Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Royal Hospital

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services responsive to people's needs?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Overall summary of services at Gloucestershire Royal Hospital

Inspected but not rated

Gloucestershire Hospitals NHS Foundation Trust provides acute hospital services from Gloucestershire Royal Hospital and Cheltenham General Hospital. The trust employs more than 8,000 staff.

We carried out an unannounced focused inspection of Gloucestershire Royal Hospital urgent and emergency care services (also known as accident and emergency - A&E) and medical care services (including older people's care), between 8 and 10 December 2021. We had an additional focus on the urgent and emergency care pathway across Gloucestershire and carried out a number of inspections of services across a few weeks. This was to assess how patient risks were being managed across health and social care services during increased and extreme capacity pressures.

As this was a focused inspection at Gloucestershire Royal Hospital, we only inspected parts of five our key questions. For both core services we inspected parts of: safe, responsive, caring and well led. We included parts of effective in medical care. We did not inspect effective in emergency and urgent care at this visit but would have reported any areas of concern.

The emergency department was previously rated as good overall with safe and responsive as requires improvement. Medical care was previously rated as good overall with responsive as requires improvement.

For this inspection we considered information and data on performance for the emergency department and medical care. This inspection was partly undertaken due to the concerns this raised over how the organisation was responding to patient need and risk in the emergency department and the wider trust in times of high demand and pressure on capacity. We were concerned with waiting times for patients, delays in their onward care, treatment and delayed discharges, as well as delayed and lengthy turnaround times for ambulance crews. It was also to review actions we asked the trust to take from our last inspection.

We looked at the experience of patients using urgent and emergency care and medical care services in Gloucestershire Royal Hospital. This included the emergency department, medical wards and areas where patients in that pathway were cared for while waiting for treatment or admission. We visited services and departments that patients may encounter or use during their stay. We also went to wards where patients from the emergency department were admitted for further care. This was to determine how the flow of patients who started their care and treatment in the emergency department and those cared for on medical wards, was managed by the wider hospital.

A summary of CQC findings on urgent and emergency care services in Gloucestershire

Urgent and emergency care services across England have been and continue to be under sustained pressure. In response, CQC is undertaking a series of coordinated inspections, monitoring calls and analysis of data to identify how services in a local area work together to ensure patients receive safe, effective and timely care. On this occasion we did not inspect any GPs as part of this approach. However, we recognise the pressures faced by general practice during the COVID-19 pandemic and the impact on urgent and emergency care. We have summarised our findings for Gloucestershire below:

Our findings

Provision of urgent and emergency care in Gloucestershire was supported by health and social care services, stakeholders, commissioners and the local authority. Leaders we spoke with across a range of services told us of their commitment and determination to improve access and care for patients and to reduce pressure on staff. However, Gloucestershire had a significant number of patients unable to leave hospital which meant the hospitals were full and new patients had long delays waiting to be admitted.

The 111 service was generally performing well but performance had been impacted by high call volumes causing longer delays in giving clinical advice than were seen before the pandemic. Health and social care leaders had recently invested in a 24 hour a day, seven day a week Clinical Assessment Service (CAS). This was supported by GPs, advanced nurse practitioners, pharmacists and paramedics to ensure patients were appropriately signposted to the services across Gloucestershire.

At times, patients experienced long delays in a response from 999 services as well as delays in handover from the ambulance crew at hospital due to a lack of beds available and further, prolonged waits in emergency departments. Patients were also remaining in hospital for longer than they required acute medical care due to delays in their discharge home or to community care. These delays exposed people to the risk of harm especially at times of high demand. The reasons for these delays were complex and involved many different sectors and providers of health and social care.

Health and social care services had responded to the challenges across urgent and emergency care by implementing a range of same day emergency care services. While some were alleviating the pressure on the emergency department, the system had become complicated. Staff and patients were not always able to articulate and understand urgent and emergency care pathways.

The local directory of services used by staff in urgent and emergency care to direct patients to appropriate treatment and support was found to have inaccuracies and out of date information. This resulted in some patients being inappropriately referred to services or additional triage processes being implemented which delayed access to services. For example, the local directory of services had not been updated to ensure children were signposted to an emergency department with a paediatric service and an additional triage process had been implemented for patients accessing the minor illness and injury units to avoid inappropriate referrals. Staff from services across Gloucestershire were working to review how the directory of services was updated and continuing to strengthen how this would be used in the future.

We found urgent and emergency care pathways could be simplified to ensure the public and staff could better understand the services available and ensure people access the appropriate care. Health and social care leaders also welcomed this as an opportunity for improvement. We also identified opportunities to improve patient flow through community services in Gloucestershire. These were well run and could be developed further to increase the community provision of urgent care and prevent inappropriate attendance in the emergency departments.

There was also capacity reported in care homes across Gloucestershire which could also be used to support patients to leave hospital in a timely way. The local authority should be closely involved with all decision-making due to its extensive experience in admission avoidance and community-based pathways.

Summary of Gloucestershire Hospitals NHS Foundation Trust - Gloucester Royal Hospital

We found:

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

Our findings

- The services mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean and most staff wore personal protective equipment in line with trust policy. However, some hand gel containers were found to be empty.
- Patients had an assessment of their infection risk and other clinical risks on arrival at the emergency department and were treated according to their priority of need. Those who needed urgent care received it.
- Managers had reviewed staffing needs and recently increased the total number of nurses and medical staff recruited. Bank and agency staff were used to fill gaps in the rotas but some shifts could not be filled. Managers were continuing recruitment processes for new roles. Locums were used to fill gaps in medical rotas and managers ensured senior staff were available on each shift.
- The services had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Key services were available seven days a week to support timely patient care.
- Staff were empathetic and caring when treating patients and demonstrated an understanding of how patients may be feeling when receiving treatment in the emergency department. Patients felt informed of their treatment choices and praised staff for care they received. A newly appointed patient experience lead for the emergency department had a positive impact on patient experience.
- The services were inclusive and took account of patient's individual needs and preferences. Staff made reasonable adjustments to help access services. They coordinated care with other services and providers.
- Managers risk assessed, adapted and rearranged services at times of extreme capacity pressures to help staff provide safe care and treatment for patients. Staff worked hard to provide care and treatment for patients who stayed in the emergency department longer than anticipated due to capacity pressures on the hospital.
- Leaders and teams used systems to manage risk and performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid compromising the quality of care.
- Managers demonstrated the skills and abilities to run the services. They understood and managed the priorities and issues the services faced. Level of pressure was communicated to executive leaders and across the trust. They were supportive and caring for patients and staff.

However:

- Due to capacity pressures and the emergency department often being at full capacity areas were reconfigured in the emergency department. Some areas were small and did not allow for patients to socially distance while waiting for treatment. Assessment and prioritising patients' needs were key for staff but space was limited. However, patients' risks were assessed to maintain their safety and follow social distancing rules. Patient referrals to other specialties were not always responded to promptly. This led to some areas being used for more patients than they were designed for. Staff did their best to protect patients' privacy and dignity but lack of space led to this being less than ideal at times.
- There were still some gaps in nursing rotas in both the emergency department and medical care which could not be filled using bank or agency staff. In the emergency department these had reduced since our last inspection. There were not enough children's trained nursing staff to cover every shift in the emergency department. Paediatric colleagues provided support and additional training in paediatric skills was provided for staff while managers undertook recruitment drives to attract paediatric trained staff.

