have a suitable space for the assessment and observation of patients who presented with mental health needs, as recommended by the Royal College of Psychiatrists.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...