

Gloucestershire Hospitals NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust

Requires improvement 

Are services at this trust safe?

Requires improvement 

Are services at this trust effective?

Requires improvement 

Are services at this trust caring?

Good 

Are services at this trust responsive?

Requires improvement 

Are services at this trust well-led?

Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

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 the imaging services. We did not visit these locations as part of this inspection.

We inspected this trust as part of our in-depth hospital inspection programme. The trust was selected as it is an example of a low risk trust according to our new intelligent monitoring model. It has been in the low risk group since March 2014. Our inspection was carried out in two parts: the announced visit, which took place on the 10–13 March 2015, and the unannounced visit, which took place during the evening of 20 March 2015.

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

Our key findings were as follows:

- The hospitals in the trust were very busy. Bed occupancy was constantly over 91%, which is above both the England average of 88% and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of a hospital. Gloucestershire Royal Hospital and Cheltenham General Hospital had been operating at near 100% occupancy in the months leading up to the inspection. This had placed significant pressures on the staff delivering the services and had impacted on the care, treatment and wellbeing of patients.
- There were issues with the flow of patients into, through and out of the hospitals. The emergency department frequently became overcrowded when

demand for services exceeded capacity. This was a hospital- and community-wide issue. In December 2014 and January 2015, the trust had declared an internal major incident when the situation became unmanageable. The standard that requires 95% of patients to be discharged admitted or transferred with four hours of arrival in A&E was consistently not being met. Trust-wide performance was 82.86%.

- Every service was found to be caring. The inspection team found that staff across the organisation were highly committed to doing their best for patients. Staff were observed to be providing kind and compassionate care with dignity and respect. Caring in critical care was outstanding, with all other areas rated as good. Staff at all levels displayed a passion for delivering the best care possible and felt frustrated when they thought this was compromised by the pressures within Gloucestershire Royal Hospital and Cheltenham General Hospital and wider system.
- In some areas, such as the surgical admissions unit and outpatients, at times privacy could be compromised when personal conversations could be overheard and procedures seen.
- Prior to the inspection, we received details of a number of concerns from patients and relatives about a lack of clear communication; however, during the inspection we found that patients and, where appropriate, those close to them, were involved in decisions about care and treatment
- Patients generally received the support they needed to help them cope emotionally with their care, treatment and condition. Spiritual support was available from within the hospitals through the chaplaincy service, which provided a 24-hour on-call service.
- Overall, the hospitals were clean; however, some areas needed attention. At Gloucestershire Royal Hospital, these included the room in the emergency department for patients with mental health needs. Some areas in the medical wards were found to be dusty, dirty and or to contain litter. We also found a

Summary of findings

number of hand gel dispensers that were empty. At Cheltenham General Hospital, building work in the imaging department was having an impact, with dust and dirt escaping into the corridor.

- Across the trust, measures to deal with infection control were effective. The number of cases of *Clostridium difficile* had been significantly lower than in previous years, and at 34 cases up to February 2015 was well below the trust's target of 55 for the year. There had been just one case of Methicillin Resistant *Staphylococcus Aureus* (MRSA) in the year to date. We saw that, with a few exceptions, staff were adhering to the trust's infection control guidelines. At Stroud Maternity Hospital, infection control risks were not fully addressed, with no process in place to identify whether equipment had been cleaned and was ready for use.
- Nursing staffing levels had been reviewed and assessed, with overseas recruitment having taken place in order to meet the National Institute for Health and Care Excellence (NICE) safe staffing guidance. Some areas, such as the flexible capacity wards, relied heavily on the use of bank and agency staff.
- Medical staffing was at safe levels in many services. However, there were some exceptions; these included consultants in acute medicine, general and old age medicine and radiology, and junior doctors in medicine and emergency care.
- In the ward areas, we found that patients had access to adequate food and fluids, observing that drinks were left within their reach.
- In most services, people's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance.
- Information about patient outcomes was routinely collected and monitored, with the trust participating in a number of national audits so it could benchmark its practice and performance against that of other trusts. In a number of these audits, the trust was performing less well than other trusts, for example the College of Emergency Medicine audits, the National Sentinel Stroke Audits, the National Heart Failure audit, and the Royal College of Physicians National Care of the Dying Audit 2104. Overall, in surgery and critical care, the trust was performing better than the England average in most of the national audits it took part in.
- Mortality rates were in line with those of other trusts as measured by the Hospital Standardised Mortality Ratio.
- Patients' pain was assessed and well managed; the exception to this was in the emergency department at Gloucestershire Royal Hospital and Cheltenham General Hospital, where not all patients had a pain score recorded and patients did not consistently receive prompt pain relief.
- Staff had access to training to develop their skills, knowledge and experience to deliver effective care and treatment. The trust's target for the percentage of staff who had an annual appraisal was 90%, with the actual figure standing at 85%.
- Multidisciplinary working was evident in all areas we inspected.
- The hospitals were working towards providing services seven days a week. The pharmacy service was open for limited hours on a Saturday and Sunday. Some on-call cover was provided at weekends by allied healthcare professionals. The palliative care team were available from 9am to 5pm, Monday to Friday, with the specialist palliative care nurses providing an out-of-hours telephone advice service for clinicians.
- Weekend ward rounds did not take place in some areas such as stroke, gastroenterology or the diabetes and endocrinology wards. In cardiology, a ward round took place on both days of the weekend.
- Weekend discharges were problematic, with significantly fewer patients discharged at this time.
- The two-week wait for urgent GP referrals for cancer and the 62-day wait from GP referral to treatment were not consistently being met. However, other targets such as the 31 days for surgery and radiotherapy were constantly met, as was the 31-day period from diagnosis to treatment.
- Systems were in place to identify patients who were living with dementia or had a learning disability and who might need additional support.

Summary of findings

We saw several areas of outstanding practice including:

- Patients living with dementia on Ward 9b in Gloucestershire Royal Hospital were able to take part in an activity group that had been organised by one of the healthcare assistants. The activity group enabled patients to become involved in activities and encouraged them to maintain their skills and independence. The group was held weekly, and patients were able to play bingo, watch films, take part in reminiscence, paint, sing and eat lunch together. Activities were tailored to individual preferences, and relatives were encouraged to be involved.
- The trust had a mobile chemotherapy unit, which enabled patients to receive chemotherapy treatment closer to their homes to prevent frequent travel to hospital.
- Patient record keeping in critical care was outstanding. All the patient records we saw were completed with high levels of detail. There were all the essential details to keep patients safe and ensure all staff working with them had the right information to provide safe care and treatment at all times.
- There was an outstanding holistic and multidisciplinary approach to assessing and planning care in the department of critical care. All staff involved with the patients worked with one another to ensure the care given to the patient followed an agreed treatment plan and team approach. Each aspect of the care and treatment had the patient at its centre.
- In critical care, there was an outstanding commitment to education and training of both nurses and trainee doctors. Nurses and trainee doctors followed comprehensive induction programmes that were designed by experienced clinical staff over many years. All the staff we met who discussed their training and development spoke very highly of the programmes on offer and of there being no barriers to continuous learning.
- There was outstanding care for bereavement in critical care. All staff spoke highly of how they were enabled to care and support patients and relatives at this time. Bereavement care had been created with input from

patients, carers, relatives and friends, and staff were particularly proud of the positive impact it had on bereaved people and patients nearing or reaching the end of their life.

- The outstanding arrangements for governance and performance management in critical care drove continuous improvement and reflected best practice. There was a serious commitment to leadership, governance and driving improvements through audits, reviews, and staff honesty and openness. All staff had a role to play in this area and understood and respected the importance of their work.
- Mobility in labour was promoted with the Mums Up and Mobile (MUM) programme, which included wireless cardiotocography (CTG) monitoring across the whole of the delivery suite.

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

Importantly, the trust must:

- Improve its performance in relation to the time that patients spend in the emergency department to ensure that patients are assessed and treated within appropriate timescales.
- Continue to take steps to ensure there are sufficient numbers of suitably qualified, skilled and experienced consultants and middle grade doctors to provide senior medical presence in the emergency department at Gloucestershire Royal Hospital 24 hours a day, seven days a week, and to reduce reliance on locum medical staff.
- Continue to reduce ambulance handover delays and take steps to ensure that patients arriving at the emergency departments by ambulance do not have to queue in the corridor because there is no capacity to accommodate them in clinical areas.
- Develop clear protocols with regard to the care of patients queuing in the corridors in the emergency departments. This should include risk assessment and the identification of safe levels of staffing and competence of staff deployed to undertake this care.

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- Work with healthcare partners to ensure that patients with mental health needs who attend the emergency departments out of hours receive prompt and effective support from appropriately trained mental health practitioners.
- Take immediate steps to address infection control risks in the ambulatory emergency care unit.
- Ensure that systems to safeguard children from abuse are strengthened and children's safeguarding assessments are consistently carried out. There must be a process to ensure all appropriate child safeguarding referrals are made.
- Ensure that senior medical staff in the emergency department are trained in level 3 safeguarding.
- Ensure that patients in the emergency departments have an assessment of their pain and prompt pain relief administered when necessary.
- Take steps to strengthen the audit process in the emergency department to provide assurance that best (evidence-based) practice is consistently followed and actions continually improve patient outcomes.
- Ensure minutes are kept of mortality and morbidity meetings in medicine so that care is assessed and monitored appropriately, lessons learnt and actions taken and recorded.
- Ensure that patients' records across the hospitals are stored securely to prevent unauthorised access.
- Ensure the premises for the medical day unit are suitable to protect patients' privacy, dignity and safety.
- Ensure an effective system is in place on the medical wards to detect and control the spread of healthcare-associated infection.
- Ensure the administration of eye drops complies with the relevant legislation.
- Ensure patients' mental capacity is clearly documented in relation to 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) and 'unwell/potentially deteriorating patient plan' (UP) forms. Improvements in record keeping must include documented explanations of the reasoning for decisions to withhold resuscitation, and documented discussions with patients and their next of kin, or reasons why decisions to withhold resuscitation were not discussed.
- Ensure that where emergency equipment in the form of resuscitation trolleys is not available, the decision to not supply it is based on a thorough risk assessment. Where emergency equipment is available, this should be ready to use at all times.
- Review communication methods within maternity services to ensure that sensitive and confidential information is appropriately stored and handled, whilst being available to all appropriate staff providing care for the patient concerned.
- Ensure that appropriate written consent is obtained prior to procedures being carried out in the outpatient department.
- Ensure that all patients (men and women) are able to access the full range of tests in the urology outpatient department.
- Ensure that systems are in place to ensure that all medication available is in date and therefore safe to use.

Professor Sir Mike Richards, Chief Inspector of Hospitals

Summary of findings

Background to Gloucestershire Hospitals NHS Foundation Trust

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.

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

In 2013/14 the annual turnover (total income) for the trust was £456.70 million, and the trust had a surplus of £3.59 million for 2013/14.

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

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

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

The inspection team inspected the following eight core services at Gloucestershire Royal Hospital:

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

At Cheltenham General Hospital, we inspected seven core services:

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

At Stroud Maternity Hospital we inspected:

- Maternity services

We did not inspect the outpatients or imaging services the trust provides at community hospitals.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, independent specialist clinical advisor

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

The team included CQC inspectors and a variety of specialists: chief executives; consultants from medicine, anaesthetics, surgery, emergency services, paediatrics, obstetrics and intensive care; a junior doctor; a newly qualified nurse; a nurse consultant in paediatrics and an emergency nurse practitioner; the head of outpatients; a

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theatre specialist; a midwife; and nurses from medicine, care of the elderly and critical care. The team also included two experts by experience, analysts and an inspection planner.

How we carried out this inspection

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

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

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

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

What people who use the trust's services say

We received information from people prior to the inspection through the listening event, emails, our website and phone calls. In addition Healthwatch Gloucestershire shared a significant amount of patient feedback that they had received. There was a mixture of positive and negative information, with some patients speaking highly of the care they had received, whilst other raised concerns. This information helped focus the inspectors on areas of the trust to visit.

Between September 2013 and January 2014, a questionnaire was sent to 850 recent inpatients at the trust, as part of the CQC Adult Inpatient Survey 2013. Responses were received from 469 patients from Gloucestershire Hospitals NHS Trust. Overall, the trust was rated the same as other trusts. One area that was highlighted as an area for improvement was patients receiving copies of letters sent between hospital doctors and GPs.

The results of the Patient Led Assessments of the Care Environment (PLACE) for 2014 showed that the trust was performing worse than the England average on cleanliness, food, privacy, dignity and wellbeing and facilities.

In the NHS Friends and Family Test, the trust was scoring above 90% for patients who would recommend the hospitals. However, the response rate was variable across services, and overall the trust was not achieving the target response rate.

In the National Cancer Patient Experience Survey 2014, the trust scored in the top 20% of trusts for all staff asking the patient what name they preferred to be called by and for doing everything to help control pain all of the time. Areas for improvement included patients being given a choice of different treatment types, patients being given the name of the clinical nurse specialist in charge of their care, the GP being given enough information about a patient's condition and treatment, and the patient's family having an opportunity to talk to the doctor.

Summary of findings

Facts and data about this trust

Overall, Gloucestershire Hospitals NHS Foundation Trust has 1,072 beds, about 7,400 staff and provides acute healthcare services to a population of around 612,000 people in Gloucestershire and the surrounding areas. There are 683 beds at Gloucestershire Royal Hospital.

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

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

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

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

CQC inspection history

Gloucestershire Hospitals NHS Foundation Trust has had a total of nine inspections since registration.


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

Four inspections have been undertaken at Gloucestershire Royal Hospital. In March 2011, an unannounced inspection was undertaken in response to concerns. Concerns were found relating to: care and welfare of people using services, nutrition, working with other providers, safeguarding, cleanliness and the environment. An inspection was undertaken in August 2011 to review these standards; four were found to have been met, and improvements had been made relating to the other two, care and welfare of people and .were undertaken in February 2103 and May 2013 at which all standards inspected were met.

Stroud Maternity Hospital has not been inspected since it was registered with this trust.

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Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>Overall, Gloucestershire Hospitals NHS Foundation Trust has 1,072 beds, about 7,400 staff and provides acute healthcare services to a population of around 612,000 people in Gloucestershire and the surrounding areas. There are 683 beds at Gloucestershire Royal Hospital.</p> <p>In 2013/14 the trust had more than 108,000 inpatient admissions including day cases. From December 2103 to November 2014, there had been 773,447 outpatient attendances (both new and follow-up) and 124,904 attendances at urgent and emergency care.</p> <p>At the end of 2013/14 the trust had a financial surplus of £3.59 million.</p> <p>Bed occupancy was constantly over 91% in 2013/14. It was above England average (85.9%) all year and above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.</p> <p>Gloucestershire Hospitals NHS Foundation Trust has a stable executive team, with the chief executive, nursing director, medical director, director of clinical strategy and director of human resources and organisational development all having been in post for over six years. The non-executive team is also stable, with the chair having been in post since 2011.</p> <p>CQC inspection history</p> <p>Gloucestershire Hospitals NHS Foundation Trust has had a total of nine inspections since registration.</p> <p>Five of these inspections have been at Cheltenham General Hospital. In March 2011, an unannounced inspection was undertaken in response to concerns. Minor concerns were found relating to: care and welfare of people using services, working with other providers, safeguarding, cleanliness and the environment. Following further concerns, an announced inspection was undertaken in July 2012. Seven standards were inspected; six were found to be met and one not met, with minor concerns relating to records. This standard was reviewed in February 2103 and was found to be met. In April 2013 following an unannounced inspection</p>	<p>Requires improvement </p>

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Four inspections have been undertaken at Gloucestershire Royal Hospital. In March 2011, an unannounced inspection was undertaken in response to concerns. Concerns were found relating to: care and welfare of people using services, nutrition, working with other providers, safeguarding, cleanliness and the environment. An inspection was undertaken in August 2011 to review these standards; four were found to have been met, and improvements had been made relating to the other two, care and welfare of people and .were undertaken in February 2103 and May 2013 at which all standards inspected were met.

Stroud Maternity Hospital has not been inspected since it was registered with this trust.

Are services at this trust effective?

Overall we rated effectiveness of the services in the trust as 'requires improvement'. For specific information, please refer to the individual reports for Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital.

The team made judgements about 14 services. Outpatient services are not currently rated for effectiveness. Of the services rated, six were judged to be good, six required improvement and two were outstanding. This demonstrated that the majority of services provided care, treatment and support that achieved good outcomes, promoted a good quality of life and were based on the best available evidence.

The trust took part in a number of national audits; performance in these varied across the trust. Overall mortality was less (better than) the national average.

Staff, teams and services mostly worked well together to deliver effective care and treatment; this was particularly in critical care where there was strong and cohesive collaboration among all staff contributing to the care of patients in the critical care unit.

There was effective management of written consent, but some improvement was required in the documentation of verbal consent. Staff were generally aware of their responsibilities relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence based care and treatment

Requires improvement



Summary of findings

- In most services, people's needs were assessed and care and treatment delivered in line with legislation, standards and evidence-based guidance, for example National Institute for Health and Care Excellence (NICE), Intensive Care Society and Faculty of Intensive Care Medicine guidelines, and specialist guidance from the royal colleges. In cases where the trust was not meeting the service-specific NICE guidance, for example in intestinal failure in adults and clinical guidance for lower limb peripheral arterial disease, these were documented on the relevant risk registers.
- End of life care within the trust was focused on the recognition of patients who might be approaching the last few days or hours of life. NICE guidance includes recognition of patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. Staff did not demonstrate an understanding of this longer period or that patients might have benefitted from earlier discussions and care planning.

Patient outcomes

- Mortality rates were below (better than) the national average as measured by the Hospital Standardised Mortality Ratio.
- In the majority of services, the outcomes of people's care and treatment were monitored. The trust participated in a number of national audits so it could benchmark its practice and performance against that of other trusts. In a number of these audits, the trust was performing less well than other trusts, for example the College of Emergency Medicine audits, the National Sentinel Stroke Audits, the National Heart Failure Audit and the Royal College of Physicians National Care of the Dying Audit. Overall, in surgery and critical care, the trust was performing better than the England average in most of the national audits it took part in.
- Services had audit plans in place; although we saw evidence of these and of the actions as a result, there were some gaps. For example, in the emergency department we saw compliance was being audited on a monthly basis for the sepsis management pathway, but we saw little evidence that other clinical pathways were regularly audited. In neonatal care, we asked the trust for the results of the latest neonatal audit, but received information from 2013. This showed that the neonatal unit had not achieved some of the standards set by the Royal College of Paediatrics and Child Health. We were not shown any action plan relating to this audit or more up-to-date results.

Summary of findings

- The critical care unit performed well in audits. Mortality levels were better than the national average, there were few transfers to other critical care units for non-clinical reasons, and patients were not discharged prematurely, evidenced by a low readmission rate.

Multidisciplinary working

- Staff, teams and services mostly worked well together to deliver effective care and treatment. Of particular note was the strong and cohesive collaboration among all staff contributing to the care of patients in the critical care unit. There were no obstructive hierarchical boundaries and all staff were valued for their input and roles, which all focused on improving patient care.
- In services for children and young people, we found several working groups had been established, particularly between children's services and the emergency department and general surgery. These groups contained staff from those particular areas that worked together to improve the care children received when being seen in the emergency department, the process of transferring to the children's unit and then, when necessary, the transfer to theatres.

Consent, Mental Capacity Act & Deprivation of Liberty Safeguards

- People's consent to care and treatment was mostly sought in line with legislation and guidance. The exception to this was in the outpatient clinics for urology, when patients were attending for a cystoscopy (a procedure in which a camera is inserted into the patient's bladder), where we found that the records did not evidence that the patient's consent had been sought, and there was confusion about which staff were doing seeking this consent. In addition in one surgical ward it was documented that a patient had early signs of dementia and confusion, no assessment was evidence of their capacity to make certain decisions.
- Four different consent forms were in use across the trust, including one for children and one for patients who lacked capacity to consent for their procedure or operation. The inspection team found that consent forms had been completed in full and included details about the procedure/operation and any possible risks or side effects.
- Most staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards, with many areas exceeding the trust's target of 90%. The exception to this was middle grade

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and trainee doctors in the emergency department, where compliance with these training requirements was less than 75%. However, staff were generally aware of their responsibilities relating to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Are services at this trust caring?

We judged the caring provided by staff as good at every service in each hospital.

For specific information, please refer to the individual reports for Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital.

The overall rating for caring was good, this included ratings of outstanding in the critical care units at both the district general hospitals. In both cases, this related to the excellent focus on patient-centred care. Staff treated patients with compassion, kindness, dignity and respect.

Staff were providing kind and compassionate care which was delivered in a respectful way. There were some areas, albeit in the minority, where at times privacy could be compromised when private conversations could be overheard and procedures observed.

Compassionate care

- Staff were providing kind and compassionate care that was delivered in a respectful way. Patients and relatives told us that they were happy with the care provided by staff. We heard staff introducing themselves and explaining what they were going to do. In critical care, we heard that staff went above and beyond their usual duties to ensure patients experienced compassionate care and to promote patients' dignity.
- There were many examples from across the trust of staff going the extra mile to care for patients. People told us how they felt safe and reassured by the way staff spoke to them and dealt with them. The words "kindness", "good humoured" and "professional" came up again and again in the conversations the team had with patients across the trust.
- There were some areas across the trust, albeit in the minority, where at times privacy could be compromised when private conversations could be overheard and procedures observed.

Understanding and involvement of patients and those close to them

Good



Summary of findings

- Patients and those close to them were involved as partners in their care. We heard nurses explaining to patients and relatives the treatment and care they were delivering. Information was provided sensitively and patients were given time to ask questions.
- Staff communicated with people in an appropriate way for their needs, so that they understood their care, treatment and condition.

Emotional support

- Patients and those close to them received the support they needed to cope emotionally with their care and treatment. Psychological support was available from within hospital. Staff from that service would visit patients on request of the clinical staff, the patient or a relative. There was also support from the chaplaincy service and a team of spiritual advisors who were on call at all times.

Are services at this trust responsive?

Overall, we rated the responsiveness of the services in the trust as 'requires improvement'. For specific information, please refer to the individual reports for Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital.

The team made judgements about 16 services across three hospitals. Of those, eight were judged to be good and eight required improvement, so although the trust was responding to people's needs this was not consistent.

The areas requiring improvements were urgent and emergency care, medical care surgery and outpatients, and improvement was needed at both Gloucestershire Royal Hospital and Cheltenham General Hospital. The biggest factor in the responsiveness of emergency and medical services was the flow of patients into, through and out of the hospitals. People were waiting for too long to be assessed, diagnosed and treated. Patients were not always cared for on the most appropriate ward for their condition. Patients were not always able to leave hospital when they were medically fit, as they were waiting for ongoing care, both social and medical, to be arranged. In outpatients, some patients experienced long delays in receiving their first outpatient appointment. We found that referral to treatment times exceeded national targets, with services not delivered in a way that focused on patients' holistic needs. Elective surgery had been cancelled in response to the pressures.

The 10 services judged to be good for responsiveness had been able to respond to changing needs; for example, critical care had been

Requires improvement



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able to increase its capacity by opening a new surgical high dependency unit. High dependency provision within children's services at Gloucestershire Royal Hospital had similarly been increased in response to increasing demand.

Service planning and delivery to meet the needs of local people

- The trust works in partnership to scope and plan to meet the needs of the population served. At the time of the inspection, the pressures leading to the declaration of a major incident in January 2015 had impacted on those working relationships, but there was evidence that these were improving. Decisions on service provision were informed by a county-wide, centrally held information system that all partners contributed to. The data was collated and analysed to help health and social care teams understand performance trends and the cause and effect of key measures. A local health resilience partnership was examining all aspects of the urgent care system and agreeing plans to address identified areas of pressure.
- Significant changes had been made in the provision of urgent and emergency care in July 2013, when night-time services at Cheltenham hospital were reduced. Self-presenting (walk-in) patients continue to be seen in the emergency department throughout the 24-hour period, but between 8pm and 8am the department operates as a nurse-led emergency care centre. Critically injured or ill patients are taken by ambulance to Gloucestershire Royal Hospital, where emergency medicine doctors are available 24 hours a day. These changes were made primarily because the trust was unable to provide sufficient medical cover to provide a full service on both sites. The trust was working with health and social care partners to ensure there was a system-wide approach to managing demand and the impact that fluctuating and increasing demand had on the emergency department.

Meeting people's individual needs

- The trust had policies and procedures in place to help ensure that those patients living with dementia and those patients who had learning disabilities were identified and supported. There was a lead for supporting patients with a learning disability, who worked with a trust-wide team, including specialist link nurses. The trust had developed resources for staff for caring for and supporting patients with a learning disability. This covered areas such as mental capacity, behaviours that challenge, and guidance about behavioural

Summary of findings

strategies. There was a guide to the top 10 tips for consultation for people with a learning disability. The speech and language team had provided guidance about swallowing and safe nutrition regimes. There was also information on communication and discharge arrangements. Patients who came to the hospitals from a community care setting were asked to bring or produce a 'hospital passport'. This is a recognised document used for people who live with a learning disability, so staff are able to know as much about them as possible should they have difficulty with communication.

- There was a specific care plan designed for patients experiencing memory loss and disorientation and known to have dementia. The care plan referenced the Department of Health National Dementia Strategy 2009 and the Mental Capacity Act 2005. Patients were assessed for memory loss, orientation and comprehension. The mental health liaison team was highlighted as a source of additional support for staff. If it was not already done, carers were asked to complete the 'this is me' document, which would be used to plan patients' care against specific needs or characteristics. There was evidence that this was not always completed in a timely manner. The trust used a purple butterfly to help identify patients with cognitive impairment. Purple butterflies were in place on wards to alert staff that patients might require extra support with some areas of their care.
- There was an arrangement with local NHS mental health services for a mental health liaison team that supported the emergency department and acute care unit from 8am to 10pm, seven days a week. The team aimed to respond verbally to all crisis and urgent referrals for mental health advice or assessment and to provide assessment according to the urgency of the referral. Between April and September 2014, all urgently referred patients were seen within two hours. Most non-urgent referrals were seen within 24 hours. Outside these hours, staff could contact the crisis home treatment service (2gether NHS Foundation Trust) or the on-call psychiatrist. Staff told us that this service was not responsive, as only two mental health practitioners covered the whole county.

Access and flow

- Access and flow had been extremely challenging for the trust in the months leading up to the inspection, to the extent that a major incident was declared in January 2015. The hospitals remained very busy, with bed occupancy consistently over 91%, which is above both the England average of 88% and the 85%

Summary of findings

level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of a hospital. Occupancy over the winter months had neared 100%. This level of occupancy, taken together with the challenges of achieving the number of health and social care discharges needed, had had a major impact on the flow of patients into, through and out of the hospitals.

- In this situation, people did not always receive care and treatment in a timely way. The trust was consistently failing to meet key national performance standards for emergency departments. The trust was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. In January 2015, neither of the trust's emergency departments met the 95% target for the fourth consecutive month; trust-wide performance was 82.86%, and Gloucestershire Royal Hospital achieved 80.59%. Fifty-nine per cent of breaches of the four-hour target trust-wide were because patients were waiting for a bed.
- The trust had commissioned the integrated discharge team (IDT) provided by Gloucestershire Care Services NHS Trust to work in the emergency department and on the acute care unit. The team, made up of health and social care professionals, assessed appropriate patients and, where possible, directed them to other services in the community. It also supported patients (inpatients and emergency department patients) who needed ongoing health or social care services after they were discharged, and helped to facilitate their early discharge. The service operated from 8am to 8pm, Monday to Friday, and from 9am to 5pm at weekends and over bank holidays. The IDT saw 1,410 patients in the emergency department or acute care unit between September and November 2014, of which approximately half were not admitted to a ward.
- The trust was meeting the 18-week referral-to-treatment time target for general surgery, trauma and orthopaedics, ear, nose and throat (ENT), oral surgery and thoracic medicine before the increased pressures on its services and beds. The exception to this was the maximum wait of 62 days from urgent GP referral to first treatment for cancer which not been met for most of the year.
- The trust had not met its target for the year for the number of patients cancelled on the day of their operation for non medical reasons and had only met the national targets for rebooking patients within the 28-day timescale in one month.

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- An integrated discharge team within the trust helped facilitate patient discharges. The team consisted of nurses, physiotherapists, occupational therapists and social workers. Members of the team attended daily ward board rounds to ascertain which patients were ready for discharge. The team supported patients to ensure they were able to be discharged home in a timely manner. For example, if a patient required mobility assessments prior to discharge, a physiotherapist ensured they were completed.

Learning from complaints and concerns

- There was information on the process for making complaints throughout the hospitals. The Patient Advise and Liaison service (PALS) office at Cheltenham General Hospital had limited opening times, but there was a freephone service for people to contact the main PALS office at Gloucestershire Royal Hospital, where this phone service was also available and advertised.
- The trust had received between 200 and 250 complaints a quarter during the previous two years. Of these, 98.5% had been acknowledged within three days in the most recent quarter prior to the inspection. The trust aimed to complete the investigations and respond to the complainant with 35 days; it had achieved this 95% of the time in the first quarter of 2014/05, but this had dropped to 89% more recently.
- The trust had undertaken a review of its complaints process in July 2013. One outcome from this was the introduction of a new complaints management framework. A more recent review of the process by outside consultants had been completed in May 2014, with a follow-up report completed in August 2014. Actions that had been taken as result of this review included improving the consistency of dealing with complaints, with the introduction of a formal policy and procedure for the managing of complaints, resulting in the production of standardised reports.
- In January 2015, the trust started participating in the National Patient Association complainant survey. We saw the initial feedback that this process has provided, but it was too early to see the benefit of this participation and subsequent actions.
- Processes were in place for the learning from complaints to be visible at board level. We saw the minutes from the March 2015 quality committee and also the patient experience strategic group (which reports to the quality committee). These minutes highlighted issues that had arisen and the action taken or

Summary of findings

planned. Examples included discharge planning and communication, with work planned around joint working with county partners and the planning of a joint forum with care home and domiciliary care providers. Complaints relating to end of life care had produced plans around reviewing the 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) process, the revision of a trust end of life care group, and the reinstating of a role of end of life champion for ward areas.

- We reviewed a number of case files for complaints. Clear tracking of the process was in place, and there were systems to send reminders to clinical staff who were required to respond to information requests relating to specific complaints. Letters written to complainants were clearly set out, and gave clear information about timescales and also contact details if more information was required. Where requested, face-to-face meetings were facilitated. In the previous 12 months, there had been 48 face-to-face resolution meetings between patients, relatives and the trust's staff. All final letters sent to complainants were drafted by the complaint managers but were seen and signed by the chief executive.

Are services at this trust well-led?

We rated the trust as good for being well-led. The trust's leadership, governance and culture promoted the delivery of high quality person-centred care. Improvements are needed in aspects of the leadership of medical and end of life care services. The team made judgements about 16 services. Of those, two were outstanding, 10 were judged to be good and four required improvement.

Improvements were needed in aspects of the leadership of medical and end of life care services at both Gloucestershire Royal Hospital and Cheltenham General Hospital, although some elements were working well. For specific information, please refer to the individual reports for Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital.

The executive team at the trust, in particular the chief executive and nursing director, are highly visible and respected by staff. There was a calm and authoritative approach among the senior leadership team. The board and other levels of governance within the organisation function effectively. There was a clear statement of vision and values, and staff knew and understood the priorities of the organisation. There was a positive culture that was patient centred. Staff were encouraged to raise concerns and felt confident to do this. The one exception to this was junior doctors, who consistently told us they often did not feel listened to when they raised concerns.

Good



Summary of findings

The issues in end of life care related to the lack of an overall strategy. The priorities for the service were not fully understood or articulated at trust board level, and there was a lack of assurance. The issues in medical care were around the autonomy of senior teams and the way that pressures within the service were impacting on staff and patients.

Vision and strategy

- The trust has set out its mission and vision as follows:

Our Mission: Improving health by putting patients at the centre of excellent specialist healthcare.

Our Vision: Safe, effective and personalised care: every patient, every time, all the time.

- The trust has set out goals in four areas as follows:

Our Services: To improve year on year the safety of our organisation for patients, visitors and staff and the outcomes for our patients.

Our Patients: To improve year-on-year the experience of our patients.

Our Staff: To develop further a highly skilled and motivated and engaged workforce which continually strives to improve patient care and trust performance.

Our Business: To ensure our organisation is stable and viable with the resources to deliver its vision.

- The trust consulted patients and staff in developing its six values, which they describe as follows:

Listening – listen to understand

Helping – valued staff with a helpful attitude

Excelling – committed to excellence

Improving – learn to improve

Uniting – work together

Caring – here for patients.

- The trust has also set out the expected standards of behaviour in the document Kindness and Respect – our standards of behaviour. There are 10 positive pledges within the document; for example, “I will encourage patients, carers and colleagues to ask questions and share concerns.” This is supported by training resources and recognised by the trust’s kindness and

Summary of findings

respect awards, which are part of the annual staff awards scheme. The trust was moving towards values-based recruitment. Values and behaviours were considered as part of the appraisal process for staff at all levels.

- A key part of the trust's future strategy is the introduction of an electronic patient record, through the Smartcare project. This has been developed in the south west with two other trusts, and the procurement and evaluation stages had been completed at the time of the inspection.
- The trust was engaged with the wider strategy for Gloucestershire. A facilitator had been engaged to work with all partners to look at future models of care.

Governance, risk management and quality measurement

- The trust's arrangements for governance and the management of quality and safety were set out in the trust's frameworks and policies and were embedded in practice. The policies and guidelines were available for all staff via the trust's intranet. There was evidence in all the services that staff had good awareness of risk-reporting arrangements.
- The board's assurance framework was made up of the most significant risks that could affect the

performance of the trust. These risks had been identified from a range of internal and external sources, including key operational risks from the trust's risk register, external assessments, audits and new guidance. The assurance framework was monitored quarterly by the board.

- The trust had a quality framework that described the quality governance arrangements within the trust. Quality was described under the headings of 'patient experience', 'safety' and 'clinical effectiveness'. The reporting arrangements and committee structure provided assurance against CQC regulations and identified areas of good practice and areas of concern. A quality standards review group reviewed compliance quarterly. Key risks to quality were monitored through the trust's risk register or board assurance framework. The trust had a quality sub-committee, chaired by a non-executive director that reported to the board. Corporative objectives included safety objectives which were monitored by the board and were part of the appraisal process.
- The trust had a risk management framework together with a risk register procedure document setting out processes. The levels at which risk registers were held was set out in the trust's

Summary of findings

risk management framework. The top risks were reviewed at each board meeting. The trust's risk register included clinical, financial, operational, reputational and environmental risks. Trust and divisional risk registers were robust in identifying plans to eliminate or reduce risk with review dates and owners assigned. The trust's risk register was managed through the trust's management team, who met monthly. This group validated new significant risks, allocated a lead director, agreed a monitoring process and removed mitigated risks from the register. This process was replicated at management meetings throughout the trust to ensure that only significant risks with management plans were on risk registers.

- Senior leaders talked consistently about quality being their priority and that discussions about finance were in the context of quality and safety.

Leadership of the trust

- The senior leadership of the trust were well known to staff. Staff talked about the chief executive and nursing director as being highly visible, well respected and trusted. Staff talked about the executive walk-around and how they had taken part. We met a number of staff who had been to the chief executive's 'meet Frank' meetings, which they described as informative and useful. Staff said they felt listened to by the executive team and things were getting done, especially in relation to patient safety.
- The board was experienced and stable. The chair, executives and non-executives were knowledgeable about quality issues and priorities. The non-executives were skilled, experienced and engaged, and were appropriately challenging in holding the management to account.
- Staff told us they felt supported and listened to by their immediate line managers, divisional management and the executive board. Managers were described as approachable, and staff emphasised that this was at all levels. Nursing staff said they felt well supported by the nursing director, and all said they could approach them with any concerns.
- There was a sense that leadership was variable between divisions. Some senior staff felt that there was too much top-down control and talked about having responsibility without power. Other senior staff felt arrangements worked well. Staff side had articulated some differences of approach and had shared these at executive level.

Summary of findings

- The '100 leaders' meetings were valued and felt to be effective in disseminating information across the trust.
- A revised people strategy was due to be presented to the board in April 2015. A health and wellbeing strategy had recently been launched.
- Staff were generally very positive about appraisals, describing them as good. Staff talked about good support for training and development, although staff in some areas felt that it was difficult to go beyond the mandatory training.

Culture within the trust

- There was a positive and open culture within the trust. Staff talked about being encouraged to speak up about concerns and also to report incidents. Staff told us that they had been encouraged to speak to CQC inspectors and to be honest and open. This contrasted with information given to the CQC in advance of the inspection that suggested a culture of bullying and intimidation and that the opinions and concerns of senior clinical staff were routinely ignored. Whilst recognising that some individual staff have had less positive experiences, the team could not find any evidence that these concerns were widely shared. There was evidence that bullying had been raised by staff and, where this had happened, investigations had been completed and in some cases disciplinary action had been taken.
- There were different views of the culture of the trust at different levels and in different services within the trust. The senior team described the trust as one organisation with a long corridor between the two main hospitals. The team found that staff identified with the culture of their particular hospital rather than the trust as a whole, with the exception of those teams that worked across both sites. To some extent, staff identified the differences in terms of the differences between the city of Gloucester and the town of Cheltenham. Whilst allowing for that local variation, there did not appear to be any material differences in the culture between the two hospitals of the kind that might impact on the quality and safety of care. Staff at different levels who had worked in both places told us that, in reality, work was carried out in the same way, which reflected that staff were working consistently with the trust and divisional policies and procedures.
- Staff at all levels were very positive about the trust as a place in which to work. Staff told us that the trust was child friendly and family friendly, and that they enjoyed good support from

Summary of findings

colleagues and managers. Staff told us that people tended to stay at the trust for a long time. Staff who we met in focus groups, drop-in sessions and on wards spoke of the pride they felt in working for the trust.

- Staff talked positively about the Outline staff magazine, which provided them with information from across the trust. Staff also talked positively about the social activities that had been organised, including baking and poetry competitions and the trust's community choir, known as the 'caring chorus'.

Fit and proper persons

- The trust became subject to a new regulation (Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) on 27 November 2014. This regulation says that individuals in authority (board members) in organisations that deliver care are responsible for the overall quality and safety of that care. The regulation is about ensuring that board members are fit and proper to carry out that role.
- The board had received a paper on the fit and proper persons test in February 2015. The trust was in the process of implementing enhanced arrangements for recruitment to executive and non-executive roles. The trust had decided to incorporate the test in the annual appraisal process and was in the process of making amendments to the relevant paperwork.
- The trust was clearly preparing to meet the requirements related to fit and proper persons.

Public and staff engagement

- The trust's engagement with the public was mainly through its membership scheme. The trust currently has around 20,890 members, of which 8,200 are staff and 12,780 are members of the public and patients. A revised membership strategy was introduced in 2014 following consultation with governors and staff. The number of members was in line with national benchmarks, so the strategy was focused on improving member engagement, communicating better with members, maintaining the membership base, and diversifying the membership to increase the number of young people and people of working age.
- Members of the public were directly engaged and involved through volunteering in the trust. The 400 volunteers undertook a range of roles, including meeting and greeting patients and visitors and directing and escorting people around the hospitals, helping with the completion of menu cards on the

Summary of findings

wards, reading newspapers to patients, doing handicrafts or art activities, talking to patients and reminiscing, and assisting on wards and departments with clerical tasks. The team met a large group of volunteers, who were very positive about the roles they undertook and the support they received from staff. They felt valued and recognised by senior management and referred to feeling “part of the family and wider team”. Volunteers valued the training they received, which included training in meeting the needs of people living with dementia. Volunteers were invited to an annual lunch, which was attended by the board.

- With the exception of the staff governors, it was not apparent that staff were engaged with the trust as members. There were regular staff engagement meetings where staff from all disciplines met with the executive team. One member of staff told us they were the representative for their department at the staff engagement meetings. They told us they fed issues from their team into this meeting and reported back again. They also felt these meetings were worthwhile and enjoyed taking part, and said that other staff taking part valued these meetings.
- The staff side told us that they had an annual away-day with the executive team, and referred to positive relationships with senior management.
- The trust had scored poorly on overall engagement in the 2013 NHS staff survey (the most recent at the time of the inspection). The trust scored within expectations for the majority of indicators. The trust scored in the top 20% of trusts nationally on three indicators. These were for the response rate to the survey and for training within the last 12 months in health and safety and equality and diversity. The trust scored in the bottom 20% nationally on eight indicators. These included staff feeling satisfied with the care they are able to deliver, staff feeling that their role made a difference to patients, staff receiving job-relevant training in the last 12 months, the percentage of staff experiencing harassment, bullying or abuse from patients, relatives and the public, the percentage of staff experiencing physical violence from patients or relatives, staff recommending the trust as a place to work, staff motivation at work and overall engagement. It was possible that these results were lagging behind some improvements, because the overwhelming majority of staff we met during the inspection were engaged, displayed good motivation and were positive about the trust as a place to work. There was less positive feedback about engagement with medical staff, but it was felt that this was improving.

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Innovation, improvement and sustainability

- The trust had national research funding in the region of £3 million and was developing the infrastructure to increase its capacity for additional and larger trials. The key focus was on recruiting patients to trials being run by other organisations, but locally there were studies open in a number of clinical specialties covering areas including diabetes, cancer, paediatrics and ophthalmology. There was good governance of research. The trust had won an award for its commercial research.
- The trust was financially and clinically sustainable. The trust had a sustainability strategy that encompassed areas such as carbon reduction, recycling, responsible purchasing and sustainable building design. The age and location of the trust's estate in both Gloucester and Cheltenham presented ongoing challenges, and executives referred to the estate as frustrating their ambitions for transforming care. A programme to update, improve and refurbish the estate was underway at both main hospitals during the inspection.
- Improvement work, focused on safety, was underway across the organisation.

Overview of ratings

Our ratings for Gloucestershire Royal Hospital

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

Overview of ratings

Our ratings for Cheltenham General Hospital

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

Our ratings for Stroud Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Gloucestershire Hospitals NHS Foundation Trust

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

Overview of ratings

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients.
2. We have rated the trust as good for being well-led. The trust's leadership, governance and culture promote

the delivery of high quality person-centred care. Improvements are needed in aspects of the leadership of medical and end of life care services, although some elements are working well.

Outstanding practice and areas for improvement

Outstanding practice

- Patients living with dementia on Ward 9b at Gloucestershire Royal Hospital were able to take part in an activity group that had been organised by one of the healthcare assistants. The activity group enabled the patients to become involved in activities and encouraged them to maintain their skills and independence. The group was held weekly, and patients were able to play bingo, watch films, take part in reminiscence, paint, sing and eat lunch together. Activities were tailored to individual preferences, and relatives were encouraged to be involved.
- The trust had a mobile chemotherapy unit, which enabled patients to receive chemotherapy treatment closer to their homes to prevent frequent travel to hospital.
- Patient record keeping in critical care was outstanding. All the patients' records we saw were completed with high levels of detail. There were all the essential details to keep patients safe and ensure all staff working with them had the right information to provide safe care and treatment at all times.
- There was an outstanding holistic and multidisciplinary approach to assessing and planning care in the department of critical care. All the staff involved with the patients worked with one another to ensure that the care given to the patient followed an agreed treatment plan and team approach. Each aspect of the care and treatment had the patient at its centre.
- In critical care, there was an outstanding commitment to education and training of both nurses and trainee doctors. Nurses and trainee doctors followed comprehensive induction programmes that were designed by experienced clinical staff over many years. All the staff we met who discussed their training and development spoke very highly of the programmes on offer and of there being no barriers to continuous learning.
- There was outstanding care for bereavement in critical care. All staff spoke highly of how they were enabled to care for and support patients and relatives at this time. Bereavement care had been created with input from patients, carers, relatives and friends, and staff were particularly proud of the positive impact it had on bereaved people and on patients nearing or reaching the end of their life.
- The outstanding arrangements for governance and performance management in critical care drove continuous improvement and reflected best practice. There was a serious commitment to leadership, governance and driving improvements through audits, reviews and staff honesty and openness. All staff had a role to play in this area and understood and respected the importance of their work.
- Mobility in labour was promoted with the Mums Up and Mobile (MUM) programme, which included wireless cardiotocography (CTG) monitoring across the whole of the delivery suite.

Areas for improvement

Action the trust MUST take to improve

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

Outstanding practice and areas for improvement

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

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	<p>Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services</p> <p>Regulation 9 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services.</p> <p>The provider had not taken proper steps to ensure that each patient was protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of:</p> <ul style="list-style-type: none">(a) the carrying out of an assessment of the needs of the service user; and(b) the planning and delivery of care and, where appropriate, treatment in such a way as to:<ul style="list-style-type: none">(i) meet the service user's individual needs,(ii) ensure the welfare and safety of the service user. <p>[Now Regulation 9 including Regulation 9(3)(a) and 9(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]</p> <p>Patients spent too long in the emergency department. Too many patients who arrived at the emergency department by ambulance waited too long to be handed over to emergency department staff. This posed the risk that their assessment, care and treatment might be delayed.</p> <p>Too many patients arriving at the emergency department by ambulance were cared for in the corridor because there were insufficient available cubicles. This impacted on their safety, privacy and dignity.</p> <p>Patients with mental health needs attending the emergency department out of hours waited too long for assessment and support from appropriately qualified mental health practitioners.</p>

This section is primarily information for the provider

Requirement notices

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision

Regulation 10 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision.

The provider had failed to protect service users against the risk of inappropriate or unsafe care and treatment by means of the effective operation of systems designed to enable the provider to:

1. regularly assess and monitor the quality of services provided.

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

The provider had not taken appropriate steps to improve care and treatment in the emergency department in response to national clinical audits.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse

Regulation 11 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse.

1. The provider did not have suitable arrangements to ensure that service users were safeguarded against the risk of abuse by means of:
 1. Taking reasonable steps to identify the possibility of abuse and prevent it before it occurs;
 2. Responding appropriately to any allegation of abuse.

[Now Regulation 13 including Regulation 13(1), 13(2), and 13(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

Children's safeguarding assessments were not consistently carried out.

This section is primarily information for the provider

Requirement notices

The rate of safeguarding referrals was not audited to ensure that it was appropriate.

Not all senior medical staff in the emergency department were trained in safeguarding level 3.

Regulated activity

Diagnostic and screening procedures
Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

Regulation 12 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control.

[Now Regulation 12 including Regulation 12(2)(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

The provider had not, so far as reasonably practical, ensured that ensure service users were protected against identifiable risks of acquiring a

healthcare-associated infection.

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

The assessment/treatment room in the ambulatory emergency care department was not suitably maintained or equipped to ensure that it provided a suitable and hygienic area in which clinical interventions could be carried out.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines

Regulation 13 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Management of medicines.

[Now Regulation 12 including Regulation 12(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

This section is primarily information for the provider

Requirement notices

The provider had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, holding, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purpose of the regulated activity.

Within the ophthalmology outpatient department nurses were using 'patient protocols' and associated guidelines to write a patient specific direction from which the healthcare assistants were administering eye drops.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises

Regulation 15 (1) (c) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safety and suitability of premises.

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

1. Suitable design and layout.

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

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

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment

Regulation 18 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Consent to care and treatment

This section is primarily information for the provider

Requirement notices

[Now Regulation 11 including Regulation 11(1), and 11(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

The provider had not have suitable arrangements in place for the obtaining, and acting in accordance with, the consent, of patients in relation to the care and treatment provided to them.

In one surgical ward it was documented that a patient had early signs of dementia and confusion, no assessment was evidence of their capacity to make certain decisions.

Regulated activity

Diagnostic and screening procedures

Surgical procedures

Treatment of disease, disorder or injury

Regulation

Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records

Regulation 20 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Records.

1. The provider had not ensured that service users were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of:

1. an accurate record in respect of each

service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user.

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

Documentation relating to patients' mental capacity was not obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records. Explanations for the reason for the decision to withhold resuscitation were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation were not discussed were not documented.

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

This section is primarily information for the provider

Requirement notices

1. kept securely and can be located promptly when required.

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

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

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

Regulated activity

Diagnostic and screening procedures

Treatment of disease, disorder or injury

Regulation

Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing

Regulation 22 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Staffing.

[Now Regulation 18 including Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.]

The provider had not taken appropriate steps to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced staff were employed for the purposes of carrying on the regulated activity.

There were not always sufficient numbers of suitably qualified, skilled and experienced staff in the emergency department.

Safe levels of staffing and a safe skill mix had not been defined in relation to caring for patients in the emergency department corridor.