Our findings

- Capacity pressures in the emergency department meant not all patients received treatment promptly, but they were assessed quickly for risk on arrival and prioritised for treatment. A major part of the problem with access to beds for patients in the emergency department was from the high number of patients who were medically fit to leave on hospital wards. They were waiting for further social care support to enable their safe discharge.
- Due to pressures on bed capacity in medical care, there were times when patients were cared for in areas not designed for that purpose, and there were occasional mixed-sex breaches in medical care.
- In medical care, patients were being moved sometimes multiple times, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.
- Some staff in medical care had the perception that some leaders were not always visible and approachable for staff. Staff morale was low due to the immense and unrelenting pressures which had been ongoing for a number of years.

How we carried out the inspection

At Gloucestershire Royal Hospital, we spoke with 18 patients and their families, and 37 staff, who included nursing, medical, administration staff and service leads. We observed care provided; a safety huddle attended by eight staff; reviewed relevant policies; documents; and 18 patient records.

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

Medical care (including older people's care)

Inspected but not rated

Gloucestershire Royal Hospital provides medical care (including older people's care) to patients in the Gloucestershire area. Medical care is provided at both hospitals with some specialist services in one location.

Since the start of the COVID-19 pandemic some medical care services at Gloucestershire Royal Hospital have been reconfigured to accommodate patients who are positive to COVID-19. There are designated areas for patients who are tested as positive to COVID-19. Also, some services have been moved to Cheltenham General Hospital.

Is the service safe?

Inspected but not rated

Cleanliness, infection control and hygiene

The service mostly controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas we visited were visibly clean and furnishings were well-maintained. Furnishings, such as chairs and flooring were wipeable and easy to clean. We did not find any dust in hard to reach places where we checked.

Managers audited cleaning records and staff compliance with infection control practices as part of a wider COVID-19 assurance framework. Staff compliance was reported to infection prevention and control specialists within the trust and actions needed were fed back to staff in the relevant area. Hand hygiene audit results for the three months prior to our inspection showed good staff compliance.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff wearing the correct PPE including surgical face masks in accordance with national guidance. All clinical staff were bare below the elbow to enable effective cleaning of their hands. Patients told us and we saw how staff cleaned their hands regularly. However, we found that a few hand gel dispensers outside wards were empty. This meant people could not clean their hands before entering some areas.

There were designated wards for patients with COVID-19 symptoms or who were known to be COVID-19 positive. Staff knew which wards were designated for these patients and were able to describe how they would provide care to patients with symptoms or newly diagnosed with COVID-19 in accordance with trust policy.

There was rapid testing available for COVID-19. Staff screened patients for COVID-19 throughout their admission on set days and if they presented with signs and symptoms.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment mostly kept people safe. Staff managed clinical waste well. However, the use of temporary bed spaces for patients was recognised as not ideal, but in the circumstances was being as safely managed as possible.

Medical care (including older people's care)

Most patients could reach call bells and staff responded quickly when called. At times when no other beds were available some patients (assessed for risk) were cared for in areas where there were no call bells, piped oxygen or suction. For example, patients who were 'boarding' (where an additional temporary bed space was created in a bay or on a ward corridor) when they were awaiting a bed space. However, these patients were cared for close to where nursing staff were based and it was possible for staff to observe them. Staff recognised patients who were being cared for in temporary beds required additional monitoring to ensure the lack of some clinical facilities did not compromise their care and treatment. Portable suction and oxygen were available in all areas where there were temporary beds.

When patients were cared for in temporary beds staff assessed patients to make sure they were well enough to be cared for in these areas. The hospital had a policy for using these beds and criteria for staff to follow but a few of those staff told us they were unsure if the hospital had a policy on boarding. However, we observed they did follow the principles of the policy in identifying who should be cared for in these areas and assessing their risk. It was nevertheless recognised the environment was not suitable for patients remaining for long periods or for treatment.

Due to environmental restrictions caused by the COVID-19 pandemic, the acute medical initial assessment unit had limited space for a waiting area. This prevented social distancing for patients and also sometimes patients having to wait on the corridor outside the unit where they were then not routinely observed by staff. However, these patients were assessed as being of lower risk. This issue was recognised and addressed in the specification for the new building which was underway and due to open in January 2022.

Staff carried out daily safety checks of specialist equipment. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure with tamper seals. We found all checks we reviewed were completed daily with the name of the staff member, date and their signature.

The service had enough suitable equipment to help staff safely care for patients and staff we spoke with did not report any shortages of equipment. We saw equipment used to safely lift patients had dates of the last and next service displayed and these were in date.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and minimised risks. Staff identified and quickly acted upon patients at risk of deterioration. However, when handing over care to other providers sometimes documentation was delayed or not available.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. This included tools to record vital observations for patients and early warning scores were used to identify patients at risk of deterioration. The use of an electronic system meant senior nursing staff and medical staff had an oversight of the clinical risk of unwell patients. The acute care response team (a team who reviewed unwell patients when it was urgent) could also access this electronic system.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 14 patient records and saw risk assessments were completed on admission and reviewed regularly and when a change occurred. Risk assessments were recorded using the same electronic system used to record vital observations. This meant risks were assessed and recorded in one place and more visible in a timely way for clinical staff.

Staff knew about and dealt with any specific risk issues for patients. Staff showed us additional assessments that would be made for patients if a risk was identified and told us of the action they would take. For example, where a falls risk to a patient had been identified, actions taken to reduce the risk were documented following an agreed risk matrix for falls management.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). This was provided through another NHS trust and was accessible through referral.

Staff shared key information to keep patients safe when handing over their care to others, although staff said there were delays in sending some discharge paperwork. During our inspections of adult social care services at the same time, providers told us they had concerns about delayed paperwork or missing information. This was difficult for providers to follow-up on with wards particularly at weekends and out of hours.

Shift changes and handovers included all necessary key information to keep patients safe. Handover documentation was clear and contained the latest updates on patient condition, plan of care and any outstanding actions to be completed.

Nurse staffing

It was recognised by senior management that shortages of staff trained in nursing care meant the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift. However, this did not always provide established levels of staffing.

Due to national shortages of nursing and support staff and high levels of staff absence the service did not always have enough nursing and support staff to keep patients safe. There were continuous advertisements for nursing and healthcare assistant vacancies. Managers of the service told us they had increased nurse staffing establishment to allow for absences and vacancies so they could provide continual safe care as much as possible. However, staff in the areas we visited told us they were often short of nursing staff.

We reviewed nurse staffing rosters for two wards and found the number of nurses and healthcare assistants did not always match the planned numbers. For example, in the four weeks prior to our inspection on 23 out of 28 days registered nurse staffing levels for the acute medical unit were below the planned numbers by at least one day or night shift. However, our inspection took place during a peak of the COVID-19 pandemic and nationally there was an increase in absence across the care sector particularly due to short term sickness.

The ward manager could adjust staffing levels daily according to the needs of patients. Staff told us this was done when they were caring for additional patients or opened escalation areas. However, staff also told us that often, additional staff would not be provided as no staff were available to fill gaps in shifts. Staff in the acute medical unit told us they would often be required to staff the acute medical initial assessment unit when this was used for overnight escalation.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. A senior nurse was allocated to manage staffing and respond to requests for support from wards. Additional staffing requirements were discussed with the wider management team throughout the day at site meetings. The team discussed whether these shifts should be escalated to non-framework agencies (an agency beyond nationally agreed funding limits).

Medical care (including older people's care)

The medical care wards often had to use bank and agency staff to fill shifts. Some of these were staff who were familiar with the wards, but not always. Staff who were unfamiliar with the ward required induction and familiarisation with systems and processes, which were provided, but put additional strain on the regular staff.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Staff told us the service had enough medical staff to keep patients safe. We saw rosters that showed the medical staff matched the planned number. There had been an increase in establishment for the number of doctors, many of whom had been recruited and there was a reducing vacancy rate for medical staff. Turnover was low as was sickness and absence.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. There was always a consultant on call for junior doctors to contact during evenings and weekends. Where there were gaps in rosters the service requested locum medical staff and they were provided when needed. However, this was sometimes said to be left to medical staff to resolve with their colleagues directly.

Is the service effective?

Inspected but not rated

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Each ward has a daily multidisciplinary discussion about the patients in their area, called a board round. This included patients' diagnosis, treatment plans, concerns and any discharge planning.

Staff worked with external clinical professionals and agencies when required to care for patients. We saw evidence of multidisciplinary working throughout our inspection and this was supported by documentation in patients' notes. For example, notes contained entries from doctors, specialist nurses, therapists and dietitians. However, staff told us they felt access to social services had become more difficult during the COVID-19 pandemic as staff had been required to move offsite for safety.

Staff referred patients for mental health assessments when they showed signs of mental ill health. The service had a contract with a local NHS mental health service to provide access to specialist teams to support patients.

Patients had their care pathway reviewed by a consultant to ensure their care and treatment was effective. In the records that we reviewed we found patients had a prompt consultant review on admission and throughout their stay on daily ward rounds.

Seven-day services

Key services were available seven days a week to support timely patient care.

Medical care (including older people's care)

Consultants led daily ward rounds on acute wards, including weekends. Patients were reviewed by consultants depending on the care pathway. We reviewed the notes of 14 patients and found they all had a clinical assessment undertaken by a consultant as required within 12 hours of admission.

Staff could call for support from doctors and other clinical professionals, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Key diagnostic tests (such as scans) could be undertaken seven days a week with urgent cases seen out of hours and at weekends. Medical staff we spoke to told us there was good access to diagnostic services.

In some areas staff told us there was access to therapies (such as physiotherapy and occupational therapy) seven days a week. However, this was not the case in all areas and there was a reduced service at the weekend that focused on patients (usually in respiratory distress) who needed help the most.

Access to pharmacy operated on reduced hours at the weekend. However, it was available seven days a week and there was an on-call service outside of usual working hours.

Managers told us that access to social services (including discharge teams) was available Monday to Friday. The service could not access social services to discharge patients at the weekend as this was limited to admission avoidance for the emergency department.

Is the service responsive?

Inspected but not rated

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. However, due to pressures on bed capacity, there were times when patients were cared for in areas not designed for that purpose, and there were occasional mixed-sex breaches.

Facilities and premises were mostly appropriate for the services being delivered. However, during and surrounding the time of our inspection, the hospital was often at full capacity and sometimes over full capacity with temporary beds opened. To meet this demand there were times when care was delivered in areas not set up for that purpose.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. We found two bays on the acute medical unit where mixed sex breaches had occurred. Staff knew the importance of reporting this so it could be monitored and told us that an incident form was completed for mixed sex breaches.

The service had systems to help staff care for patients in need of additional support or specialist intervention. The service had a variety of specialists including specialist nurses who were available to offer advice and support to staff and patients. For example, the service had access to a tissue viability team to help with patients developing or at risk from developing a pressure ulcer.

The medical care service relieved pressure on other departments when they could treat patients in a day. We visited the acute medical initial assessment unit, a unit which sees ambulatory patients, some of who were transferred from the

emergency department. Patients referred to this unit had been assessed as needing short-term care which should be possible to provide in the same day. Staff in the unit would see patients the same day and told us they were able to ask them to return for follow-up appointments if needed. Patients could also be referred to rapid access 'hot clinics' for consultant review and not have to stay overnight. Rapid access respiratory and cardiology clinics occurred two or three times each week.

The discharge waiting area staff team supported patients who were awaiting discharge to relieve pressure on other departments. Staff told us how they felt their role was to support busy wards and departments and that they were currently prioritising the emergency department with patients who could go home the same day.

The service mostly had suitable facilities to meet the needs of patients' families. In most areas we visited there were rooms available for patients' families. During the COVID-19 pandemic the trust had implemented different levels of visiting restrictions which meant visitors were not always allowed. However, owing to high demand these areas were sometimes used to accommodate patients to provide care.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers. However, due to pressure on bed capacity, the use of temporary beds meant the privacy and dignity of patients at times was not meeting their needs.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff we spoke to were understanding of the needs of patients with dementia. During our inspection trainers were visiting wards to specifically raise awareness on patient deconditioning, as part of the national 'end PJ (pyjama) paralysis' campaign (this encourages patients to get up, get dressed and get moving as they might at home). Staff were receiving refresher training on the key principles of how to stop deconditioning.

Wards we visited were set up to meet the needs of patients living with dementia. The service had a specific ward dedicated to the assessment of frail patients, the frailty assessment unit. This ward was staffed by a multidisciplinary team to support a variety of patient needs. There were also specific wards designated for the care of older people.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Carers were able to download the 'This is me' document from the trust website to fill in and bring in for staff to learn about more important information about caring for the patient.

During times of increased demand when boarding of patients was taking place, privacy and dignity had the potential to be compromised. However, staff were aware of this and told us how they would use screens to maintain patient privacy and dignity although accepting this was not ideal. On the frailty assessment unit, we saw screens were available if patients were being cared for in temporary beds.

Staff understood and applied the trust's policy on meeting the information and communication needs of patients with a disability or sensory loss. The service was able to provide access to British Sign Language interpreters if needed. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff were able to arrange access to foreign language interpreters to support patients and relatives during their stay.

Staff told us patients were given a choice of food and drink to meet their cultural and religious preferences. If patients had any special dietary requirements staff were able to contact the catering team to have these needs met.

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on bed capacity. There were significant numbers of patients unable to leave the hospital as they were waiting for onward care packages to be set up. Patients were being moved sometimes multiple times, sometimes at night, in order to admit them to the right place once a bed became available. Some patients were needing longer stays while they awaited treatment.

The hospital had significant capacity problems with available beds due to the high number of patients who were medically fit to go home, but there was no care package immediately available for discharge to be carried out safely. The situation was made worse by the complexities of COVID-19 pathways and keeping some patients isolated. Staff were required to monitor the number of delayed discharges and look at how to manage these effectively.

However, a number of the delays we reviewed were categorised in records as being for 'unknown' reasons. For example, on 9 December 2021 the trust had 241 delayed patient discharges. Of these, 47 were waiting for local authority funding, 52 were awaiting assessment arrangements when they went home, and 41 were in the 'unknown' reason for delay category. We discussed this with managers, and they recognised this was unhelpful but were taking actions to improve their understanding of the delays.

Wards we visited had high numbers of patients who had delayed discharges and no longer needed to be in an acute hospital bed. On the acute frailty assessment unit, a short stay ward, 9 out of 19 patients were medically fit for discharge and consequently the frailty team were reviewing more patients in the emergency department as there were no beds available to admit patients onto this unit.

On ward 4A, 14 out of 30 patients were medically fit for discharge and on ward 6B, 27 out of 35 were medically fit for discharge. The patients were waiting for a package of care, a discharge to assess bed in the community or continuing healthcare assessments to progress their discharge. There were many patients waiting for community hospital beds for rehabilitation after an acute illness and these patients had complex needs with most wanting to return to their own home.

Due to complexities in assessing patients who needed onward care, and the lack of packages available to be purchased or arranged by social services, there were long delays in getting patients home. The staffing shortages in adult social care providers had a detrimental effect on the whole system of access and flow for medical care.

Managers recognised the impact that delayed discharges were having on flow in the service and were aware of the poor flow through the wider Gloucestershire care system. They had discussed improvement plans with social care colleagues and felt there was a high level of system working towards resolving these issues.

Staff supported patients when they were referred or transferred between services. Staff made prompt referrals to other services where these were needed. Where care was required beyond the hospital, staff arranged referral and the service had access to an onward care team who acted as discharge coordinators.

To manage access and flow to acute medical services, community partners including primary care and the ambulance service used an electronic system to contact the acute medical team. This 24 hour a day, seven day a week service was staffed by a consultant during the day and a junior doctor at night. Decisions were made on whether patients would be

admitted, and if so, where they should attend. Medical staff were able to give clinical advice to manage patients at home if this was indicated in their assessment. Medical staff then used the system to record referral information and form initial plans meaning that when the patient arrived at hospital nursing staff and junior doctors could commence care promptly.

Managers worked to minimise the number of medical patients being cared for on non-medical wards (known as outliers). They were discussed at all site meetings. While managers attempted to reduce the number of outlying patients this was made more challenging by the bed capacity pressures on the service. Managers had arrangements for medical staff to review any medical patients on non-medical wards and there was a medical team responsible for the care of outlying patients.

Managers monitored waiting times and aimed to make sure patients could access services when needed and received treatment within agreed timeframes and national targets. However, given the significant strain on capacity in services it was not always possible to do this.

The medical care leaders were aware of the current status of the service. Managers and clinical leaders participated in site meetings held regularly throughout the day, every day. During these meetings managers discussed the number of patients waiting to be provided with beds within the service, the number of discharges planned for patients, and plans on how to manage shortfalls between the two.

The hospital policy was to keep patient moves between wards to a minimum. The use of an electronic system allowed managers efficient oversight of this. However, owing to significant issues with bed capacity in the service, patients were moved between wards multiple times. For example, a patient had been admitted to a temporary bed overnight and moved to another temporary bed the following morning (in anticipation of a discharge on that ward). At that point ward staff explained there was no bed currently available on the ward, so the patient was likely to be moved to another ward.

As it was recognised as adding at least stress and anxiety for patients, staff tried not to move patients between wards at night. Patients were allocated beds throughout the night with planned moves to take place the following morning. However, staff told us this was not always possible due to the high demand on beds and sometimes patients were moved between wards at night.

There was some inefficiency in transport arrangements when patients were moved to the other hospital in Cheltenham. As part of a hospital trust with two acute hospitals, sometimes patients needed to be moved between hospital sites. Beds would be reserved for patients for this purpose. However, we were told transport would often be delayed. This meant beds could be unoccupied for some time while waiting for transfers or the move would be cancelled, and the bed given to another patient.

Due to bed capacity problems, staff told us the length of stay in short stay wards and assessment areas had sometimes increased beyond what was clinically expected. This was as a result of demand on beds elsewhere in the hospital and patients being found a bed in areas which were not those planned for their care and treatment. However, the average length of stay in the acute medical unit in the four weeks prior to our inspection was 25 hours.

Managers and staff started discharge planning for patients as early as possible. Most staff said discharge planning started from when the patient arrived. Staff planned discharge carefully, particularly for those with complex mental health and social care needs. The hospital had specific teams to support with discharge planning and finding onward care.

Medical care (including older people's care)

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff discussed patient discharge plans daily and there was active challenge on whether their chosen pathway remained correct.

The hospital used a discharge waiting area for patients who were going home that day. This meant patients could be moved to this area when ready for discharge allowing beds to be made available. The discharge waiting area was well located with direct access to an ambulance bay which was designed for efficiency in taking people home who needed ambulance transport.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. However, they were sometimes not always visible and approachable in the service for patients and staff. Staff morale in the service was low due to the immense and unrelenting pressures which had been ongoing for a number of years.

The medical care service had a clear senior management leadership structure. This was divided into planned and unscheduled care with further departmental divisions beyond this. The service had a joint leadership team between the trust's two sites, Gloucestershire Royal Hospital and Cheltenham General Hospital.

Leaders had the skills and abilities to run the service and we saw evidence that they were actively engaged and committed to safe patient care and supporting their staff. However, this was challenging given the pressure the service was facing. Leaders were aware of issues with delayed discharges impacting flow and were working hard to maintain patient safety.

Leaders told us they felt they were more visible at Gloucestershire Royal Hospital as this was needed for their response to the COVID-19 pandemic. Leaders were using electronic communication methods to increase their responsiveness and visibility. We spoke with one member of staff who praised a director who they found proactive and supportive and staff told us they received regular email communication from leaders, and they found this was helpful. However, some staff told us they had the perception some leaders were not always visible or approachable and some staff told us they could not recall when they last saw divisional and executive leaders in their area.

The service had a coherent leadership strategy that was shared by service leaders. They had processes to review and improve the leadership strategy. Leaders wanted to support staff to have the best working environment they could and were keen to support development. Staff told us they felt there were development opportunities and staff wellbeing support was good. However, with all the immense and unrelenting pressure on the whole service, nursing staff told us morale was low and this had been recognised by medical staff who were concerned for their colleagues.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid compromising the quality of care.

Medical care (including older people's care)

The service had systems for recording, reviewing and managing risks. The risk register for the service was comprehensive and had been reviewed regularly. Many of the risks on the register recognised the impact that poor flow had on increased risk to patient care and there was evidence of trying to manage those risks.

Leaders in the service attended quality and performance meetings and contributed to them to improve the service. We saw evidence leaders were actively challenged from board members on how they were working to manage risks and improve services. Leaders responses gave us further assurance they understood the risks of the service.

Staff told us they were well informed by leaders on the risks the service and wider trust was facing including daily updates and key areas of focus. Medical staff told us they felt involved in the process of managing risks.

Managers from the service took part in daily site meetings which had a focus on improving flow through the hospital where possible. These meetings were attended by colleagues from across both hospital sites meaning risk could be considered as an overall trust and shared.

Outstanding practice

We found the following outstanding practice:

- The use of an electronic system to record referrals received from community partners including GP services. This 24 hour a day, seven day a week service was staffed by a consultant during the day and a junior doctor at night. Decisions were made on whether patients would be admitted and where they should attend. There were initial plans meaning when the patient arrived at the hospital nursing staff and junior doctors could commence care promptly.

Areas for improvement

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

Action the trust SHOULD take to improve:

Gloucestershire Royal Hospital Medical Care

- The trust should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Gloucestershire.
- Continue to regularly review the nursing staffing levels in order to increase these to meet establishment levels.
- Check hand gel is available prior to entering wards and departments.
- Staff working in wards where patients are admitted to temporary beds should be familiar with the trust policy on boarding patients.
- Look at the patients who are in the discharge category with unknown reasons for the delay in order to help staff expedite the process.

Medical care (including older people's care)

- Review the timeliness and effectiveness of discharge documentation including prompt completion to support safe discharge of patients. Offer the health and care community a way to contact key staff when paperwork or discharge arrangements are lacking or missing.
- Review the transport arrangement for patients transfers where this was leading to inefficiency in bed management.

Urgent and emergency services

Inspected but not rated

Gloucestershire Royal Hospital provides emergency department services for adults and children. The emergency department accepts patients transported by ambulance or those who arrive independently. It is open 24 hours a day, seven days a week. The trust also runs an emergency department at Cheltenham General Hospital which operates as a minor injuries and illness unit at night.

Total A&E attendances at Gloucestershire Royal Hospital between June and November 2021 were 50,944. Of these, 11,867 (23%) were children. This included children who were directed from A&E to the children's assessment unit prior to the configuration of a children's area in the emergency department. There was a slight increase in attendances over this time although they were below the England average.

Since the pandemic, the emergency department at Gloucestershire Royal Hospital has been reconfigured to accommodate patients who are positive to COVID-19 and a designated area established .

There is a designated paediatric area, which has a restricted access door from the adult majors area.

Is the service safe?

Inspected but not rated

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff understood the different forms of abuse and what action to take to promote patient safety. They explained how they would report safeguarding concerns and they could access the hospital's safeguarding team with questions or to seek additional advice when necessary. Staff said the trust-wide safeguarding practitioners were supportive and approachable with any concerns staff raised.

Staff were confident in the action they would take to ensure patients' safety.

There were systems which flagged up if there were any safeguarding concerns about children.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas we visited were visibly clean and had suitable furnishings which were well-maintained. Furnishings, such as chairs and flooring were wipeable and easy to clean. We did not find any dust in hard to reach places.

Managers audited staff compliance with infection control practices as part of a wider COVID-19 assurance framework. Staff compliance was reported to infection prevention and control specialists within the trust and actions needed were fed back to staff in the department. Managers monitored and reviewed all areas of the department each month and documented areas that needed more cleaning or repairs. This information was fed back to cleaning or maintenance staff for action. Hand hygiene audit results for September, October and November 2021 showed good staff compliance.

Staff mostly followed infection control principles including the use of personal protective equipment (PPE). We observed staff being bare below elbows for more effective hand-washing and wearing surgical masks at all times. Staff wore disposable gloves when required. Some but not all staff wore disposable aprons when this was required as they were assisting patients with personal care. Staff had access to PPE and hand gelling stations or sinks to enable hand washing.

Most staff were up to date with training in infection prevention and control with records showing 84% compliance in the emergency department across both locations.

There was a designated area for patients who presented with COVID-19 symptoms or were testing as COVID-19 positive. We did not go into this area but saw staff wearing PPE in line with national guidance when they entered the area. Signs were visible to prevent unauthorised people accessing the area.

There was rapid testing for COVID-19. Staff screened patients for signs and symptoms when they attended the emergency department. If patients arriving by ambulance tested positive, the ambulance crew took them to a designated 'red' area, or they were held in the ambulance until space was available. This red area of the department had a separate entrance and five separate rooms where patients were admitted. Patients were tested again for COVID-19 using a fast PCR test which gave a result in 30 minutes. This test was also used for patients admitted to the majors part of the department (majors is for patients who are most unwell).

Staff told us they tested themselves for COVID-19 but the hospital did not keep staff testing records for assurance that testing was carried out. All staff had been offered COVID-19 vaccinations and boosters in line with national guidance.

Staff cleaned equipment after each patient contact and we saw which was less often used equipment was clean with labels to show when it was last cleaned.

Environment and equipment

In times of normal demand and capacity in the emergency department, the design and maintenance of facilities, premises and equipment kept people safe. However, the use of premises during times of excessive capacity pressure did not always keep patients safe.

Patients could reach call bells most of the time and staff responded quickly when called. At times of high capacity pressure, some patients were cared for in areas where there were no call bells. For example, patients who were assessed as being fit to sit in a chair while they awaited results or for ongoing observation waited in a 'sub waiting area'. The area was close to the main hub/nurses' station but patients did not have access to call bells in the event they felt unwell. However, staff were aware of this and these patients were observed by staff who were close by.

Due to capacity pressures, patients were sometimes cared for overnight in areas not usually used for inpatient care. This included an X-ray waiting area in use overnight (and supported by ambulance personnel) which did not have call bells, piped oxygen, or permanent suction facilities. Staff used portable oxygen and suction facilities in these areas. Staff followed an assessment process to ensure only patients who were safe to be held in those areas stayed there overnight.

Urgent and emergency services

Department managers and trust executives were aware of some issues with safety of these areas and privacy and dignity for patients. Staff did their best to maintain privacy and dignity by using portable screens between patients but this did not stop patient consultations being overheard by other patients. A decision had been taken to convert other areas in the department to more suitable facilities for short-team use.

We saw some fire doors which were propped open which was not in line with national recommendations on fire safety or trust policy.

The use of the designed premises and environment did not always follow national guidance. The extreme capacity pressure on the service had created greater challenges in using the environment for the purpose it was designed. The adult waiting room was small which resulted in difficulty for patients to observe social distancing although guidance was available for people attending to maintain social distancing of at least one metre. To alleviate some of the pressure, patients were moved to other clinical treatment areas by clinical staff when initial triage was completed to reduce the numbers of patients in the waiting area.

As with all emergency departments, the area was designed to accommodate patients for short periods of time while they were assessed and treated. However, due to capacity pressure, some patients had been in the department for long periods of time (up to 22 hours). Staff told us they did their best to meet patients' personal hygiene needs, but the facilities were not designed for patients to remain for long periods in the department.

In order to meet the pressure caused by excess capacity, the department had as an initial response to extreme pressure, established cohorting areas to relieve pressure on ambulances queuing. The areas were staffed by ambulance personnel and used for looking after patients who would otherwise be held on an ambulance. Two rooms were used for up to six patients (three in each). Managers had completed risk assessments of these areas to ensure there was enough space for social distancing (to prevent COVID-19 transmission). Staff had access to a standard operating procedure which detailed actions they needed to take to assess risk of COVID-19 or any other infectious illness. They were to use the rooms in a way which kept patients a minimum of one metre apart (from head to head). Another larger room was being converted for use as a cohort area and fitted with equipment needed for patient care and privacy. This was in use shortly after our visit. Staff were provided with a strict protocol of the number of patients to be admitted to each area.

The emergency department had a designated children's area which maintained children's safety. It included a waiting area, three consultation rooms and a triage room. The rooms were bright and there was restricted access from the main waiting area. However, we found the door to the main emergency department was not always closed and this enabled unrestricted access. Staff ensured this was closed when we highlighted the issue.

The minor injury and illness unit was located some way away from the main emergency department. This was a nurse-led unit run by emergency nurse practitioners. However, the waiting area was a designated area in a part of the main concourse of the hospital. There was no clinical oversight of patients and the children's waiting area was in full sight of adults waiting and the public which was not ideal. We were not aware of any clinical incidents in relation to the visibility of patients in this area.

There was no paediatric resuscitation equipment in the minor injuries and illness unit although children with illnesses were directed to the paediatric assessment unit. Children with minor injuries were triaged in the paediatric emergency department and directed to the minor injuries unit for further care.

Urgent and emergency services

In the emergency department, staff had enough suitable equipment to help them to safely care for patients. Staff carried out daily safety checks of specialist equipment most of the time. Staff had access to emergency resuscitation trolleys for adults and children and knew where the nearest one was in the emergency department.

Staff mostly completed daily and weekly checks on equipment and consumables stored on these trolleys. However, records showed there were some gaps in daily checking of emergency and specialist equipment. For example, the resuscitation trolley in the children's department had not been checked on two dates in November 2021. There was a specific daily checklist in the 'pitstop' area (a triage area for newly arrived ambulance patients) which prompted staff to check equipment and medicines. However, there were some gaps in how often it had been completed.

Two small oxygen cylinders were stored on the floor of the majors area without being secured. This was not in line with national guidance. Trust staff had identified this as a risk and were awaiting the arrival of new equipment to secure these cylinders.

The service had suitable facilities to meet the needs of patients' families. Managers had reduced the risk of potential transmission of COVID-19 by reducing the numbers of people wating with patients in the department. Family and friends could wait in the relatives' room. Staff assessed whether patients needed their relative with them based on individual needs.

Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal and specific sharps disposal bucket for sharp instruments such as needles used for injections.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, audit results for patient safety measures were reporting poor compliance either with record-keeping or with timely care for patients.

Staff used nationally recognised tools to identify deteriorating patients and escalated them appropriately. This included tools to record vital observations and to assess for possible sepsis (severe reaction to an infection) for adults and children of different ages in accordance with national guidance. Early warning scores were used to monitor patients' vital observations. This information was logged and shared through the electronic dashboard to allow the emergency physician in charge (consultant) and nurse in charge oversight of the clinical risk of patients in the department.

Staff completed risk assessments for each patient on arrival using a recognised tool, and reviewed this regularly, including after any incident. Patients arriving by ambulance were brought into a designated (pit stop) area of the emergency department for assessment, review and an initial treatment plan by senior clinicians. Time-critical treatment would be given or initiated before patients were moved into the majors area or if there was no capacity, patients would move back into the ambulance or the cohorting areas.

Not all patient records showed safety metrics linked to assessing and responding to risk were being recorded in a timely way. Staff used an electronic version of the emergency department safety checklist in accordance with national guidance. This checklist prompted staff to complete and record, for example, vital observations, early warning scores, antibiotic compliance and pain management every hour. The electronic record system was introduced in July 2021 with the paper-based version phased out by the end of November 2021.

Urgent and emergency services

Audit results were of concern as they reported for November 2021 an overall completion of patient safety measures as just 40%. However, this was due to failure of the new system to accurately process data.

Within the new system, none of these key metrics met the level for compliance with safety. However, the audit records showed that prior to the introduction of the electronic system, all metrics met the safety threshold. The audit information for the emergency department across both sites, was being improved using electronic systems. Instead of paper based audits of a small number of records, every patient record was audited which provided more accurate results.

The checklist was continued for patients who had been in the department for longer periods due to delays in beds being available or waiting for decisions. Records we reviewed for long-stay patients confirmed they had received care, prescribed medicines, food and drinks. There was a drive to ensure patients at risk of pressure ulcers were offered a hospital-style bed rather than a trolley if they were in the department for more than four hours. We saw these patients on beds instead of trolleys and other patients on beds if they remained in the department for eight or more hours.

Staff received training in how to recognise signs and symptoms of sepsis. During the COVID-19 pandemic to alleviate pressures on NHS services and allow staff to prioritise clinical need, NHS trusts had received guidance that, as a temporary measure, audit data collections would not be mandatory. Managers reviewed which audits were essential to provide assurance on treatment provided, which included continuation of the audit around sepsis care and treatment.

The sepsis audit gave cause for concern. Audit information showed seven records had been audited for Gloucestershire Royal Hospital emergency department, in November 2021. Of these, the time the antibiotics was given was not recorded in one record and not showing as prescribed in another record. In only three of seven records the antibiotics were given within one hour and within two hours in a further patient record. This evidence showed either the records were inaccurate or the care was not in accordance with evidence-based practice.

Staff had access to guidance, policies and procedures about treatment pathways for patients presenting with different health conditions. However, we found some of the documents staff were using had not been reviewed when they should have been to ensure guidance was current and in line with evidence-based practice.

The service had 24-hour access to mental health liaison and specialist mental health support. Mental health support was available 24 hours a day for patients aged over 16 years and between 9am to 5pm for children aged 11 to 16 years. The emergency departments at both Gloucestershire Royal Hospital and Cheltenham General Hospital had seen an increase in people attending with mental health needs during the COVID-19 pandemic.

Staff made sure they had shared key information to keep patients safe when care was handed over from others. Some patients were looked after in an area referred to as the cohorting area. There were strict criteria for patients who could be cared for in this area to reduce risks to patients. Care was provided by ambulance staff under the direction of medical staff in the department. The crews of two ambulances were assigned to this role with one paramedic and an emergency medical technician per three patients. This meant four ambulances could be released to respond to further calls. We reviewed records of six patients who had all received their planned care and investigations including blood tests, electrocardiograph (ECG) and computer tomography (CT) scans.

Staff shared key information to keep patients safe when care was handed over to others. Staff we met on visits to the ward areas in the hospital told us they had good handover notes and records from the emergency department when a patient was transferred to their care.

Urgent and emergency services

Shift changes and handovers included all necessary key information to keep patients safe. Nursing and medical staff attended handovers when they first commenced their shift. There were planned safety briefing five times a day. Staff from each area of the emergency department, the matron, the hospital ambulance liaison officer and a member from management and the site team were listed as being required to attend. There was a set agenda to discuss 16 different measures and provide a score of green, amber, red or black depending on pressure for services in the department. Information about the status of demand and capacity pressure in the emergency department was shared across the trust by managers and executive leads. However, we looked at records from these safety briefings and noted they were not always held five times a day and it was not always clear who, of the required people had attended.

Nurse staffing

It was recognised by senior management that shortages of staff trained in emergency care meant the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and efforts were made to increase staffing levels for each shift.

Nursing staff were employed to work across both emergency departments. Employed nursing staff numbers had increased since our previous inspection in March 2021 with new staff being employed. The department had also increased the number of nursing staff it required on shifts (establishment) since our last inspection. Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance and to keep patients safe. However, due to vacancy rates and sickness absence, the service was not able to always have enough nursing and support staff to meet the newly assessed staffing numbers needed.

A review of the nursing establishment in September 2021 had increased the total number of nurses needed in the department to meet increased pressure. This had created nursing vacancies, some of which had been recruited to, so actual numbers of recruited nursing staff had increased. The remaining vacancies were in the recruitment process. Vacancy rates were calculated across both hospital sites for the emergency department. This showed the highest number of vacancies were in the band 5 nursing roles (24%). Before the nursing establishment review, the band 5 nursing vacancy rate had been 51%.

During our inspection there were not as many nurses on duty as planned. Data supplied by the trust for November 2021 showed across both emergency departments there were 19% of shifts not filled according to the calculated requirement. Much of this was related to the increase in establishment numbers for nursing staff. Managers requested staff who were familiar with the service where they could and provided staff with an induction if they were new to the service. There was a high reliance on bank and agency nursing staff to fill gaps in rotas.

There were not enough children's trained nursing staff in the department to cover the emergency department. This was because the emergency department at Gloucestershire Royal Hospital had recently changed the pathway for children's attendances. The change was planned to manage the anticipated increase in children's respiratory illnesses over the winter period. Before this time children, except for those needing resuscitation, were directed to the paediatric assessment unit which was staffed by paediatric trained staff. Managers had an interim arrangement with the paediatric service that some nursing staff would work in the emergency department paediatric area. This did not cover every shift but managers had risk assessed the times they would be most needed. Managers had agreed with executive leads, establishment levels of paediatric nursing staff for recruitment, which was underway at the time of our inspection. There was an additional paediatric skills training programme that many emergency department staff had attended and was monitored by managers.

Urgent and emergency services

The minor injuries unit was staffed by emergency nurse practitioners (ENPs) in accordance with the planned number required. The emergency nurse practitioners worked mostly on a shift rota that ensured there were two emergency nurse practitioners in the department.

The service monitored staff absences and reasons for these absences. Data supplied by the trust showed the sickness rate for nursing staff in the emergency department across both sites was around 11% for November 2021 of which more than half related to COVID-19 absences.This was higher than the service aimed for but included staff who were absent due to COVID-19 related issues.

The department had employed a patient experience lead whose focus was on supporting patients in the department. This was in response to recognising that nursing staff could be taken away from clinical care to answer queries from patients' relatives and in providing food and drinks for patients. The patient experience lead was proactive in telephoning relatives to provide an update on patient condition, provided companionship and oversaw a small team of volunteers in the department. They had introduced a drinks cart, hot and cold meals, snacks and provided newspapers for patients who were staying in the department for longer than would usually be expected. Staff told us of the positive impact this had brought, freeing up the time for nursing staff to focus on their role, as well as improving the patient experience in difficult situations. The department managers confirmed this had led to a reduction in the number of complaints received in the department.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

Medical staff were employed to work across both emergency departments. The department had reducing vacancy rates for medical staff. Gaps in medical rotas had been a concern at our last inspection in March 2021. Since this time, newly recruited staff had included three consultants and five junior doctors to work across both departments. There was a plan to recruit four physician associates (who, while not a doctor, work to the medical model and perform a similar role as junior doctors) and two advanced care practitioners (ACPs). Emergency department managers had developed a five-year plan to meet staffing levels as recommended by the Royal College of Emergency Medicine.

Managers observed working time directives for junior doctors although this at times made it difficult to fill weekend rotas. However, senior staff were confident there had not been any incidents where patients had come to harm because there had not been enough doctors on duty. Incident records we reviewed confirmed this. Medical rotas confirmed any gaps were filled using locums. Many of the locums used were familiar with the department. Managers made sure locums had a full induction to the service before they started work.

The service always had a consultant on call overnight and at weekends and staff informed us they could contact them if needed. Consultants filled gaps to ensure there were enough senior clinical decision makers available for patients in the department out of hours.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. However, the trust did not employ a paediatric emergency medicine consultant. This was not in line with national guidance from the Royal College of Emergency Medicine and recruiting to this role was part of an improvement plan for the service. Two medical staff working in the emergency department had specific paediatric training and when they were unavailable staff used the expertise of medical colleagues from paediatric services.

Urgent and emergency services

Is the service caring?

Inspected but not rated

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. This was challenging at times when there were more patients than the planned capacity of the department. Staff did their best to provide privacy for patients by using portable screens and equipment to provide patient privacy. Some areas were small and it was difficult to protect confidentiality when staff reviewed patients. This was particularly evident in cohorting rooms where both male and female patients were being cared for in the same room. Staff treated patients with kindness and compassion and lowered voices as much as they could so as not to be overheard. Several patients described the kindness staff had shown to them and one we spoke with told us “I’ve received an excellent level of care”.

We observed staff taking time to explain treatment options. A separate room was available for families who received distressing news or needed a greater level of privacy.

Staff understood and respected the individual needs of each patient. They showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs and referred to the mental health liaison team when needed. Staff spoke to patients in a calm and considerate way and took time to explain treatment options. Staff explained treatment in different ways to ensure understanding. Every patient we spoke with knew the next stage of their treatment plan and were happy with the level of care they had received.

Staff considered and managed patient comfort. Patients were offered food, fluids and pain relief when they needed it and if they were able to eat and drink. The increased demands on staff in the department had created a gap at times in providing for patient comfort. This had increased because patients were spending longer within the department while waiting for an inpatient bed. Staff had a focus to identify patients who may spend longer than 12 hours in the department and provide them with a bed instead of waiting on a trolley.

A newly recruited patient liaison lead had implemented methods of improving patient comfort and communication with relatives. This ensured patients who could eat and drink were provided with hot meals and fluids while they were in the department and companionship for patients. The patient liaison role also made sure patients’ relatives were kept informed of treatment plans by telephoning them. This included patients who were waiting in ambulances.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. We saw staff providing care in a way which met patients religious needs such as specific foods and how privacy was provided.

Is the service responsive?

Inspected but not rated

Urgent and emergency services

Access and flow

People could access the service when they needed it but did not always receive the right care promptly due to pressures on capacity caused by shortages of available beds for transferring patients. Staff risk assessed patients who attended the emergency department and treated those with urgent needs promptly. However, reviews for patients in the emergency department from doctors in other specialities were not happening in accordance with agreed timescales.

Managers monitored waiting times and adapted services to support patients' access to emergency services. They monitored treatment within agreed timeframes and national targets but due to capacity pressures were not always able to achieve them. The emergency department collected data and monitored how many people were in the department, how long they had been there and how many ambulances were queueing to handover patients. This data was reviewed continuously by the emergency physician in charge and the nurse in charge/coordinator.

There were set safety briefings in the department held five times a day. In this meeting, escalation triggers were discussed and assessed in accordance with the risk (green, amber, red and black) across 16 measures. They did not use this information to arrive at an overall capacity status and did not share this with clarity with the rest of the trust. Information about capacity was shared with senior managers across the trust six times each day. The information was provided to staff following these meetings and prompted further action to free up bed capacity across inpatient areas. Managers recognised this was not the most effective method of sharing information and work was ongoing to improve this. A new electronic system was planned to provide real-time information and would be implemented in January 2022.

The trust had struggled now for many years to achieve the NHS constitutional standard to see, treat, admit or discharge 95% of patients within four hours. In October 2021, Gloucestershire Hospitals emergency departments achieved 52% for this performance measure, which was worse than the England average of 75%.

Patients received initial reviews within national timeframe standards. Systems had been adapted to increase the number of patients who were assessed within 15 minutes of arriving by ambulance. At the time of our visit, we saw most patients had received assessment within this time which was an improvement when compared with performance measures in previous months.

Children brought in by ambulance were assessed in a pitstop area designated for children. Staff referred children to the paediatric assessment unit or the minor injuries unit when possible. The sickest children were admitted to a designated area of the emergency department or the resuscitation bay.

Staff referred patients to in-hospital teams if they needed to admit patients to the hospital. However, most specialities were slow to respond to referrals, with the exception of the stroke team. Managers had developed professional standards for doctors to follow, which included length of time to respond to referrals from the emergency department. However, during our inspection, doctors did not respond within the identified timeframe.

To assist with improving efficiency, an initiative where a radiographer was assigned to the pitstop area of the emergency department helped effective coordination of diagnostic procedures in line with national guidance.

Service managers and trust executives monitored demand levels and managed existing bed capacity and acted to create areas where patients could receive care and treatment. For example, discussions between managers and trust executive team members identified how many additional beds were needed for patients for the day or night. Where possible, staff had adapted non-clinical areas in the hospital for the care of patients.

Urgent and emergency services

Ambulance staff had been asked to monitor a cohort of patients which allowed these patients to be cared for in the department instead of in the ambulance. If the majors department was full and the site team for bed management approved, patients were accommodated in a small cohorting area at the back of the department (previously consulting rooms) or in the X-ray waiting area overnight. Staff told us this happened regularly and it had become at times difficult to move patients early enough so the X-ray department was clear the following morning. These arrangements helped to release some ambulance staff to attend patients waiting in the community. However, this was not in line with cohorting principles agreed between the hospital and the NHS ambulance trust where it was agreed this would only happen in exceptional circumstances. We were told the trust was looking to replace the ambulance personnel with trust staff shortly after our inspection.

Managers and staff worked to make sure they started discharge planning for patients as early as possible. To help with pressure on capacity, managers had developed alternative pathways for patients who did not need to be admitted to a hospital inpatient bed or who could be treated in alternative areas to the emergency department. These pathways included a minor injuries and illness unit adjacent to the emergency department, medical assessment units, and a Gloucester priority assessment unit (GPAU). The priority assessment unit was a system of supporting primary care colleagues with specialist advice and alternative avenues of care to attending the emergency department.

There was access to frailty assessment teams, areas where patients could sit to wait for treatment (ambulatory care) and pathways in collaboration with primary care services.

The primary care pathway (a GP-led service provided by another NHS organisation) was not always able to provide timely support due to demand pressures. For example, patients could be diverted to the primary care service, which was located within the hospital grounds. However, they had to telephone for an appointment and were often unable to get access due to high levels of demand within the primary care service. During this time, patients would wait within the emergency department.

Staff looked for ways to create space in the department to provide more patients with treatment and care when they arrived at the emergency department. Staff followed processes and directed patients to other services where they could receive the treatment they needed. An improvement project was in progress focusing on reception staff actively streaming patients who presented with limb injuries and guiding them to the on-site minor injuries unit. There was clear guidance on action cards for reception staff to use when streaming patients.

When demand was in excess of bed spaces, the ambulatory care areas were used to provide overnight care for patients. This then created a delay in directing patients from the emergency department to ambulatory care the following morning while reorganisation took place.

The frailty team assessed patients and discharged them within the same day with additional support wherever they could. This was to avoid unnecessary admissions and the deterioration in health that hospital admissions can have on people waiting too long to leave.

Is the service well-led?

Inspected but not rated

Urgent and emergency services

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The leadership of the emergency department comprised of two clinical leads (managers), a general manager and a matron. Each of the leaders had a defined role within the department.

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 good quality care and treatment. They clearly articulated the challenges within the department, as well as celebrating the successes they had achieved.

We observed effective leadership in the department. The emergency physician in charge, the nurse in charge, matron and deputy divisional director for quality and safety provided good leadership. They retained oversight of demand and capacity in the department. Staff told us the emergency department leadership team were very visible and approachable to their staff and others.

Prior to this inspection, a letter had been written to the executive team by staff within the emergency departments in Gloucester and Cheltenham. This raised concerns regarding the "unsustainable" working conditions, and risks to patient safety. During this inspection, staff at Gloucester emergency department told us they recognised these pressures were felt across the country, but that did not negate the concerns they had regarding the enormous pressure in the department. The leaders within the department recognised there were challenges to meet the expectations of all staff. They told us there was a reliance on using emails to update staff and provide feedback, and staff did not always have the time to read emails. They told us they were looking at how to communicate more effectively with staff.

Staff told us they had opportunities to progress within the department and had been encouraged to do so by managers. The management team had requested a peer review of the department in July 2021 to explore nursing leadership, nurse education and training and patient safety. This had resulted in providing all band 7 nurses with mentors, training in quality dashboards, and clearer roles and responsibilities. Band 6 development days had also been introduced, including in managing sickness, and appraisals. Band 5 and band 6 staff had been booked on bronze and silver quality improvement courses within the trust and were leading on a number of quality projects.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. However, staff felt they needed space to support their wellbeing at times.

Most staff told us the leadership in the department was strong, and they were able to speak up, were respected, supported and valued.

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. We saw a flat hierarchy where staff at all levels were able to speak up and challenge colleagues in a supportive way. Staff were open and honest with patients and told us they were quick to apologise when a patient was unintentionally delayed. This was confirmed by patients we spoke with who told us they felt well cared for, that they were involved in decisions about their care, and understood why they were in the department instead of on a ward.

Urgent and emergency services

During the inspection we heard and saw many examples of strong cultural behaviours and values. All the patient interactions we observed were seen to be kind, caring and empathetic. Despite the pressures in the department, we saw the focus remained on ensuring patients were cared for, ensuring patients had their pain managed, and were fed and given drinks.

Staff were encouraged to report incidents and mostly had feedback from serious incidents which was shared for learning. All band 6 staff had training in how to investigate incidents. All staff told us they would report high risk incidents. However, some staff told us that due to pressures in the department they may not report all low risk incidents, or they might report them from home after their shift had finished. The majority of incidents reported related to admissions and patient transfers. When we asked staff whether they received feedback on the incidents they reported, we received a mixed response. Some staff told us they did not receive feedback, but this may be because they did not always have time to read emails. We did see however that feedback from serious incidents was included in safety briefs.

Some staff felt they did not have good facilities for health and wellbeing at times. Staff said they did not have access to adequate rest areas, and there was no availability of hot food overnight for staff. Staff had previously had access to a 'wobble room' where staff could take a break for their mental health. However, at the time of this inspection the wobble room was being used as a relatives' room.

The department had employed a patient experience lead whose focus was on supporting patients in the department. All staff we spoke with told us of the positive impact this had brought, freeing up the time for nursing staff to focus on their role, as well as improving the patient experience. The department managers confirmed this had led to a reduction in the number of complaints received in the department.

Management of risk, issues and performance

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

There was a departmental risk register and risks were reviewed and reported through an assurance report to the emergency care board. The risk of delayed assessment and treatment for patients in an emergency department which was full to capacity as a result of poor patient flow and delays to patient discharge was identified on the risk register. This applied to patients in the department, those waiting to be handed over from ambulances and those waiting for a response to a 999 call in the community.

Managers told us they felt urgent and emergency care (including the ambulance service) were holding a significant amount of risk for the health and social care system across the county. This was felt by frontline staff too. Managers told us they did not get feedback from the urgent and emergency care board and were not represented at these meetings.

Managers had created an action plan following the previous CQC visit to the department in March 2021. This was updated with actions and progress every other month. Actions completed included: an increase in staffing levels; triage processes were constantly reviewed and adapted according to demand on the service; and patients who were anticipated to spend longer in the department were provided with food and liquids and were place on hospital beds instead of trolleys.

Urgent and emergency services

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.

Gloucestershire Royal Hospital Emergency Department

Action the trust MUST take to improve:

- The trust must ensure care and treatment is provided in a safe way for service users. The risks to the health and safety of service users receiving care and treatment must be assessed and the trust must ensure it is doing all that is reasonably practicable to mitigate any such risks. Therefore, the trust must ensure: patients receive treatment in a timely way; ensure patients are cared for, at all times (including overnight) in areas designed for this purpose; and with the facilities, clinical and otherwise, which meet their needs. Ensure patients are admitted from the emergency department to a ward bed in a timely way; and have a timely response from specialty doctors to assess emergency department patients in line with the agreed protocol. Ensure patients do not experience long waits for treatment in ambulances and in cohorting areas to reduce the number of ambulances being held at the emergency department. **Regulation 12 (1) (2) (a) (b) (d)**

Action the trust SHOULD take to improve:

- The trust should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Gloucestershire.
- Look at ways for staff to have oversight of children waiting to be seen in the department.
- Resolve the issues with the system producing audit results which show patient records are not being updated as they should or some elements of patient care, such as sepsis management, are not being provided in a timely way.
- Required staff should attend safety briefings.
- Continue with plans to improve staffing levels for nurses and medical staff to full establishment.
- Work with colleagues to meet the timescales for emergency department patient review by clinical specialists from elsewhere in the hospital.
- Consider how to better support emergency department staff overnight so they feel safe and not at risk from violence and aggression.
- Department managers should discuss how to communicate more effectively with staff and look for options to support wellbeing.
- Review the representation of the emergency department leadership at the urgent and emergency board to allow their views to be included.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two specialist clinicians and six other CQC inspectors. The inspection team was overseen by Catherine Campbell, 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
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment