Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Royal Hospital

Inspection report

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Ratings

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

Our findings

Overall summary of services at Gloucestershire Royal Hospital

Good 

We carried out a focused inspection of Gloucestershire Royal Hospital urgent and emergency care service (also known as accident and emergency – A&E) on 30 March 2021 as part of our winter pressures programme. As this was a focused inspection, we only inspected parts of three of our key questions: safe, responsive and well led. We did not inspect effective or caring on this visit, but we would have reported on them if we found areas of concern. At our previous inspection in 2018, caring and effective were rated as good.

For this inspection, we considered information, data and the concerns this raised over the ability of the department to respond to patient need (also known as performance) of the department and the wider trust in relation to responsive care (around timely patient flow) and waiting times for patients. We were also concerned with delayed and lengthy turnaround times for ambulance crews.

Our inspection had a short announcement (around 30 minutes) to enable staff to arrange to meet with us and for us to carry out our work safely and effectively.

Focused inspections can result in an updated rating for any key questions that are inspected if we have inspected the key question in full across the service and/or we have identified a breach of regulation and issued a requirement notice, or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Previous ratings were not all updated during this inspection. However, the rating for urgent and emergency care for safe and overall went down. We rated safe and the urgent and emergency care overall as requires improvement. The previous rating for responsive remained as requires improvement and well led remained as good. We did not change the overall ratings for the location.

Please refer to the 'areas of improvement' section for more details.

During our inspection we found:

- The reconfiguration and use of some areas of the department did not always keep patients and staff safe despite the efforts the service had made during the pandemic. We were concerned with crowding in the department, which did not promote safe social distancing.
- Patients' dignity and respect were compromised, and social distancing was not always possible because patients were cared for in corridors of the department.
- The service did not have enough medical staff and nursing staff to meet the recommended guidance for the type and size of the department or to be able to expand the service. The department did not have middle grade and junior doctors throughout various parts of the day but managed to cover the department through the use of locum doctors, bank and agency staff as required.

Our findings

- Patients did not always receive care and treatment promptly, although there were significant efforts made to keep them safe. Pressure from high demand, COVID-19 restrictions, a lack of beds in the rest of the hospital available for patient transfer, and patients being more unwell meant patients attending the urgent and emergency care service did not get seen in a time considered safe and responsive to their needs.
- Patient handover from ambulance crews and waiting-time performance for onward admission to the hospital was worse than NHS national standards. It is well understood how these delays cause harm to patients, lengthen response times and delay ambulances needed in the community. However, staff were actively looking for improvements and short and long-term solutions, both internally and externally with system partners. Also, there were few delays in the decisions taken around onward patient care. The department had resolved several flow problems which were in its own control but was limited by external factors.
- Some of the trust's senior leadership team were not sufficiently visible and approachable for some staff to provide assurance and support, demonstrate recognition and awareness of the risks and struggles staff experienced.
- Although leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact, these did not always have the desired outcome in times of crisis.

However:

- Staff understood how to protect patients from abuse and acted on any concerns. They recognised when abuse might be occurring and were trained in how to deal with their concerns to keep patients safe.
- Staff kept detailed and comprehensive records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to staff providing care.
- Patients had an assessment of their infection risk and other clinical risks on arrival at the department.
- Leaders in the emergency department demonstrated the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were supportive, caring and approachable in the service for patients and staff.
- Staff in the department felt respected, supported and valued by their colleagues. They were focused on the needs of patients receiving care. There were strong examples of staff feeling able to speak up and raise concerns without fear.
- There were effective systems to recognise, report and understand performance, including a live dashboard available to staff to be able to track performance.

Areas for improvement

We found areas for improvement including six breaches of legal requirements the trust must put right. We found three further areas where the trust should make improvements to comply with a minor breach that did not justify regulatory action, to prevent beaching a legal requirement, or to improve service quality.

For more information, see the 'Areas for improvement' section of this report.

How we carried out the inspection

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

Urgent and emergency services

Requires Improvement 

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services from Gloucestershire Royal Hospital, and Cheltenham General Hospitals.

The trust employs more than 8,000 staff including 887 medical staff, 1730 Nursing staff, 1136 therapists/scientific staff and 2393 ancillary, administrative and support staff, and has an annual turnover of £608 million.

Patients are admitted for emergency and planned surgery, and a full range of medical care services. There are a range of outpatient services, services for older people, acute stroke care, cancer services and a full pharmacy service.

The trust provides comprehensive maternity services, including a midwife-led maternity unit, community midwifery antenatal care, postnatal care, and home births. The trust has a special care baby unit and children's services including emergency assessment, inpatient and outpatient care.

Diagnostic services include pathology, CT scanning, MRI scanning, ultrasound, cardiac angiography and a respiratory laboratory.

The trust provides full emergency department services for adults and children, and critical care for adults. The emergency department is located on the main hospital site to the right of the main entrance. The emergency department accepts patients transported by ambulance or those who arrive independently. It is open 24 hours a day, seven days a week for patients who require emergency treatment. There is a separate entrance to the majors area (areas where the most serious patients are treated) for patients arriving by ambulance.

In response to the COVID-19 pandemic and to maintain the prevention and control of infection, the trust transferred the emergency department at Cheltenham General Hospital to Gloucestershire Royal Hospital. Since June 2020, the service at Cheltenham had been converted to a minor injuries and illness unit. We only inspected the emergency department at Gloucester Royal Hospital on this visit.

Total A&E attendances for the period of December 2019 to November 2020 were 126,171 of whom, 17,431 (14%) were children and 44,981 (35%) were attendees arriving by ambulance. This was down by around 30,000 patients over typical patient annual attendance (in line with the national fall in patient numbers during the months of the first pandemic lockdown) and notably lower in April, May and June 2020. Eight percent of patients had an unplanned reattendance to A&E within seven days which was similar to the national average of 8.7%.

Since the pandemic, the emergency department has reconfigured the majors, minors (for less serious injuries or illnesses) and resuscitation (for seriously ill patients who may require life support) areas to accommodate patients who are positive to COVID-19. The green majors area has 23 spaces of which, two are used for triage and assessment of patients arriving by ambulance. There is also one room for patients with suspected infectious diseases. The green resuscitation area has spaces for three adults and one child. The red area, which was previously the paediatric minors and majors area, has three cubicles and two trolley spaces. Apart from minor injuries and children requiring care in the resuscitation area, all children attending the department are streamed to the paediatric assessment unit.

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There is a Gloucestershire Priority Assessment Unit (GPAU) located next to the extended majors area for patients who need more medical input than could be provided in the community. This unit has seven side rooms and 13 trolley spaces. There is also a same day emergency care unit located near the main hospital entrance which had six consulting rooms and a treatment area with six spaces.

Is the service safe?

Requires Improvement 

The rating for safe went down. We rated safe as requires improvement.

Safeguarding

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

Staff we spoke with were clear about how they would identify patients they felt were at risk of abuse. A range of staff from different grades and disciplines were able to clearly describe what the signs were of suspected abuse that would worry them.

Staff knew who they should inform either in the department or within the trust with concerns. There was a trust-wide team of higher-level trained safeguarding staff who had the responsibility to investigate any safeguarding concerns. These were raised with the relevant local authority who had the statutory duty to act on allegations of abuse. Staff we asked said the safeguarding practitioners were very supportive and approachable with any anxieties staff might raise, however small they might seem.

Staff told us they received regular training updates in adult safeguarding and child protection and training was delivered to all new staff at their induction as a mandatory subject. Those staff we met had been trained to various levels in accordance with their role. In the most recent performance report provided by the department as of March 2021, the uptake of safeguarding and paediatric training compliance was between 65% and 72% against a trust target of 90%. Staff told us training accessibility was normally very good and had been affected by the current pandemic. However, these would be back to normal from April 2021.

Cleanliness, infection control and hygiene

In most aspects, the department controlled infection risk well and it was visibly clean in areas we visited. Staff wore the right personal protective equipment (PPE) to keep themselves and others safe from cross infection. However, we did see crowding in the department's corridors, which did not promote effective social distancing.

There was an increased risk of nosocomial infection where patients were waiting in crowded areas.

Staff carried out triage and assessment of patients, referred to as PITSTOP, in a designated area. However, when the department was full, this area was not available for the PITSTOP assessment, meaning staff carried out assessments and triage in the ambulance entrance or in the corridors. Patients who were able to be cared for in chairs in the majors areas, were seated in the corridor with plastic screens in between each patient. Some patients were also cared for on trolleys in the corridors. This was also the case in the minors area where patients were cared for in chairs. At one point during our inspection, we observed nine patients being cared for in the corridors. This reduced the amount of space available to enable effective social distancing. This was not in line with The Royal College of Emergency Medicine (RCEM) best practice guideline on Emergency Department Infection Prevention and Control (IPC) during the Coronavirus Pandemic.

Urgent and emergency services

The leadership team told us they minimised the risks of infections by placing trolleys in such a way that patients were positioned "head to toe" and patients were required to wear face masks. However, we observed in some cases, patients got up from their trolley and took their face mask off. Staff in the department could not always ensure patients adhered to the infection prevention and control measures established by the trust.

Staff used equipment and control measures well to protect patients, themselves and others from infection. We observed staff wearing the correct personal protective equipment (PPE) depending on where they were working. The trust had a policy that all staff working within the emergency department had to wear eye protection and we observed staff adhering to this. Staff said they had not encountered any shortages of PPE since the start of the pandemic and they had been well provided for. Staff told us they had received effective training in putting on (donning) and removing (doffing) PPE safely to prevent the risks of cross infection. They said they were regularly checked by the trust's infection prevention and control team to ensure their practice remained safe and effective. We were offered surgical masks and eye protection when we were met by the Medical Director. They also checked that the inspection team had undertaken a COVID-19 test and that the result was negative.

If staff were carrying out a more high-risk procedure, such as one which may generate aerosols into the atmosphere (known as an AGP); signs were placed at the doors of any room being used to alert all staff to the correct PPE to be worn in those areas. Fit testing had been carried for all staff required to work in those areas.

The premises were visibly clean in those areas we visited. Surfaces including floors and desk areas were visibly clean as were beds and the equipment around them. There was a cleaning regime by domestic and the department's staff.

Environment

The reconfiguration and use of some areas of the department did not always keep patients and staff safe, despite the efforts the service had made during the pandemic.

The emergency department had been reconfigured in response to the COVID-19 pandemic, in an aim to meet national guidance, and to improve patient flow. There were distinct and separate pathways for patients with known or suspected COVID-19 (red), unknown status (amber) or known negative status (green).

We observed the environment being crowded. Patients were being cared for in corridors, which resulted in poor patient experience. In addition to the infection control risks, we found patient dignity and privacy was compromised while they waited on trolleys. Furthermore, patients in some areas of majors could overhear confidential conversations about patients, which compromised patient confidentiality. There was a risk on the trust's risk register related to overcrowding and the trust continued to review actions and make improvements for the department's flow to reduce crowding. Staff told us that they had reconfigured the minors and majors area about six times to respond to demand and to ensure they could see patients safely.

The department's management team had recognised that patients with mental health issues had poor experience in the department and were therefore taking actions to improve the environment. This included working with a local charity that promoted the use of art to support patients with mental health. The department had plans to implement artwork in the mental health assessment room.

Urgent and emergency services

Assessing and responding to patient risk

Patients had an assessment of their infection risk and other clinical risks on arrival at the department. The department had a system for monitoring patients who were either at risk or found to be deteriorating. This included patients who were waiting on ambulances to be admitted to the department when demand was high or patient flow out of the department was blocked or slow.

All patients were assessed for their risk of COVID-19 when they entered the emergency department and directed to the correct pathway. The department had been working with the local ambulance trust to undertake a patient COVID-19 lateral flow test before arriving at the hospital. Additionally, the department had near patient testing facility for quick turnaround of test results.

Patients arriving in the minors' area independently from the ambulance service were triaged by the nursing team and any risks, which required them to be seen more quickly were recognised through that process.

Staff used a national early warning score (NEWS2), which recorded clinical indicators and required staff to respond when the score reached or passed certain limits. This nationally recognised tool was well-embedded with clinical staff. Those we talked with about it said it was used well and was part of the toolkit for responding to risk of patients deteriorating. However, we found that the department's computer system did not enable the nurse in charge to have oversight of deteriorating patients. The nurse in charge told us they relied on the nursing and medical team to inform them if the score had changed from the point of admission. Staff told us that the computer system was being changed, with completion by the end of April 2021 and the changes will enable them to have better overview of deteriorating patients.

To support the department in times of pressure a rapid triage and assessment (called PITSTOP) of patients arriving by ambulance between 1pm and 10pm Monday to Friday. This process ensured patients were assessed as quickly as possible during busy times. Data provided by the department (which was not verified at the time of writing this report) showed the average time taken from patients arriving to triage between September 2020 and February 2021 for Gloucester Royal Hospital was 22 minutes.

To address the possibility of patients' deteriorating in the ambulance while waiting, the department relied on the ambulance crew to keep the hospital ambulance liaison officer (HALO) or hospital team informed. There was a standard operating procedure, which clearly highlighted that the department was responsible for all patients being held on the ambulance and that patients may be assessed on ambulances, when there was no capacity to offload. However, in practice, the department relied on ambulance crews carrying out observations on patients and escalating deteriorating patients to the HALO or department staff. We saw staff had attended to a patient waiting in the ambulance and had set up initial treatment such as intravenous drip. The staff we spoke with were clear that patients on the ambulance were immediately entered into the hospital system and deemed the responsibility of the hospital staff. Once patients arriving by ambulance were booked onto the department's computer system, the HALO worked in collaboration with the Emergency Physician in Charge known as EPiC and Nurse in Charge to maintain oversight of the patients awaiting to be offloaded.

We observed in the majority of patient records treatment was given promptly. However, there was one case in those records we reviewed where a patient arrived in the department at 10.30am and was prescribed antibiotics at 11.55am, which were not administered until 12.55pm.

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Nurse staffing

The pressures of COVID-19 meant the service struggled at times to have enough nursing staff. Measures were taken to ensure staff were brought in where possible to reach safe numbers. The trust and the nursing leadership were aware of the critical position for nursing staff and it was under constant review.

The COVID-19 pandemic brought pressure to all hospitals in the country due to staff either becoming infected, being required to self-isolate after contact with a positive person, or from the usual sickness which afflicts staff at times. There was also pressure from patients needing more care, PPE taking time to apply and remove, and a reduction in the availability of temporary staff. This was coupled with a national shortage of nursing staff before the pandemic.

The department's matron told us there was a band seven nurse in supervisory role on each shift. The aim was to have 19 nurses (all grades) in the morning, 20 on the late shifts and 19 through the night. However, on average the department was down between two to three nurses on each shift. There was currently a vacancy of 11 nurses. Staff told us staffing had been a challenge and they needed more nursing staff to support the department. When staffing was not meeting planned levels, the trust used bank or agency staff or redeployed from other areas if possible.

Medical staffing

The service did not have enough medical staff to meet the recommended guidance for the department or be able to expand the service. There were insufficient numbers of middle grade and junior doctors and rotas were not always filled.

The Royal College of Emergency Medicine (RCEM) recommends (RCEM Workforce Recommendations 2018: Consultant Staffing in Emergency Departments in the UK, February 2019) consultants are on duty in the department from 8am to midnight in all medium and large systems. With usually more than 100,000 patient attendances each year, the adult emergency department at the Gloucestershire Royal Hospital would be classed as a large emergency department. The department was meeting this recommendation. The department had 16.5 whole time equivalent consultants at the time of our inspection and there was a plan for ongoing recruitment of consultants and other grades of doctors.

On arrival, children were streamed to the Paediatric Assessment Unit, apart from those with minor injuries who were seen in the department's minors area. The trust had one paediatric emergency medicine consultant available in the emergency department. The leadership and management team told us they worked closely with the paediatric team and staff in the department had received additional training to enable them to deal with children.

Consultant cover was provided seven days a week from a roster of 8am to midnight. The overnight hours were covered by a middle grade and junior doctors. There was a consultant on call for the hours where they were not physically present within the department.

There was a range of differently skilled and experienced middle grade, junior doctors and trainees. The department was not always able to cover the shortage of middle grade and junior doctors. For example, on Monday 22 March, the department was unable to cover:

- One middle grade and one junior doctor shift between 8am and 6pm.
- One middle grade and one junior doctor between 11am and 8pm.
- Two middle grade and two junior doctors between 12pm and 10pm.
- Two middle grade and one junior doctor between 3pm and midnight.

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In spite of the staffing challenges, the rosters we reviewed showed that the department was able to provide cover by using locum doctors, bank and agency staff. Staff told us that some consultants also covered some of the middle grade and junior doctor requirement on certain days. Staff also told us they were exploring innovative ideas such as using more physician's associates to work alongside of the medical team.

We observed a safe, effective and thorough medical handover. This took place each day at 8am, 1pm, 4pm and 10pm. Issues relating to patient management were covered fully and senior staff reviewed patients after the handover as required. The Emergency Physician in Charge (EPiC) role provided clear clinical leadership in the running of the department and supporting the team of junior staff. They took on the role of coordinating care plans and running the patient review (board round). This supported the department in having an oversight of their performance in taking decisions to admit patients and the four-hour performance (see below). This also enabled the department to enact their escalation plans as necessary.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, and easily available to all staff providing care.

We reviewed six sets of patient notes. All record nursing and medical records we reviewed, were of good quality. They were clearly written and had timely reviews of patients. Each set contained the national emergency department safety checklist, which was a tool required to be completed hourly. This covered completion of observations, whether a patient was undressed, and if a patient had received food and drink. Most medicines records we saw, showed that medicines were given in a timely manner and charts properly completed. However, we observed in one case where a patient did not receive their medicine in a timely manner as described above.

Following our inspection, we shared with the trust our immediate concerns regarding capacity, flow, ambulance handover delays, and crowding in the department. The trust responded with actions they would take to mitigate the impact to patient safety while they continued to review and action the issues around access and flow.

Is the service responsive?

Inspected but not rated

We did not rate responsive this time and the previous rating of requires improvement remains.

Access and flow

Patients could not always access the emergency department when needed, to receive timely treatment.

Performance data showed delays in patients both accessing the emergency department and waiting to be seen. Improvements had not been sustained within the emergency department for effective patient flow.

Pressure from high demand, COVID-19 restrictions, a lack of inpatient beds available for transfer, and patients being more unwell meant patients did not always receive care and treatment promptly. Patient handover from ambulance crews and the compliance with four-hour standards around patient flow was worse than NHS national standards. It is well understood how these delays can cause harm to patients, lengthen response times and delay ambulances needed in the community. However, staff were actively looking for improvements and short and long-term solutions, both internally and externally with system partners. The trust had not sustained improvements since the CQC inspection in

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October 2018, where the trust was told it must "ensure patients in the emergency department commence their treatment within an hour in line with national performance targets." The trust had responded to this within their action plan. However, this inspection (2021) identified similar themes, which impacted on patient safety and patient flow. The department had resolved several flow problems within the department and those within its own control but was limited by external factors.

The trust had a patient flow and escalation policy which detailed the different triggers for escalation and responsibilities of the different management teams across the trust. The department also had an escalation policy which detailed the various points when the policy should be triggered. For example, the escalation policy was triggered when certain performance measures fell short of the required standard. This included long waits on ambulances and overcrowding elsewhere in the department.

We were not assured the escalation policy for the department (when it was experiencing high demand and pressure) was always effective and had support throughout the trust. Evidence to show it was effective and gave the right results was not apparent. We were concerned as to how it demonstrated to staff it was working as expected and whether the actions were being taken as needed and making a positive difference. For example, the trust held regular bed capacity meetings to identify flow, escalation, discharge planning and any potential breaches, these were attended by people with the appropriate skills and knowledge. During our inspection, we attended the 4.30pm bed meeting, which covered the emergency department briefing on issues and capacity. The meeting identified there was a shortage of beds available for admission to the wider hospital and as a result 23 patients were waiting for an inpatient bed. We were told during the inspection, there was 100 patients in the trust who were fit for discharge but there was no discharge destination available for those patients and discharge from wards took place late in the day. We were not assured this meeting placed enough emphasis and urgency on the wider team to take actions in order to improve flow in the hospital. We recognised alongside this that there were pressures on other parts of the hospital, particularly in the inpatient wards.

National performance data showed the trust had struggled to achieve the NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours. In the first three months of 2020, prior to the first COVID-19 lockdown at the end of March 2020, the department achieved the four-hour standard for between 73-79% of patients, similar to the national average of 74%. Performance improved to an average of 87% in the four months from April 2020, as attendances dropped in the first lockdown. Performance then dropped to 71-75% in the six months to March 2021 (Source NHSE Monthly A&E statistics). The trust's emergency department saw an average of 10,500 patients each month in the period of December 2019 to November 2020 which included the drop in attendances during the first national lockdown.

In other performance measures, patients in the department had experienced very few delays of more than 12 hours following a decision to admit in the year 2019/20, but the winter months of 2020/21 showed a different picture. In December 2020, 37 patients waited more than 12 hours from a decision to admit them to a hospital ward until that happened. In January 2021, this rose to 95 patients (Source: NHS E Monthly A&E statistics). The delays were caused by a lack of available beds in the rest of the hospital.

The number of patients waiting in ambulances had increased, as had long delays in patient handovers. Due to restrictions on movement and rules around prevention of the spread of infection, coupled with poor capacity in the rest of the hospital to admit patients, ambulances were facing long delays at busy times.

Data from early December 2020 until late March 2021 showed there had been incidences of high numbers of ambulances waiting over 60 minutes on most days. The department was experiencing delays reported as worse than the England

average. For example, in the week between 15 March and 21 March 2021, the proportion of ambulance handovers delayed between 30 to 60 minutes was 11% compared to the national average of 7%. The proportion of ambulance handovers delayed over 60 minutes was 6% in the same period, compared to the national average of 2%. (Source: NHS E Urgent & Emergency Care Daily Situation Reports 2020/21.)

The leadership team were fully aware of the risk to patients held in ambulances. The department recently experienced a case where a patient deteriorated rapidly while under the care of the ambulance crew. A full investigation had been carried out, which we reviewed and discussed with the department's team during the inspection. Following this incident, the leadership team told us they were focusing efforts on reducing ambulance delays rather than looking at how to improve facilities so they can perform resuscitation on ambulances.

To aid flow from ambulances, the local NHS ambulance provider had placed a hospital ambulance liaison officer (HALO) in the entrance to the emergency department. The HALO was onsite from 1pm to 11pm seven days a week. Their role was to ensure the smooth offload of patients into the department, to look after ambulance crew welfare, to liaise with the emergency department about patients waiting in ambulances and help manage the flow of ambulance patients into the emergency department. They confirmed that patients were brought into the department by priority and that they were in constant liaison with the consultant in charge of the PITSTOP (rapid triage and assessment of patients) area and the ambulance crews.

Patient ambulance handovers were often delayed, as evidenced by performance data and observed during our inspection. During our inspection, there were consistently between seven and nine ambulances outside waiting to transfer patients into the department. This delay meant patients did not receive the treatment they needed in a timely way.

Initiatives had been set up to support the department in times of pressure or when recognising the overall deterioration in performance. These included:

- The introduction of a rapid triage and assessment (called PITSTOP) of patients arriving by ambulance between 1pm and 10pm Monday to Friday.
- Moving the paediatric service to the paediatric assessment unit to create a red area for patients who were confirmed positive for COVID-19.
- A facility for primary care clinicians to provide direct access to senior clinical staff in speciality teams, to give guidance and advice and potentially avoid an admission for patients. GPs contacted senior clinicians through an App where consultants who were logged on to the system would pick up the call. Patients who needed further input from senior consultants would arrive through to the GP assessment unit or the Acute Medical Initial Assessment Unit.

Staff also told us the radiology department was designed for a limited number of patients and they were also overwhelmed with demand. The processes required for radiology caused imaging and reporting delays.

There was a lack of flow coordinator support within the department to track patient progress, and to escalate to the Emergency Physician in Charge (EPiC) and nurse in charge (NIC) when patient's onward progression was stalled. There was no support for coordinating flow of patients within the department's footprint nor for coordinating flow of patients to wards or other destinations within the Trust. These roles were performed by the EPiC and the NIC, which was a major distraction from managing the clinical care. We were not assured that there was enough emphasis on flow coordinator support within the department.

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Following our inspection, we shared with the trust our immediate concerns regarding capacity, flow, ambulance handover delays, and crowding in the department. The trust responded with actions they would take to mitigate the impact to patient safety while they continued to review and action the issues around access and flow. These included:

- Re-locating the ambulance receiving areas to a new recently completed modular building to decongest the department.
- Using another area adjacent to the department as a receiving area for patients who may have had to wait on an ambulance or be cared for in corridors.
- Starting the ED patient safety checklist for all patients checked in to the department but who remain on ambulances, thereby ensure the hospital clinicians were aware of the status of patients awaiting transfer into the department.
- Implementing a process to divert patients who presented to the minors department to other suitable services, where this would be more appropriate.
- Developing better communication with the community to inform the local population of minor injuries unit available and of the reduced waiting times at those services.

The trust sent us further performance information in May following implementation the temporary ED accommodation reconfiguration of flow through the department. The trust told us ED corridor care has been largely eliminated. Performance metrics provided by the trust showed:

- Time to initial nurse triage has improved by 42% from an average of 29.9 minutes to 17.4 minutes.
- Time to medical review (PITSTOP) has improved by 37% from 62.8 minutes on average to 39.7.
- Delays over 30 minutes have reduced from an average of 29 a day in March to 11 a day in May.

Staff told us adult mental health liaison team were responsive to requests for support, although the number of patients with mental health problems and being more unwell was growing. This caused long delays between patients with mental health needs being seen by the department and receiving an assessment from the mental health team (a service provided by another NHS trust). There was a consultant lead for mental health in the department. A Healthwatch report was recently published on the experience of mental health patients in the department, which highlighted that those patients they surveyed had negative experiences. This was presented to the trust's board who acknowledged there were deficiency in provision of care for patients with mental health issues. As a result, working groups had been established, which included staff from the emergency department and experts by experience. We were told by the lead consultant that this had enabled the team to understand the shortfalls and issues faced by patients with mental health issues. Some of the actions taken to make improvements included implementing information cards at reception so patients experiencing poor mental health can communicate with reception staff about the reason they were presenting at the department, without having to verbally give too much information in order protect their privacy and dignity. The team were also developing mandatory mental health training for staff and additional training so that some staff could act as mental health champions. In addition, one of the nurses was attending a mental health training programme, which meant at the end they would be able to register as a mental health nurse. This was in a bid to have more mental health trained staff in the department.

The trust had introduced a 'same day emergency care' service (known as SDEC), which had been a national directive from the Royal College of Emergency Medicine and NHS England and NHS Improvement for establishment by April 2020. This care model was designed to minimise and remove delays for patients allowing them to receive care and treatment on the same day and avoid hospital admission. The NHS had recognised how most growth in unplanned admission to

hospital, was for patients who spent one or two days in hospital. It had been recognised how many of these patients could be safely and effectively assessed, diagnosed and treated in the same day. It was recognised by the clinical team as a significant opportunity for the trust and the department to reduce the number of patients who needed to be admitted. The service was planned to run with joint working with medical colleagues and operate as a seven-day consultant led service.

External support to the emergency department came from other specialities in the trust, to whom patients would be referred for further clinical opinion or admission to their care. However, the responsibilities for the problems faced by the emergency department were not shared by the rest of the trust as a whole. There was an effective process with the medical division, but this was not considered as effective or responsive with other specialties. We found frustration among the senior team and the clinical site team that the ease of referral in the medical directorate was not replicated with the surgical directorate and other specialities. The medical director was working with the leadership team to address these issues.

The triage and assessment team were committed to safely diverting patients to other services if they did not require emergency care. Staff in the department had undertaken an analysis of attendance at the department between 1 and 22 March 2021. This showed:

- There were 3,046 walk-in attendances, which accounted for 51% of admissions through the department.
- Seventy-two percent of all walk-in attendance were between 10am and 8pm. There would have been alternative pathways available during that time.
- Walk-in attendance from areas outside of central Gloucester was around 50% and the acuity and the time of the day they attended would suggest those patients had access to other pathways.

This analysis showed a large proportion of walk in attendances contributed to delays and crowding in the department. The trust was planning to use this information to divert patients to more suitable services where this would be more appropriate.

We met with several of the ambulance personnel who were on site waiting to handover their patient. They told us if they were concerned about a patient, they would either alert the clinical team on site or the HALO. We met with the HALO who was managing ambulances who were queuing in the holding bay outside. They felt their role was of benefit to the crews, the patient, and the emergency department in their liaison work. They also felt it gave them a better understanding of the pressures the department was under to be able to bring some balance to the concerns of delayed crews. They also supported the crew with getting breaks and being able to end their shift on time as much as possible. A welfare station had been set up by the holding bays so the crew could have access to drinks and snacks while they were waiting.

Within the delays in ambulance handovers in the department, was the consequent delay in releasing crews to help other patients who were waiting for an ambulance in the community. Staff we met said they were very aware of the risks. The trust's leadership team recognised this risk and had acknowledged this in their immediate response to our concerns.

Is the service well-led?

Inspected but not rated

Urgent and emergency services

We did not rate well led at this time and the previous rating of good remains.

Leadership

Leaders in the emergency department demonstrated the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible, supportive and approachable in the service for patients and staff. However, some of the trust senior leadership and senior managers were perceived as not present enough in the department to provide assurance, demonstrate awareness of the risks and struggles with performance, and be visible and approachable.

The department leadership team were committed to safe patient care and supporting their staff. They demonstrated to us they had the skills and abilities to run the service, particularly in such a challenging environment in which to provide safe and quality care and treatment. They were innovative and looking to find solutions to problems directly. They prioritised staff education and wellbeing. This was demonstrated through the work they were undertaking to improve mental health provision for both patients and staff. We found a team who had a clear view of the departmental approach and their own role, as well as the key issues both currently and longer term. This was consistent among the people we spoke with. The teams met each week, and this had become better attended since options to call in virtually were arranged. We were told the meetings had good challenge and discussion and concluded with defined outcomes.

There was effective and supportive management of the department by the emergency physician in charge and the nurse in charge. This was undertaken well and with regular reviews of each patient in their charge, to check on safety and progress.

There were numerous routes for communication within the department. This included emails, alert posters from the Royal College of Emergency Medicine, and the use of intranet workspaces with all guidelines visible and updated.

We were concerned that many staff we met could not recall seeing some of the senior leaders and senior managers in the department or at team meetings. However, they told us the chief executive had been in the department and had supported reconfiguration of the department several times during the pandemic. They also told us the medical director understood the processes and problems faced by the department and worked with the team to escalate those issues. Staff told us they were visible in the department and took time to listen and provide support.

There have been long-standing concerns around safety in urgent and emergency care services at the trust, some of which have been resolved, but long-term problems remain with patient access and flow. Although the leadership team had demonstrated there was actions plans and system wide collaboration to manage the pressures faced by the department, these were not always having the desired impact.

Culture

Staff in the department felt respected, supported and valued. They were focused on the needs of patients receiving care. There were strong examples of staff feeling able to speak up and raise concerns without fear.

There were strong examples of a resilient and committed culture in the team. Those staff we spoke with said they felt valued by the leadership team in the department and the directorate. They felt there was effective team working and support. There were three department managers trained as Trauma Risk Management (TriM) practitioners and a further three members of staff were being put forward for the training. TriM is a trauma-focused peer support system to help staff who have experienced a traumatic or potentially traumatic event. A psychologist and psychology link workers were available to emergency department staff and were in regular contact.

The mental health well-being of staff had also been considered as part of the improvement plans. A room had been allocated to staff to take breaks if they needed to step away from stressful situations and cards were available for them to contact someone if they needed to talk about issues they were experiencing.

We heard numerous examples of strong cultural behaviours and values, including:

- All patient interactions we observed were seen to be caring, kind and empathetic.
- Despite growing activity during the day, the department remained calm and professional throughout.
- We were told the team had thrived despite the pressures of the job. The department was reconfigured several times throughout the pandemic to respond to demand. We were told the staff were willing and supportive to help.
- Two divisional focused groups had been set up. One was a patient experience group and the other a staff experience group. The aim was to improve both patient and staff experience across the trust and the groups met twice monthly.
- One of the newer members of the medical team told us staff were “really friendly and supportive”.

The 2020 NHS staff survey showed that the trust’s results were in line with national averages. The response rate from the trust was 48% (which accounts for 3,519 staff) compared to 45% nationally. The main highlights of the results (out of a score of 10 where 10 is the best) showed:

- The trust scored 9.0 for equality, diversity and inclusion, 6.1 for health and well-being and 6.2 for morale. The medical division, of which the emergency department formed part of, scored similar or better to the whole trust.
- The trust scored 8.0 for working in a safe environment free from bullying and harassment, and 9.5 for working in a safe environment free from violence. The medical division, of which the emergency department formed part of, scored similar or better to the whole trust.
- Seventy-eight percent of staff who responded stated that the trust made adequate adjustment(s) to enable them to carry out their work. This was an increase from previous year’s results.
- Thirty-two percent of staff who responded stated that the organisation took positive action on health and well-being. This was an increase from previous year’s results.
- Forty-six percent of staff who responded stated that they had come to work despite not feeling well enough to perform their duties. This was a significant decline from previous year’s results.
- Forty-five percent of staff who responded stated that they had felt unwell as a result of work-related stress in the last 12 months. This was an increase from previous year’s results.
- Eight percent of staff who responded stated that they had personally experienced discrimination at work from manager / team leader or other colleagues. This was a slight increase from previous year’s results.
- All the results from the survey was either slightly better or in line with national averages.

Staff were open and honest with patients and told us they were quick to apologise when a patient was unintentionally delayed or perhaps relocated. There were good working relationships between staff in the department and the team worked well together given the high demands and pressures in the department.

There were some concerns around the quality and experience of the security staff, who also acted as porters. There had not been significant incidents in relation to violence in the department. However, some staff did not feel this team were adequately trained and were concerned about their ability to respond quickly given their dual role.

Urgent and emergency services

Managing risks, issues and performance

Leaders and teams identified and escalated relevant risks and issues and identified actions to reduce their impact. However, actions did not always have the desired impact. There were many effective systems to recognise, report and understand performance.

There was a departmental risk register and risks were reviewed and reported on through an assurance report to the division. Although the risk of delayed care and treatment was recognised on the departmental and the trust risk registers, actions had not always had the desired impact. Leaders explained the combination of patients being more unwell, the pandemic and the need to remove beds for social distancing had an impact on flow through the hospital. The risks had not changed considerably over time, but we noted it had become significantly worse of late with the emergence of long waits for patients in ambulances and trolleys while awaiting transfer within the hospital. We saw the risk register, including the risks identified within the department, were shared with the trust board and were reviewed monthly.

Although the department's computer system did not provide the nurse in charge with oversight of deteriorating patients, they had a system of communication with the nursing and medical team to inform them if there were signs of a patient deteriorating. However, we were told that the computer system was changing at the end of April 2021 which would then enable updated recording of new early warning score (NEWS2) being visible to the nurse in charge.

The emergency department leadership team had developed a comprehensive analysis of the CQC and ED consultant-designed Patient First conversation document. This was a document produced by CQC in late autumn 2020 and designed to be used by clinicians and departmental leads to support practical solutions to support good, efficient and safe patient care. The leadership team had used the guidance within this document to make improvements.

Areas for improvement

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

The urgent and emergency care service must:

- Ensure patient care and treatment is provided in a safe way and that risks are being fully mitigated while patients wait to access the emergency department. Ensuring there is adequate oversight and responsibility of the patients who are waiting to be seen, while they wait in ambulance queues or walk into the emergency. Regulation 12(1)(2)(a)
- Ensure patients are safe while they wait in crowded areas. To include appropriate protection in line with COVID-19 infection prevention and control guidelines and ongoing monitoring while they wait. Regulation 12(1)(2)(h)
- Provide care and treatment in a safe way for patients by ensuring there is flow through the emergency department. Patients were waiting on ambulances in queuing systems which had the potential to be unsafe. Some patients were waiting on trolleys for more than 12 hours after a decision had been made to admit them to a hospital bed. Regulation 12 (1)(2)(a)(b)
- Review the arrangements for flow in the hospital to ensure the prompt and safe discharge from wards throughout the trust. Regulation 12 (1)(2)(a)(b)

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- Have safe and sufficient numbers of nurses to support the department, and all grades of medical staff to meet the needs of patients. Regulation 18 (1)
- Have sufficient numbers of flow coordinators to support the department with flow. Regulation 18 (1)

The urgent and emergency care service should:

- Monitor and provide mandatory training and facilitate uptake to improve compliance.
- Consider how to address the perception in the staff team in the emergency department that there was limited senior leadership and senior manager visibility, recognition, understanding and support.
- Review the provision for security and portering to improve efficiency.

Our inspection team

The team that inspected the service comprised a CQC inspector and two specialist advisors. The inspection team was overseen by Amanda Williams – Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing