Gloucestershire Hospitals NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust

Are services at this trust safe?	
Are services at this trust effective?	
Are services at this trust caring?	
Are services at this trust responsive?	
Are services at this trust well-led?	

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out an announced inspection 24-27 January 2017 and an unannounced inspection at Gloucestershire Royal on 6 February 2017. This was a focused inspection to follow-up on concerns from a previous inspection. As such, not all domains were inspected in all core services and the trust has not been rated following this inspection.

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

• Urgent and emergency services

• Medical care (including older people's care)

• Surgery

• Maternity and gynaecology

• Services for children's and young people

• End of life care

• Outpatients and diagnostic imaging

The following services were inspected at Cheltenham General Hospital

• Urgent and emergency services

• Medical care (including older people's care)

• Surgery

• End of life care

• Outpatients and diagnostic imaging

As this was a focused inspection we did not inspect the critical care services at either location (previously rated outstanding) and did not inspect all domains within the core services covered. This also meant we were not able to rate the organisation overall at this inspection.

Safe

We rated the safe domain as requires improvement in urgent and emergency services, medicine, surgery, and outpatients and diagnostic imaging in both hospitals. In Gloucester Royal Hospital we rated the safe domain as requires improvement in maternity and gynaecology and good in children's and young people's services. We rated the safe domain as good for end of life services across both hospitals.

- We had concerns about patient safety, particularly when the emergency department was crowded. Lack of patient flow within the hospital and in the wider community created a bottle neck in the emergency department, creating pressures in terms of space and staff capacity. This in turn increased the risk that patients may not be promptly assessed, diagnosed and treated.
- Crowding was compounded by an acute shortage of staff. There was an acute shortage of middle grade doctors and there were particular concerns raised by medical and nursing staff about medical cover at night. Consultants regularly worked longer hours to support their junior colleagues and there were concerns about whether this could be sustained. Analysis of demand patterns indicated that more senior decision-makers were required at night. The department was not fully staffed with nurses. There was a heavy reliance on bank and agency staff to fill gaps in the rota. When the department was crowded staff felt vulnerable because planned safe staff to patient ratios could not be maintained.
- There was no designated room for mental health practitioners to conduct mental health assessments within the emergency department. Patients would be assessed in one of the review rooms, which did not meet the safety standards recommended by the Royal College of Psychiatrists.
- There was no senior (band seven) nurse employed to manage each shift as recommended by the National Institute for Health and Care Excellence (NICE).
- Support staff functions were not adequately resourced. Healthcare assistants performed housekeeping duties, doctors, nurses and managers moved patients, and the nurse coordinator was frequently occupied with administrative duties.
- Crowding in the emergency department meant that ambulance crews were frequently delayed in handing over their patients.
- Patients were not always assessed quickly on their arrival in the emergency department. Initial assessment (triage) often consisted of a verbal handover from ambulance staff to the nurse coordinator without a face to face assessment of the patient.

Summary of findings

- Record keeping was generally poor and we could not be assured that patients received prompt and appropriate assessment, care and treatment. In particular, we were concerned about the recording of observations and the calculation of early warning scores. Patient observations were not always carried out consistently or early enough and early warning scores were not consistently calculated.
- Within the medical service, not all specialties held regular and structured mortality and morbidity meetings to ensure learning could be identified and shared.
- Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes.
- Wards did not display evidence of when areas such as toilets were last cleaned and we did not see environmental audit result displayed on the wards we visited.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- The fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in all areas in line with the trust's policy.
- Medicines were not always managed correctly. Fridge temperatures were not monitored or actions taken where these fell out of normal range. There were a number of out of date patient group directives (PGD's) in use in maternity services.
- Records were not stored safely to ensure patient confidentiality was maintained at all times.
- Staff did not always assess risks to patients and followed up with mitigating care interventions.
- Nursing staffing levels were below establishment and wards, departments and operating theatres relied on bank and agency to cover shifts every day.
- The trust did not use a recognised tool to assess the acuity of patients daily to ensure safe staffing levels were in place on each shift and particularly at night.
- The number of surgical site infection rates for replacement hips and knees and spinal surgery had increased since our last inspection.
- Mandatory training for all staff was not meeting the trust's target.
- The day unit was being used as an inpatient ward but domestic cover had not been set up for weekends to provide environmental cleaning or drinks to patients.
- There was no cleaning carried out over the weekend in diagnostic imaging, and some outpatient treatment rooms and waiting areas were visibly dirty.
- Staff were finding it difficult to trace patient notes since the introduction of a new computer system, and there was not a reliable system to track the numbers of temporary notes being used since its implementation. There were also some ongoing issues with allocation of baby NHS numbers and records migrating to the new system.
- Some staff were unsure of their responsibilities in a resuscitation situation, and staff in ophthalmology did not know where to locate their nearest defibrillator.
- In some areas, a systematic check of emergency resuscitation trolleys was not documented as having being carried out on a daily basis. There were no up to date Resuscitation Council (UK) guidelines available on the resuscitation trolleys. Intravenous fluids on the emergency resuscitation trolleys were not stored securely to ensure they were tamper evident.
- Community midwives could not always print out clinical notes from the electronic system to go into women's handheld notes. They also reported poor mobile phone coverage which meant there was sometimes a delay in getting messages.
- Junior doctors in obstetrics did not attend skills drills training when they started at the trust though they did carry an emergency bleep and could be the first to arrive in the delivery.
- There were often long waiting times in the maternity triage area. Women were not seen within 15 minutes of attending the unit.
- Consultant presence, on labour suite, was below the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance**.**
- Not all outpatient waiting areas in the hospital had specific children's areas. Areas that were not solely for children's use in other parts of the hospital had waiting areas that were shared with adults.
- The trust did not assess the acuity of patients daily to ensure safe staffing levels were in place on each shift and particularly at night.

Summary of findings

- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again. Not all staff within these specialities were aware of the never events and the learning from these.
- Kemerton and Chedworth Suite was at times being used as an inpatient ward but domestic cover had not been set up for weekends to provide cleaning and drinks to patients

However:

- Staff understood their responsibilities to raise concerns and report incidents using the electronic reporting system. There was a culture of shared learning from incidents.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- Most areas we visited were visibly clean and tidy. Staff were seen adhering to the trusts infection control policies including 'bare below the elbows".
- There was a robust security system in place within the maternity unit, including locked doors, entry systems a baby security tagging system and CCTV.
- There were systems in place for recognising and reporting safeguarding concerns. Staff were confident to raise any matters of concern and escalate them as appropriate.
- There was good access to mandatory training within the maternity service, including skills drills training day and a one-day maternity update.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- The endoscopy unit held join advisory group (JAG) accreditation and had procedures in place in line with the national safety standards for invasive procedures. Equipment was decontaminated and sterilised in line with best practice.
- Within the emergency department, there were hourly board rounds undertaken by senior clinicians in the department. This provided an overview of the department's activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams. Patient safety checklists had been introduced, which provided a series of time-sequenced prompts. There was a well-structured medical staff handover where patients' management plans and any safety concerns were discussed.

Effective

Where inspected, all services were rated as good with the exception of medical care which was rated as requires improvement in both hospitals.

- People's care and treatment was mostly planned and delivered in line with current evidence-based guidance and standards.
- There was a range of recognised protocols and pathways in place and compliance with pathways and standards was frequently monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance.
- Within the emergency department, nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated and multidisciplinary way.
- The trust had been identified as a 'mortality outlier' in to relation reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions had implemented had made improvements and these were ongoing at the time of our inspection.
- Staff understood that end of life care could cover an extended period for example in the last year of life or patients and that patients benefited from early discussions and care planning.
- End of life care was delivered with the principles of the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's
- Within end of life care, medicines to relieve pain and other symptoms were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them.

However:

Summary of findings

- Pain was not always promptly assessed and managed within the emergency department and we could not be assured that patients' nutrition and hydration needs were consistently assessed or met.
- The trust was not meeting the standard which requires the percentage of patients re-attending (unplanned) the department within seven days to be less than 5%.
- The trust had been identified as a 'mortality outlier' in to relation reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions had implemented had made improvements and these were ongoing at the time of our inspection.
- The medical service did not consistently contribute to and review the effectiveness of care and treatment through participation in national audits.
- The emergency theatre was only manned on site for 20 hours each day. The remaining four hours were covered by 'on call' staff, which potentially placed patients at risk.
- Theatre utilisation figures were low however; the trust was looking at ways of improving this.
- The new computer system was causing issues for staff resulting in work arounds to prevent any risks to patients.
- Staff appraisals were not meeting the trust targets in all areas.
- Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.
- Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation attempts had been made were not always documented.
- There was no organisational oversight of staff competency with regards to syringe driver training as records were not held centrally.
- There was not a seven day face to face service provided by the in-patient and community end of life care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- The learning needs of all staff delivering end of life care were not identified.
- Whilst in some cases the possibility of dying had been recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, not all appropriate patients experienced this.

Caring

We rated caring as good in all services where we inspected this domain, across both hospitals.

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- Staff took the time to interact with people who received end of life care and those people close to them in a respectful and considerate manner.
- Staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and respectful of cultural and religious differences in end of life care.
- Emotional support for patients and relatives was available through the in-patient and community end of life care team, through clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services.

However:

- The discharge lounge was a mixed sex unit and did not have curtains to screen individual chairs and provide privacy for patients in their pyjamas or when assistance was needed with personal care needs.
- Whilst responses to the friends and family test was positive, response rates were frequently low.

Summary of findings

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

Responsive

We rated the responsive domain as requires improvement in all services where we inspected this domain with the exception of the end of life service which was rated as good across both hospitals.

- The emergency department was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department.
- Patients frequently spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.
- Crowding meant patients frequently queued in the corridor, where they were afforded little comfort or privacy. When the department became congested, relatives had to stand because there was insufficient seating.
- Patients with mental health needs were not always promptly assessed or supported, particularly at night time when there was no mental health liaison service. Adolescents who had self-harmed did not receive a responsive service and were frequently inappropriately admitted while awaiting specialist assessment and support.
- There was a lack of an appropriate welcoming space for patients with mental health needs.
- The delivery of cardiology services did not meet the needs of the local population.
- There were delays to discharges, which meant patient flow through both hospitals was compromised.
- There was a waiting list for patients requiring an endoscopic procedure.
- The environment did not meet the needs of patients with dementia.
- The trust reported 32 breaches of mixed sex accommodation in the period from January 2016 to October 2016 of which 11 were in the acute medical admissions unit.
- The trust was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- Due to pressure for beds and the demand on services, some patients had to use facilities and premises that were not always appropriate for inpatients. At times of high operational pressure patients were temporary admitted to endoscopy and medical day unit wards however, these were not identified as 'escalation areas' in the inpatient capacity protocol.
- Elective operations were being cancelled due to the pressure on the beds within the trust and medical patients were being cared for on surgical wards to meet the demand.
- Not all patients had their operations re-booked within the 28-day timescale.
- Six patients had been waiting over 52 weeks for treatment, which is not acceptable.
- The trust was not meeting the 62 day target for cancer patients.
- The diagnostic imaging department had a reporting backlog of 19,500 films and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety.
- Implementation of new computer systems had impacted on waiting lists as some specialties could not see live waiting lists.
- The trust was not meeting referral to treatment target in all specialities.
- There were no designated beds for people receiving care at end of life. Side rooms were used when available but could not be guaranteed.
- The percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not all known for all wards or hospital sites.
- End of life complaints were not always handled promptly and in accordance with trust policy.

However:

- The emergency and urgent care service had a number of admission avoidance initiatives in place to improve

patient flow. These included the integrated discharge team who proactively identified and assessed appropriate patients who may be able to be supported in the community rather than admitted to the hospital.
- We saw evidence that complaints were used to drive improvement.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enabled staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services has been better than the England overall performance.
- The average length of stay was for non-elective patients was better than the England average.
- Staff in theatres and recovery had guidance in place to help reduce the anxiety of patients living with dementia when they using their services.
- Rapid access assessment clinics were provided in some specialities, and some clinics were performing airway assessments via skype.
- The hospital had introduced a new waiting list validation process to discharge patient's ongoing follow up care to community based services such as GPs.
- A project placing therapists on wards had helped increased patient discharges, and radiographers attended ward briefings to identify inpatients waiting for scans.
- The in-patient specialist palliative care team was available to ward staff to provide advice and training regarding communication and end of life care; this included communicating with patients and carers.
- The trust was one of two sites in the country which had been developing a medical examiner role and improved death certification process project since 2008. Benefits included better support for relatives over the explanation and causes of death as well as ensuring better oversight of signing of death certificates
- The specialist palliative care team responded promptly to referrals, usually within one working day.

Well-led

We rated the well led domain as requires improvement in urgent and emergency care and medical care in Gloucestershire Royal Hospital and in medical care in Cheltenham General Hospital. Were inspected elsewhere, we rated the well led domain as good.

- There was a strong, cohesive and well-informed leadership team within the emergency and urgent care service who were highly visible and respected. The service had a detailed improvement plan in place with clear milestones and accountability for actions. However, safety concerns which we identified at our last inspection had not been addressed, despite the introduction of new processes. Poor patient flow remained the major barrier to progress. The emergency department was unable to influence the cultural shift which was required to address this significant barrier to improving patient flow and capacity.
- The emergency department's management team did not feel there was a culture of collective responsibility within the trust in relation to patient flow. There was frustration expressed that the emergency department bore a disproportionate level of risk, while the responsibility for the exit block sat with others.
- Pressures faced by staff in the emergency department in relation to crowding were well understood and articulated by the management team but it did not appear that the risks relating to staff wellbeing, resilience and sustainability, had been widely shared or escalated within the organisation and they were not included on the department's risk register.
- There was a limited approach to obtaining the views of people who used the service. Workload pressures prevented opportunities for staff reflection or meaningful staff engagement and involvement in shaping the service.
- There was no risk register specific to end of life care for the trust so there was no easy trust wide oversight of

risk relating to the service. There was a program of internal and national audits; however, these were behind schedule due to recent staff shortages within the team.

- Within the medical service there was a lack of overview and governance around mortality and morbidity (M&M) meetings. Risks registered on the risk register were not always aligned with risks in the service.
- There was a lack of understanding of the risk to safe patient care, the acuity of patients have on daily basis.

However:

- The emergency department produced high quality information which analysed demand capacity and patient flow, and was used to inform the improvement plan.
- There were robust governance arrangements in place within the emergency and urgent care service. Clinical audit was well-managed and used to drive service improvement. Risks were understood, regularly discussed and actions taken to mitigate them.
- There were cooperative and supportive relationships among staff. We observed exceptional teamwork, particularly when the emergency department was under pressure. Here, staff felt respected, valued and supported. Morale was mostly positive, although to an extent was undermined by workload pressures. Service improvement was everybody's responsibility. Staff were encouraged and supported to undertake service improvement projects.
- The trust had a clear vision and strategy to deliver care at end of life linked to national best practice including Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's.
- The governance framework for end of life care ensured that responsibilities were clear and that quality, performance and risks were understood and managed.
- The leadership and culture of the specialist palliative care teams in the trust reflected the vision and values of the trust. Leadership encouraged openness and transparency and promoted good quality care. There were leads on the wards for delivery of end of life care which supported the development of high quality end of life care.
- Staff felt respected and valued. There was a strong emphasis on promoting the safety and wellbeing of staff delivering end of life care in the community.
- Services within specialist palliative and end of life care had been continuously improved and sustainability supported since the last inspection.

We saw several areas of outstanding practice including:

- The diagnostic imaging department sent radiographers onto wards to liaise with staff to identify inpatients who were waiting for scans, in order to help speed up treatment and ultimately discharge.
- The therapies department had placed occupational therapists and physiotherapists on wards over Christmas to support and speed up patient discharges during a period of high pressure.
- The inpatient specialist palliative care team had won an annual staff award the trust - patient's choice award 2016. This was from patients and others who recognised the NHS staff who had made a difference to their lives.
- The consultant in the specialist palliative care team was part of a multi-disciplinary team who had won the national Linda McEnhill award 2016. The award was recognition by the Palliative Care of People with Learning Disabilities professional network of excellence in end of life care for individuals with learning disabilities. Work included improving how different teams worked better together.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- Direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.

Summary of findings

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

Importantly, the trust must:

- Review processes to monitor the acuity of patients to ensure safe staffing levels.
- Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health (COSSH).
- Review processes for ensuring effective cleaning of ward areas and equipment and patient waiting areas.
- Review the governance and effectiveness of care and treatment through participation in national audits.
- Ensure patient records are kept securely at all times.
- Ensure equipment is replaced to ensure safe diagnosis and treatment.
- Ensure the medical day unit is suitable for the delivery of care and protects patients dignity and confidentiality.
- Ensure all staff are trained and understand their responsibilities in a resuscitation situation.
- Ensure resuscitation equipment is readily available and accessible to staff.
- Ensure there are systems in place to allow patients in receipt of intravenous therapy during the transfer to other hospitals to safely continue this during transfer.
- Ensure specialities have oversight of all of their waiting lists.
- Ensure that all information related to patients' mental capacity and consent for 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) is available in patient records.
- Ensure trust staff comply with all the requirements of the Mental Capacity Act (2005).
- Ensure the emergency department is consistently staffed to planned levels to deliver safe, effective and responsive care.
- Review support staff functions to ensure the emergency department is adequately supported.
- Ensure that all staff are up-to-date with mandatory training and receive yearly appraisals in line with trust policy.
- Ensure patients arriving in the emergency department receive a prompt face-to-face assessment by a suitably qualified clinician.
- Improve record keeping so that patients' records provide a contemporaneous account of assessment, care and treatment.
- Ensure patients in the emergency department receive prompt and regular observations and that early warning scores are calculated, recorded and acted upon.
- Ensure the mental health assessment room in the emergency department meets safety standards recommended by the Royal College of Psychiatrists.
- Ensure that a suitable space is identified for the assessment and observation of patients presenting at the emergency department with mental health problems.
- When using Kemerton and Chedworth Suite for inpatients, provision must be made for the cleaning of the units at weekends and to provide patients with clean water jugs and drinks.
- Ensure emergency resuscitation trolleys are checked and have guidelines attached according to best practice guidance and in line with trust policy.
- Ensure the safe management of medicines at all times, including storage, use and disposal and the checking and signed for controlled drugs.
- Ensure all drug storage refrigerator temperatures are checked and the results recorded daily. Additionally if the temperatures fall outside of the accepted range action is taken and that action recorded.
- Ensure patient group directives are up to date and consistent in their information.
- Ensure women attending the triage unit within the maternity service are seen within 15 minutes of arrival.
- Ensure machines used for near patient testing of patient's blood sugar, are calibrated daily and this is recorded or ensure all staff are trained in how to use the new machine so the old machines can be removed.
- Ensure steps are taken to reduce the current typing backlog in some specialities

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Gloucestershire Hospitals NHS Foundation Trust

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

The trust has three main locations that are registered with the Care Quality Commission (CQC), which are Gloucestershire Royal Hospital, Cheltenham General Hospital and Stroud Maternity Hospital. There are 1,075 beds across these three hospitals. There are 683 beds at Gloucestershire Royal Hospital.

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

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

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

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

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

• 127,369 A&E first attendances

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

• 451,771 Outpatient attendances

• 6,388 births

• 2,067 referrals to the specialist palliative care team

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

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

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

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

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

Our inspection team

Our inspection team was led by:

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

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

The team included CQC inspectors and a variety of specialists: directors of nursing and governance,

Summary of findings

consultants and medical staff from medicine, surgery, emergency services, paediatrics, a junior doctor; a senior midwife; senior nurses in paediatrics, medicine, surgery, theatres, care of the elderly and palliative care. The team also included one expert by experience, analysts and an inspection planner.

How we carried out this inspection

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

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

We carried out an announced inspection 24-27 January 2017 and an unannounced inspection at Gloucestershire Royal on 6 February 2017. We held focus groups and drop-in sessions with a range of staff including nurses, junior doctors, consultants, student nurses, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff, porters and maintenance staff. We also spoke with staff individually as requested.

We talked with over 300 staff and 75 patients. We observed how people were being cared for, talked with carers and family members, and reviewed over 90 patients' records of their care and treatment.

What people who use the trust's services say

The trust's Friends and Family Test performance (% recommended) was generally worse than the England average between November 2015 and October 2016. In the latest period, November 2016 trust performance was 95.2% which is the same as the England average of 95.2%. The trust's performance has stayed consistently between 93% and 97%.

In the Cancer Patient Experience Survey 2015 the trust was in the top 20% of trusts for two of the 34 questions, in the middle 60% for 28 questions and in the bottom 20% for four questions. The two questions in the top 20% of trusts were 'all staff asked patient what name they preferred to be called by' and 'hospital staff did everything to help control pain all of the time'.

In the CQC Inpatient Survey 2015, the trust performed about the same as other trusts in 10 of the 12 questions examined by the CQC and worse than other trusts in one question. The one question that performed worse was 'were hand-wash gels available for patients and visitors to use?'

Facts and data about this trust

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Summary of findings

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

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- 6,388 births
- 2,067 referrals to the specialist palliative care team

Between Q1 2015/16 and Q2 2016/17, the trust's bed occupancy has been consistently higher than the England average by 2 to 8%. This was above the level, 85%, at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients and the orderly running of the hospital.

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

CQC inspection history

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

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? As we did not inspect this domain in all services we are unable to re rate. Overall, we found: • We had concerns about patient safety, particularly when the emergency department was crowded. Lack of patient flow within the hospital and in the wider community created a bottle neck in the emergency department, creating pressures in terms of space and staff capacity. This in turn increased the risk that patients may not be promptly assessed, diagnosed and treated. • Crowding was compounded by an acute shortage of staff. There was a shortage of middle grade doctors and there were particular concerns raised by medical and nursing staff about medical cover at night. Consultants regularly worked longer hours to support their junior colleagues and there were concerns about whether this could be sustained. Analysis of demand patterns indicated that more senior decision-makers were required within the emergency department at Gloucester Royal Hospital at night. There was a heavy reliance on bank and agency staff to fill gaps in the rota. Without these, the departments were not consistently staffed to planned levels, and when crowded, staff felt vulnerable because planned safe staff to patient ratios could not be maintained. • There was no designated room for mental health practitioners to conduct mental health assessments. Patients would be assessed in one of the review rooms, which did not meet the safety standards recommended by the Royal College of Psychiatrists. • There was no senior (band seven) nurse employed to manage each shift within the emergency department as recommended by the National Institute for Health and Care Excellence (NICE). • Within the emergency department, support staff functions were not adequately resourced. Healthcare assistants performed housekeeping duties, doctors, nurses and managers moved patients, and the nurse coordinator was frequently occupied with administrative duties. • Crowding in the emergency department meant that ambulance crews were frequently delayed in handing over their patients. • Patients were not always assessed quickly on their arrival in the emergency department. Initial assessment (triage) often consisted of a verbal handover from ambulance staff to the nurse coordinator without a face to face assessment of the	

patient. Record keeping was generally poor and we could not be assured that patients received prompt and appropriate assessment, care and treatment. In particular, we were concerned about the recording of observations and the calculation of early warning scores. Patient observations were not always carried out consistently or early enough and early warning scores were not consistently calculated.

- Within the medical service, not all specialties held regular and structured mortality and morbidity meetings to ensure learning could be identified and shared.
- Staff did not always follow infection control procedures when entering wards and ensuring the cleanliness of equipment such as commodes.
- Wards did not display evidence of when areas such as toilets were last cleaned and we did not see environmental audit result displayed on the wards we visited.
- Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH).
- The fabric of the building did not always ensure efficient cleaning could be carried out.
- Daily checking of equipment such as resuscitation equipment was not carried out in all areas in line with the trust's policy.
- Medicines were not always managed correctly. Fridge temperatures were not always monitored or actions taken where these fell out of normal range. There were a number of out of date patient group directives (PGD's) in use in maternity services.
- Records were not stored safely to ensure patient confidentiality was maintained at all times.
- Staff did not always assess risks to patients and followed up with mitigating care interventions.
- Nursing staffing levels were below establishment and wards, departments and operating theatres relied on bank and agency to cover shifts every day.
- The trust did not use a recognised tool to assess the acuity of patients daily to ensure safe staffing levels were in place on each shift and particularly at night.
- The number of surgical site infection rates for replacement hips and knees and spinal surgery had increased since our last inspection.
- The day unit was being used as an inpatient ward but domestic cover had not been set up for weekends to provide environmental cleaning or drinks to patients.
- There was no cleaning carried out over the weekend in diagnostic imaging.Kemerton and Chedworth Suite was at

times being used as an inpatient ward but domestic cover had not been set up for weekends to provide cleaning and drinks to patients. Some outpatient treatment rooms and waiting areas were visibly dirty.

- Staff were finding it difficult to trace patient notes since the introduction of a new computer system, and there was not a reliable system to track the numbers of temporary notes being used since its implementation. There were also some ongoing issues with allocation of baby NHS numbers and records migrating to the new system and the development of theatre lists.
- Some staff were unsure of their responsibilities in a resuscitation situation, and staff in ophthalmology did not know where to locate their nearest defibrillator.
- In some areas, a systematic check of emergency resuscitation trolleys was not documented as having being carried out on a daily basis. There were no up to date Resuscitation Council (UK) guidelines available on all the resuscitation trolleys. Intravenous fluids on the emergency resuscitation trolleys were not stored securely to ensure they were tamper evident.
- Community midwives could not always print out clinical notes from the electronic system to go into women's handheld notes. They also reported poor mobile phone coverage which meant there was sometimes a delay in getting messages.
- Junior doctors in obstetrics did not attend skills drills training when they started at the trust though they did carry an emergency bleep and could be the first to arrive in the delivery.
- There were often long waiting times in the maternity triage area. Women were not seen within 15 minutes of attending the unit.
- Consultant presence, on labour suite, was below the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance.
- Not all outpatient waiting areas in the hospital had specific children's areas. Areas that were not solely for children's use in other parts of the hospital had waiting areas that were shared with adults.
- The trust did not assess the acuity of patients daily to ensure safe staffing levels were in place on each shift and particularly at night.
- There had been two never events reported in surgery since our last inspection. These had been investigated and actions taken to prevent these happening again. Not all staff within these specialities were aware of the never events and the learning from these.

However:

Summary of findings

- Staff understood their responsibilities to raise concerns and report incidents using the electronic reporting system. There was a culture of shared learning from incidents.
- Staff spoke confidently about the duty of candour and gave examples of where it had been applied. Relevant staff had received training.
- Most areas we visited were visibly clean and tidy. Staff were seen adhering to the trusts infection control policies including 'bare below the elbows".
- There was a robust security system in place within the maternity unit, including locked doors, entry systems a baby security tagging system and CCTV.
- There were systems in place for recognising and reporting safeguarding concerns. Staff were confident to raise any matters of concern and escalate them as appropriate.
- There was good access to mandatory training within the maternity service, including skills drills training day and a one-day maternity update.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- The endoscopy unit held join advisory group (JAG) accreditation and had procedures in place in line with the national safety standards for invasive procedures. Equipment was decontaminated and sterilised in line with best practice.
- Within the emergency department, there were hourly board rounds undertaken by senior clinicians in the department. This provided an overview of the department's activity and provided an opportunity to identify and communicate safety concerns to the site and trust management teams. Patient safety checklists had been introduced, which provided a series of time-sequenced prompts. There was a well-structured medical staff handover where patients' management plans and any safety concerns were discussed.

Duty of Candour

- Staff were familiar with their responsibilities under the Duty of Candour regulation. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, was introduced in November 2014.
- We reviewed investigations into serious incidents. There was a section within the standard framework, which detailed support given to patients and carers. However, there was no specific evidence that the outcomes of the investigations were shared

with patients and their carers as appropriate. The trust employed an administrator whose function was to ensure Duty of Candour letters were written and sent appropriately and organise meetings as required.

Safeguarding

- There were processes in place for the identification and management of adults and children at risk of abuse (including domestic violence and female genital mutilation). Staff understood their responsibilities and were aware of safeguarding policies and procedures.
- There were identifiers and prompts within care and assessment records to support staff in identifying and auctioning safeguarding concerns. For example, previous child attendances to the emergency department in the last 12 months and frequent attenders (more than three attendances in last year with different conditions) were notified to the local safeguarding children services. The emergency department strengthened processes to include a review of all child attendances by a children's' safeguarding nurse and completion of any missed paediatric liaison forms. All child attendances were notified to GPs, health visitors and school nurses.
- Whilst training compliance was generally good, there were some areas where safeguarding training compliance fell below the organisational targets. For example, only 82.9% of medical staff had completed level 2 safeguarding training for adults and children within the emergency department.
- Ward and other department staff were also aware of their responsibilities for identifying and reporting safeguarding issues. Staff we spoke to knew how to report and escalate concerns and to make referrals as appropriate.
- Ward and department staff were supported by a safeguarding team which included leads for dementia, and domestic abuse. A 'vulnerable women's team' had been developed to support the maternity service. The team included a full time perinatal mental health midwife, substance misuse and teenage pregnancy midwife and the lead safeguarding midwife. The team were able to offer an enhanced service to those women identified as being at risk and to offer advice and support to midwives who had concerns.
- All safeguarding incidents and concerns were reported via the trusts incident reporting system and viewed by a member of the trustwide safeguarding team.
- The trustwide safeguarding team worked closely with the local authority safeguarding board to ensure training needs were

aligned. As a result, the organisation was about to commence level 3 adults safeguarding training which would be multiagency in format. Whilst yet to be agreed as mandatory for staff, it was felt by many to be an essential training need for senior nurses.

- Structured clinical supervision regarding safeguarding occurred within maternity and paediatric services on a bi-monthly basis but was available from the team for any member of staff who requested.
- The safeguarding teams undertook peer review visits from neighbouring organisations. Peer review had been undertaken in dementia care and learning disabilities and the team were developing a 'critical friend' network.
- The new computer system had caused some issues with creation of a 'did not attend' alert for GPs in the case of children. This had been identified quickly and changes put in place to ensure the continuation of alert letters. This was in the process of being rolled out to adults.
- Reports were presented to the trust quality and performance committee every three months and annually to the trust board of directors. These reports included safeguarding activity, staff training and national developments.

Incidents

- There were systems and processes in place to identify report, investigate and monitor incidents. Learning was shared with teams. Staff were aware of how to report incidents via the trust electronic incident reporting system. The culture was one of openness where staff were actively encouraged to report incidents.
- Learning ranged from theme of the week, to newsletters and posters.
- Whilst most services reviewed patient mortality and morbidity (M&M) we found there was variable input, content, and insufficient evidence to show how agreed actions were delivering improvements.
- Incidents were recorded on divisional quality dashboards and overseen by the quarterly quality committee. Where serious incidents and never events occurred, the board received notification monthly.

Staffing

- There was a considerable shortfall in nurse staffing across the trust. This was particularly so in emergency and urgent care and medical care. In December 2016, the trust's overall vacancy rate for Band 5 nurses was 8.9% however, within the emergency

department in Gloucester the vacancy rate was 14.7% and general old age medicine had a vacancy rate for Band 5 nurses of 29.6%. Sickness level was 3.6% for registered staff and 4.9% for healthcare assistants but the turnover rate for both registered nurses and health care assistants was high at 15.5% for registered staff and 18.7% for healthcare assistants. As a result, these areas had a high reliance on bank and agency staffing. The trust was committed to address this and had several projects in place to support recruitment.

- The surgical division used 'The Keith Hurst' tool, often referred to as the Safer Nursing Care Tool, which helps nurses decide on safe nurse staffing for acute wards based on patients' level of sickness and dependency. This tool has the added benefit for benchmarking staffing as it included data on skill mix, levels of clinical dependency, clinical speciality and quality markers as part of the overall staffing assessment. Not all surgical wards were meeting their safer staffing numbers.
- Patient acuity (a term used to describe the level of care required) was not assessed on a daily basis to ensure sufficient staffing in wards such as acute repository or cardiology where patient needs and intensity could fluctuate considerably.
- There was not a dedicated paediatric trained workforce in the emergency departments, though steps were being taken to upskill adult-trained nurses in order to meet the standards set out in the Royal College of Paediatrics and Child Health Standards for Children and Young People in Emergency Care Settings (2012).
- At the time of our inspection, the diagnostic imaging department across both sites, had seven band 5 radiographer vacancies, and seven band 6 radiographer vacancies. There were ongoing recruitment plan to engage with universities to encourage newly qualified staff to apply to the hospital to help fill these positions.
- The funded midwife-to-births ratio was 1:29.5, which is worse than the England average of 1:29.
- Many of the medical staff we spoke with raised concern about medical staffing at night. The emergency department risk register highlighted the lack of 24 hour middle grade doctors and concerns were expressed by both medical and nursing staff there about the lack of senior decision makers at night.
- The trust reported 75 hours of dedicated obstetric consultant cover on the delivery suite. This was below the recommended 168-hour consultant presence to meet the recommendations of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth (2007) guidance. However, staff told us consultants attended when called out of hours and felt the

consultant presence on the delivery suite was currently at safe levels. The maternity services clinical scorecard between April 2016 to November 2016 showed little use of locum consultants with six out of the nine months using one whole time equivalent (WTE) and three months using two WTE

- From 1 August 2016 to the 31 August 2016, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior doctors (foundation year 1-2) staff was lower.

Are services at this trust effective?

As we did not inspect this domain in all services we are unable to re rate. Overall, we found:

- People's care and treatment was mostly planned and delivered in line with current evidence-based guidance and standards.
- There was a range of recognised protocols and pathways in place and compliance with pathways and standards was frequently monitored through participation in national audits. Performance in national audits was mostly in line with other trusts nationally. There was evidence that audit was used to improve performance.
- Within the emergency department, nursing and medical staff received regular teaching and clinical supervision. Staff were encouraged and supported to develop areas of interest in order to develop professionally and progress in their careers.
- Care was delivered in a coordinated and multidisciplinary way.
- The trust had been identified as a 'mortality outlier' in to relation reduction of fracture of bone (Upper/Lower limb)' procedures, which included fractured hip. However, the actions had implemented had made improvements and these were on going at the time of our inspection.
- Staff understood that end of life care could cover an extended period for example in the last year of life or patients and that patients benefited from early discussions and care planning.
- End of life care was delivered with the principles of the Priorities for Care of the Dying Person set out by the Leadership Alliance for the Care of Dying Patient's
- Within end of life care, medicines to relieve pain and other symptoms were available at all times. Wards had adequate supplies of syringe drivers (devices for delivering medicines continuously under the skin) and the medicines to be used with them.

However:

- Pain was not always promptly assessed and managed within the emergency department and we could not be assured that patients' nutrition and hydration needs were consistently assessed or met.
- The emergency theatre was only manned on site for 20 hours each day. The remaining four hours were covered by 'on call' staff, which potentially placed patients at risk.
- Theatre utilisation figures were low however; the trust was looking at ways of improving this.
- The new computer system was causing issues for staff resulting in work arounds to prevent any risks to patients.
- Staff appraisals were not meeting the trust targets in all areas.
- Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.
- Explanations for the reason for the decision to withhold resuscitation attempts were not consistently clear. Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation attempts had been made were not always documented.
- There was no organisational oversight of staff competency with regards to syringe driver training as records were not held centrally.
- There was not a seven day face to face service provided by the in-patient and community specialist palliative care team. The trust provided a face to face service 9-5 Monday to Friday. Out-of-hours there was a telephone advice line available 24 hours, 7 days a week for health care professionals.
- The learning needs of all staff delivering end of life care were not identified.
- Whilst in some cases the possibility of dying had been recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, not all appropriate patients experienced this.

Evidence based care and treatment

- Staff on the ward, units and in theatres had access to policies and procedures that were based on national recognised guidance. For example, there were core care plans for patients known to have dementia based on the Royal College of Nursing: SPACE model for dementia care in hospitals 2012; for patient with peripherally inserted central catheters (PICC) care practices followed best guidance from the Royal Marsden NHS Trust Manual of Clinical Procedures third edition. Within the emergency departments National Institute for Health and Care

Excellence (NICE) guidelines and the Royal College of Emergency Medicine's (RCEM) Clinical Standards for Emergency Departments were evident. For example, there were clear pathways, supported by proformas for the management of conditions such as stroke and sepsis.

- The focus of end of life care had moved from the recognition of patients who might be approaching the last few days or hours of life to understanding it encompassed the last year of life and should include patients with non-cancer diagnoses such as dementia.
- The trust was classified as a Dr Foster outlier for mortality in patients admitted with cellulitis or subcutaneous skin infections. Although the trust concluded the increased mortality was related to miscoding of primary cause of death, we could not be assured that patients received best evidence-based care for cellulitis or subcutaneous skin infections as the cellulitis treatment pathway was out of date with a proposed review date of September 2015.

Patient outcomes

- Information about patient outcomes was routinely collected and monitored in most services, however they were not measured in some medical services. For example, the latest audit information for the National Heart Failure Audit and the National Diabetes Inpatient audit was from 2015, as was data from the Lung Cancer Audit. For the Myocardial Ischemia National Audit Project (MINAP), the latest audit information the trust provided was from 2013/14. This meant the trust was unable to benchmark their services against other services nationally.
- There were two active Dr Foster mortality outlier alerts at the time of inspection. Reduction of fracture of bone (upper/lower limb) had been presented to the national outlier expert panel and action plans were presented. Skin and subcutaneous tissue infections was a new alert.

Multidisciplinary working

- Effective multidisciplinary working was evident in all areas we inspected .We observed multi-disciplinary board meetings where staff worked together to assess and plan ongoing care, treatment and discharge planning. All necessary staff, including those in different teams and services was involved in assessing, planning and delivering patient's care and treatment. We

observed multidisciplinary teamwork in theatre in relation to the use of the World Health Organisation surgical safety checklist. Each member of the team had a recognised role and took part as required.

- There was a good relationship with the mental health trust and regular multidisciplinary meetings with the emergency department, mental health trust and the police to discuss regular attenders.
- There were two primary care pilots in the emergency department, commissioned by the local clinical commissioning group. In minors, self-presenting patients attending the emergency department on weekdays between 10am and 10pm were greeted by a clinical navigator (a nurse employed by the local ambulance service) who streamed appropriate patients (those with minor illnesses) to see a GP or an advanced nurse practitioner. There was also a GP based in majors from midday to 10pm who identified patients who could potentially be managed in the community. The GP worked closely with the integrated discharge team. There was an Assisted Discharge Service provided by the British Red Cross from Monday to Friday from 10.30am to 10.30 pm
- Emergency department staff reported that they were well supported by some specialties; however, there was a general feeling that there was a lack of ownership of the four hour target in the rest of the hospital. There were frequent difficulties in transferring patients from the emergency department to appropriate beds once the decision to admit had been made. On the day of our unannounced inspection there were 22 patients in the emergency department waiting for beds at 8am, some of whom had been in the department for up to 13 hours. This exit block was a source of immense frustration amongst clinicians in the emergency department and there was a feeling expressed by some that more could be done by the rest of the hospital to support the emergency department. Delays in specialist review were monitored and reported on in weekly breach meetings and at the monthly emergency care board, however, internal professional standards had only recently been published.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Patients' consent to care and treatment was sought in line with legislation and guidance. Staff were aware of the importance of obtaining consent before any care or treatment interventions.
- Staff received training in awareness of 'mental capacity act' (MCA) and 'deprivation of liberty safeguards' (DOLS). Training

compliance for these topics were at or just below the trust target of 90%. However, we observed some practice by ward based staff that resulted in incomplete records so full information relating to patients consent to care and treatment was not always available in patient records.

- The trust had made 78 DOLs applications between April 2016 and December 2016. Of these, 70 had been discharged before an assessment was undertake. As a result, changes were being introduced to the training for staff. The safeguarding team held a register of patients for whom a DOLs application was in progress. This enabled them to track progress and provide support to staff if required.

Are services at this trust caring?

As we did not inspect this domain in all services we are unable to re rate. Overall, we found:

- All of the patients we spoke with during our inspection commented very positively about the care they received from staff. This was consistent with the results of patient satisfaction surveys, which were mostly positive.
- Patients were treated with compassion and kindness. We saw staff providing reassurance when patients were anxious or confused.
- Patients were treated with courtesy, dignity and respect. We observed staff greeting patients and their relatives and introducing themselves by name and role.
- Patients and their families were involved as partners in their care. They told us they were kept well informed about their care and treatment. We heard doctors and nurses explaining care and treatment in a sensitive and unhurried manner.
- Staff took the time to interact with people who received end of life care and those people close to them in a respectful and considerate manner.
- Staff and volunteers who worked with the department for spiritual support, bereavement officers and the mortuary were aware of and respectful of cultural and religious differences in end of life care.
- Emotional support for patients and relatives was available through the in-patient and community specialist palliative care team, through clinical psychology, social worker, ward-based nurse specialists and end of life champions, the chaplaincy team and bereavement services.

However:

Summary of findings

- The discharge lounge was a mixed sex unit and did not have curtains to screen individual chairs to provide privacy for patients in their pyjamas or when assistance was needed with personal care needs.
- Whilst responses to the friends and family test was positive, response rates were frequently low.
- Information about patients was not always kept confidential.
- The results from a patient-led assessment of the care environment demonstrated that privacy for patients was not always provided.

Compassionate care

- We observed staff interacting with patients and their relatives in a respectful and considerate manner. Patients and relatives described staff as caring, compassionate, friendly and engaging.
- We observed many examples of how staff sought to maintain patient's privacy and dignity, such as staff pulling curtains around the bed space when assisting with personal hygiene or other care interventions. However, the discharge lounge was a mixed sex unit and did not have curtains to screen individual chairs and provide privacy for patients in their pyjamas or when assistance was needed with personal care needs.
- The Friends and Family Test response rate was generally low. For example, between November 2015 and October 2016, the response for medical care at the trust was 14%, which was worse than the England average of 25%.
- Within the emergency department response rates had increased significantly since the introduction of a new digital methodology and in September 2016 it was 27.5%. However, the percentage of respondents who would recommend the service started to decline in September 2016. In December 2016, 78% of responses were positive, compared with and England average of 86%.

Understanding and involvement of patients and those close to them

- We spoke with patients who praised the communication skills of the staff when they needed further information or asked questions. They described being involved in decision making with doctors and nurses about their care and treatment.
- We reviewed care records and saw that staff delivering end of life care had recorded some discussions with patients and relatives. These included discussions about care and

treatments and their implications. We also saw records of actions staff should take in response to patients' and relatives' wishes. These included requests to speak with a member of the chaplaincy.
- Ward staff communicated sensitively with patients and those people close to them so that they understood their care, treatment and condition. Patients approaching the end of life were given the opportunity to create a shared care record and an advance care plan. This included wishes and any advanced directives they wished care staff to take on their behalf.

Emotional support

- We witnessed staff speaking compassionately with patients (and their relatives) who had presented with serious (potentially life-changing) illness. Staff spoke sensitively about treatment options and prognosis. We observed caring interactions from staff when patients showed signs of being in distress.
- However, some patients expressed beginning to feel very low in mood or depressed because of the uncertainty about when they could go home, the boredom and the restricted opportunities for exercising and moving around.
- Patients who received end of life care and those people close to them received the support they needed to cope emotionally with their care, treatment or condition. Patients were enabled to have contact with those close to them and to link with their social networks or communities although there was limited space for relatives to stay. Chaplaincy volunteers provided non-religious as well as religious support. Often offering time for the patient to 'just' talk with no other purpose than to listen.

Are services at this trust responsive?

As we did not inspect this domain in all services we are unable to re rate. Overall, we found:

- The emergency department was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at the emergency department.
- Patients frequently spent too long in the emergency department because they were waiting for an inpatient bed to become available. Lack of patient flow within the hospital and in the wider community created a bottleneck in the emergency department, causing crowding.

Summary of findings

- Crowding meant patients frequently queued in the corridor, where they were afforded little comfort or privacy. When the department became congested, relatives had to stand because there was insufficient seating.
- Patients with mental health needs were not always promptly assessed or supported, particularly at night time when there was no mental health liaison service. Adolescents who had self-harmed did not receive a responsive service and were frequently inappropriately admitted while awaiting specialist assessment and support.
- There was a lack of an appropriate welcoming space for patients with mental health needs.
- The delivery of cardiology services did not meet the needs of the local population.
- There were delays to discharges, which meant patient flow through both hospitals was compromised.
- There was a waiting list for patients requiring an endoscopic procedure.
- The environment did not meet the needs of patients with dementia.
- The trust reported 32 breaches of mixed sex accommodation in the period from January 2016 to October 2016 of which 11 were in the acute medical admissions unit.
- The trust was not always compliant with the accessible information standards and information leaflets were not readily available for patients for whom English was not their first language.
- Due to pressure for beds and the demand on services, some patients had to use facilities and premises that were not always appropriate for inpatients. At times of high operational pressure patients were temporary admitted to endoscopy and medical day unit wards however, these were not identified as 'escalation areas' in the inpatient capacity protocol.
- Elective operations were being cancelled due to the pressure on the beds within the trust and medical patients were being cared for on surgical wards to meet the demand.
- Not all patients had their operations re-booked within the 28-day timescale.
- Six patients had been waiting over 52 weeks for treatment, which is not acceptable.
- The trust was not meeting the 62 day target for cancer patients.
- The diagnostic imaging department had a reporting backlog of 19,500 films and was not meeting its five day reporting target for accident and emergency x-rays.
- A significant typing backlog was causing delays in sending out patient letters impacting on patient safety.

Summary of findings

- Implementation of new computer systems had impacted on waiting lists as some specialties could not see live waiting lists.
- The trust was not meeting referral to treatment target in all specialities.
- There were no designated beds for people receiving care at end of life. Side rooms were used when available but could not be guaranteed.
- The percentage of patients dying in their preferred location and the percentage of patients discharged within 24 hours were not all known for all wards or hospital sites.
- End of life complaints were not always handled promptly and in accordance with trust policy.

However:

- The emergency and urgent care service had a number of admission avoidance initiatives in place to improve patient flow. These included the integrated discharge team who proactively identified and assessed appropriate patients who may be able to be supported in the community rather than admitted to the hospital.
- We saw evidence that complaints were used to drive improvement.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.
- Multi-agency management plans had been developed for patients with mental health needs who were frequent attenders in the ED. These enabled staff to better support patients and had resulted in a reduction of both ED attendances and admissions to hospital.
- The trust's referral to treatment time (RTT) for admitted pathways for medical services has been better than the England overall performance.
- The average length of stay was for non-elective patients was better than the England average.
- Staff in theatres and recovery had guidance in place to help reduce the anxiety of patients living with dementia when they using their services.
- Rapid access assessment clinics were provided in some specialities, and some clinics were performing airway assessments via skype.

- The hospital had introduced a new waiting list validation process to discharge patients ongoing follow up care to community based services such as GPs.
- A project placing therapists on wards had helped increased patient discharges, and radiographers attended ward briefings to identify inpatients waiting for scans.
- The in-patient specialist palliative care team was available to ward staff to provide advice and training regarding communication and end of life care; this included communicating with patients and carers.
- The trust was one of two sites in the country which had been developing a medical examiner role and improved death certification process project since 2008. Benefits included better support for relatives over the explanation and causes of death as well as ensuring better oversight of signing of death certificates
- The specialist palliative care team responded promptly to referrals, usually within one working day.

Service planning and delivery to meet the needs of local people

- The trust was working closely with commissioners to identify system-wide strategies to improve patient flow.
- Facilities and premises were not wholly adequate. The emergency department in Gloucester was frequently crowded. Patients queued in the corridor, some on arrival in the department, others while waiting to be seen, and some while waiting to be transferred to a ward. In November 2016 the average number of patients in the ED corridor at GRH was 86 per day
- There was often lack of patient flow within the hospital and in the wider community. Patients queued into the emergency department from the ambulance entrance, stretching to the other end of the department. •
- The emergency department in Cheltenham lacked a separate room which could be used to undertake mental health assessments or a quiet space where people with mental health needs could wait.
- Cardiac services were situated in both locations however; the service provision did not always meet the needs of patients. Patients were admitted to the cardiac wards at Gloucester Royal Hospital from the emergency department but at times required transfer to the cardiac catheterisation laboratory (cath lab) in Cheltenham. However, this was not open seven days a

week and the emergency department in Cheltenham did not admitted patients brought in by ambulance from 8pm. This resulted in patients being transferred to other NHS hospital trusts to access their acute care needs.

- There was daily teleconference with commissioners, the local authority, the ambulance service and both hospital locations to discuss the availability of beds and any patient flow issues. There was a separate teleconference where staff discussed bed availability and the potential number of discharges, as well as any staffing issues that may compromise capacity.
- The trust had witnessed an increase of surgery admissions of over 1000 patients in a year since our last inspection in March 2015, which had affected their services. Plans were in place to improve the elective surgery pathway with the aim to improve patients experience and outcomes. This included, looking at staggered admissions times so patients would not wait for long periods before surgery and a one-stop clinic and pre operation assessment. As part of service planning due to winter pressures and the increase demand on beds in the trust two surgical wards were being used for medical patients. This had an impact on the number of elective operations that could be undertaken. The day surgery unit was being opened both day and night and at times had medical inpatients when the demand for beds within the hospital was high.
- Senior staff attended a countywide group attended by commissioners, other providers and relevant stakeholders. The aim was to share good end of life practice and consistency in services through the development of a county plan for end of life care for 2016 - 2019.
- The trust, along with commissioners and local GPs had been involved in developing a process for reviewing all pending and follow up patients. In June 2016, local GPs had begun to identify patients who were currently under the care of the hospital, who could be discharged back to community services such as community hospitals and GP surgeries for their on-going care and follow up. This had begun to free up more capacity in the hospital clinics to accept new patients.

Meeting people's individual needs

- There were two learning disability leads who worked across all hospitals sites. They monitored a live tracking system that allowed them to identify patients in the trust with learning disabilities, in order to ensure staff were meeting their needs.
- There was guidance available for emergency department staff to assist them to identify and manage patients with a learning disability. Staff received awareness training as part of their

induction which included meeting the trust's learning difficulties team, understanding what their role was, how to contact them, and what they could offer patients. Support included the production of individual support plans for patients with a learning disability. These were produced in an easy-read format and included patients' likes and dislikes and preferences for care.

- There was a mental health liaison team which supported the emergency department and the Acute Care Unit from 8am to 10pm seven days a week. The team, who were employed by the local mental health trust, aimed to respond verbally to all crisis and urgent referrals for mental health advice or assessment and provide assessment within two hours. Between June and October 2016 the service received 120 urgent referrals, of which 55% were seen within two hours.
- Telephone translation services were available for staff to access in the event that English was not the patient's first language.

Dementia

- Staff received dementia awareness training as part of their induction. Purple butterfly stickers were used on patients' records and purple wrist bands used to identify patients with cognitive impairment. Staff had access to 'twiddlemitts' for patients who were restless or anxious. Twiddlemitts are knitted mittens with items of varying texture attached inside and out. They provide simple stimulation for people with dementia and other memory conditions, minimising agitation, increasing flexibility of the fingers and soothing fidgety hands.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved. The consultant had recently recruited a nurse and a porter as GEEC champions and at the time of our inspection was in the process of publicising the aims of the group. They planned to hold a 'tea party' in the staff room the week following our inspection to encourage staff to join the group.
- The trust had a dementia strategy and introduced 'dementia champions' on many wards. The strategy outlined actions to provide dementia friendly care, provide processes to assess and refer patients with dementia and ensure staff receive training in caring for patients with dementia. It also included a vision to enhance the healing environment

Summary of findings

- In a patient-led assessment of the care environment (PLACE, 2016), the score for dementia awareness on medical wards ranged from 46 % on ward 8A to 96% in the cardiology ward
- Whilst a high percentage of nursing staff (84%) had attended dementia training dementia awareness level 2, only 25% of medical staff had attended.
- Staff described 'John's campaign,' an initiative to invite relatives of patients with dementia to come in outside of normal visiting hours to assist with meal times and personal care if appropriate.
- The trust was in the process of introducing 'this is me' diaries for patients with dementia, where relatives could add information about the patient to help inform nurses and other healthcare professionals of specific likes and dislikes of the patient which would promote understanding and communication. Most wards had large dementia friendly signage.

Access and flow

- Access and flow was a significant challenge for the trust. As a result, people did not always receive care and treatment in a timely way. The trust had an occupancy rate of 92-94% between January and June 2016. It is recognised that a bed occupancy rate above 85% may affect the flow of patients from admission to discharge and affect the quality of care and treatment. There were 2,355 bed days occupied by patients deemed medically fit for discharge in October 2016. In the same month, there were also 45 delayed discharges.
- Due to a lack of flow, the trust was consistently failing to meet key national performance standards for emergency departments. The trust was consistently failing to meet the standard which requires that 95% of patients are discharged, admitted or transferred within four hours of arrival at A&E. The trust did not meet the standard between January and December 2016 and was worse than the England average, which was also below the standard. The trust also failed to meet the standard recommended by the Royal College of Emergency Medicine (RCEM) in relation to the time from arrival to treatment (one hour) in 10 out of 12 months in the period December 2015 to November 2016.
- Between January and December 2016, the trust's monthly percentage of patients waiting between four and 12 hours from the decision to admit until being admitted was generally better than the England average. The trust's performance had

improved over time and in December 2016 trust performance was 12%, compared to an England average of 17%. Over the same reporting period, four patients waited more than 12 hours from the decision to admit until being admitted.

- The emergency department operated a clinical model (known as UTOPIA), whereby all emergency admissions, including those patients referred by their GP, attended the department. There was recognition that the increasing numbers and acuity of patients, and poor patient flow within the hospital leading to crowding and associated risks, made this model unsustainable. Detailed diagnostic work was underway both within the emergency department and within the wider system to develop a model which was affordable and sustainable.
- Analysis of the main contributing factors to four hour breaches in November 2016 showed that bed availability was by far the biggest single cause of breaches (35.9%). The second biggest cause was 'awaiting assessment' (20.57%) and the third biggest cause was 'others' (this included waiting for diagnostics, porters, transport and specialists).
- The trust had an escalation policy with action plans in place for each escalation status. Actions included opening additional beds, providing additional staff, cancelling training and diverting patients to other hospital sites. When escalation status was declared black, a major incident would be declared.
- The trust had developed a number of initiatives to prevent unnecessary emergency department attendance and/or admission to hospital and thereby improve patient flow. All GP calls for an ambulance were handled by the Gloucestershire Single Point of Access run by a local care trust, where alternatives to emergency department attendance would be considered first. The trust's website provided advice to members of the public to encourage them to choose the most appropriate service when they needed urgent healthcare advice or treatment. There were links to a range of local services, including primary care (including out of hours), NHS 111, pharmacies and local minor injury and illness units. Live information was also posted on the website showing how busy each emergency department was and the average time patients would have to wait to be seen.
- Between November 2015 and October 2016, the trust's referral to treatment time for admitted pathways for medical services had been better than the England overall performance and between January 2016 and November 2016, the referral to treatment time for admitted pathways for surgical services has

been about the same as the England overall performance. Between November 2015 and October 2016 the trust's referral to treatment time for non-admitted pathways was worse than the England overall performance.
- There were 1,172 cancelled operations for the period October 2015 to September 2016, of which 7.8% (91) were not re-booked for surgery within 28 days.
- The end of life team responded promptly to referrals, usually within one working day. A review of preferred place of care for patients was undertaken between July and August 2016. In 21 cases 65.6% successfully achieved a preferred place of care or death where information was recorded.
- Discharge for patients at end of life took place at an appropriate time of day. All relevant teams and services were informed and discharge took place only when any ongoing care was in place. Most delays experienced for end of life care were attributed to the lack of availability of care in the community.

Learning from complaints and concerns

- Between November 2015 and October 2015 there were 891 complaints about the trust. The trust complaints policy states complaints should be responded to in 35 working days. However the trust took an average of 38 days to investigate and close complaints.
- Patient care was the most complained about theme with 162 complaints, followed by clinical treatment with 155 complaints. The profession 'Doctor – no grade specified' received 244 complaints followed by 'nursing' with 237 complaints.
- Cheltenham General Hospital received 258 complaints, of which patient care received the highest number of complaints; 47 (18%).
- Gloucestershire Royal Hospital received 621 complaints of which patient care received the highest number of complaints; 114 (18%).
- There were complaints leaflets in the department which advised people how to complain, and these were also available via the trust's website. Where possible, complainants were encouraged to speak with a senior member of staff or to the Patient Advice and Liaison Service (PALS).
- Complaints featured on quality dashboards within divisions and were reviewed through the quality committee. Patients' concerns and complaints were used to help improve the quality of care. Learning from complaints was encouraged with leads responsible for identifying themes and disseminating learning.

Summary of findings

Are services at this trust well-led?

As we did not inspect this domain in all services we are unable to re rate. Overall, we found:

- The trust had been placed into financial special measures by NHS Improvement at the end of October 2016 following the sudden and significant deterioration in the Trust's reported financial position. At that point, the trust projected year end deficit of £18.3 million against a previously forecasted surplus of over £4 million.
- The trust board had undergone a significant change. The seven months preceding the inspection had seen a change in chief executive, director of finance, chief operating officer, chairman and two non-executive directors.
- Some concerns which we identified at our last inspection had not been addressed with sufficient pace.
- There were some gaps in director files in relation to the fit and proper persons regulations.

However:

- The new board were addressing the financial issues with openness and transparency. Culture within the organisation was described as open with the new chief executive 'a breath of fresh air.'
- There was a clear organisational vision and strategy that services were aligned to.
- The trust had a governance framework that set out responsibilities for managing quality, performance and risks. There was a clear divisional structure and onward reporting to the board.
- There was visibility at board level of equality and diversity and the trust produced the required data for reporting under their legal and regulatory obligations in line with the Equalities Act 2010 and the Workforce Race Equality Standard.

Vision and strategy

- The trusts overarching vision is described as 'Best Care for Everyone' with the aim to improve health by putting patients at the centre of excellent specialist care. There were five pillars of transformation to achieve this vision. These included, building capacity and capability, improving patient flow, modernising their hospitals, working in partnership and delivering best value. Staff were aware of the trust's values and information was displayed inwards and corridors.
- Organisational vision and strategy fed down into departmental and service strategy. For example within the emergency department where an operational plan for 2016/17 existed with

priority areas which included addressing the inability of the local health and social care system to manage demand within current capacity, matching workforce with clinical needs and developing the physical estate. The emergency care pathway was identified as a trust priority for improvement and plans were set out in the emergency care programme. There was a strategy in cardiology to combine cardiac services across the two sites into one location. Senior staff felt this would improve patient care and treatment, help to recruit and retain staff and enable consistency in training opportunities for nurses. The ambulatory service had a long-term plan to become a seven-day service but due to the vacancies in nursing and medical staffing this was not possible at the time of our inspection. The trust had a clear vision and strategy to deliver care at the end of life. The vision was to embed pride in end of life care delivery across the trust to ensure that the care was as good as it can be for every individual and those important to them, every time. The end of life vision also included improving patient experience, clinical effectiveness, the establishment of the end of life care group and patient safety.

Governance, risk management and quality measurement

- The trust had a governance framework that set out responsibilities for managing quality, performance and risks. There was a clear divisional structure and monthly quality and performance committee meetings and monthly quality reports. These were presented to board meetings for discussion about quality and performance.
- The board assurance framework set out the means by which the organisation tracked its progress as well as setting out controls to mitigate potential risks to the delivery of annual objectives. It contained details of the risk, the risk owner, controls and gaps in controls and the direction of travel to indicate if the controls and assurances were improving. There were four principle risks rated as 15 or above, all of which were aligned with the main divisional risks and those voiced by staff at an operational level
  - Risk of not being able to recruit and retain a workforce with the right profile to deliver the clinical services (rated 20)
  - Risk of not meeting financial targets (rated 25)
  - Risk of delay to patient discharge impacting on patient experience and the timely delivery of care closer to home (rated 16)
  - Risk of the failure of the local health and social care system to manage demand with agreed levels (rated 20)

- The trust had a risk management framework that was due for review at the time of inspection. This identified the process and function of risk management at an operational level and how board oversight of operational risks was achieved. This was in the form of a risk register which was populated at department level. Lower level risks were monitored at divisional level, with organisational level risks receiving board scrutiny.
- There was a quality framework in place which incorporated clinical governance arrangements and was aligned to the care quality commission five key questions. This clearly laid out the roles and responsibilities to support quality and governance functions.
- The safety and quality improvement academy was part of a program for developing a continuous culture of improvement. Previously setting 'top down' standards of quality for the divisions to achieve, a new model was proposed in December 2016 which would enable specialities to be responsible and develop a 'bottom up' approach to quality. Staff were encouraged to go through the academy and progress from bronze (and introduction to quality improvement methodology and techniques) through to platinum (advanced quality improvement). Training data indicated a total of 544 staff had undergone training to receive the bronze award and 27 staff had completed the silver level, between them completing a total of 18 quality improvement initiatives. These includes reducing the wait for clerking for medical patients, improving chest drain insertion in the emergency department and improving the quality of discharge summaries and clinical coding in paediatrics.

Leadership of the trust

- Staff felt supported and listened to by their immediate line managers and divisional management
- Managers appeared competent, enthusiastic and knowledgeable about their services and the challenges within the wider community.
- The executive team had recently undergone a period of significant change having been a previously stable and longstanding board. The previous chief executive retired in April 2016 having been chief executive since 1 May 2008. The new chief executive took up their role in June 2016 and a new chairman joined the trust in November 2016. The finance director and two non-executive directors stood down in September 2016. The two non-executive directors had been replaced at the time of the inspection. There was an interim chief operating officer and an interim finance director in post.

Summary of findings

Culture within the trust

- Staff described a change in the culture of the organisation that now felt truly open and engaged. The chief executive was described as a 'breath of fresh air' in the organisation. Staff received updates on a weekly basis in the form of a chief executive message that mixed both personal and professional messages.
- The increase in openness amongst staff at all levels was tangible on this inspection in comparison to the last. There was a willingness to talk about issues and solutions without the defensiveness that had characterised some of the previous engagement. Some staff, including those at a senior level, told the team that they had felt unable to speak up and to be heard previously. This was not identified as a particular issue at the previous inspection but the team noted the tone of the engagement as evidence as an improvement in the culture of the trust and the experience of staff working there.
- The current financial deficit and difficulties with the newly implemented computer system were felt to be being addressed with openness and honesty. For example in the email of apology and explanation of immediate actions to address which was sent to all staff in December once concerns with the system became apparent. An external report into the financial issues had been commissioned but was not available at the time of the inspection or at the time of publication of this report. The trust had undertaken to make the findings public.
- Whilst many services were managed across both sites, there remained a divide in culture between hospitals. Staff identified with the culture of their particular hospital rather than the trust as a whole. However there did not appear to be an impact on the quality and safety of care. Staff worked consistently with the trust and divisional policies and procedures regardless of where they worked.

Equalities and Diversity – including Workforce Race Equality Standard

- There was visibility at board level of equality and diversity and the trust produced the required data for reporting under their legal and regulatory obligations in line with the Equalities Act 2010 and the Workforce Race Equality Standard. The information and data produced and reported was to a high standard and in an easily readable form.
- The 2015 staff survey showed a mixed picture in relation to Black and minority ethnic (BME) staff experience:

Summary of findings

- The percentage of BME staff who had experienced harassment, bullying or abuse from patients, relatives or the public had reduced very slightly from 29% to 28%. This figure was in line with the national average. The figure was slightly higher (worse) for white staff, at 29%.
- The percentage of BME staff who had experienced harassment, bullying or abuse from staff had increased slightly from 24% to 27%, although was 1% below the national average. The figure was slightly lower (better) for white staff, at 25%.
- The percentage of BME staff who believed the organisation provided equal opportunities for career progression or promotion had deteriorated from 79% to 75%. This was in line with the national average, but lower (worse) than the percentage of white staff (89%).
- A higher percentage of BME staff reported experiencing discrimination at work from a manager, team leader or colleague when compared to white staff (BME staff at 13%, white staff at 5%). However, this was a small reduction (improvement) from 15% and was in line with the national average.
- The trust's action plan in response to the staff survey did not include any actions specifically relating to the experiences and responses from BME staff.
- The trust's workforce was broadly representative of the population. In the trust's 2014/15 Equality Report the BME population in Gloucester and Cheltenham was shown to account for 4.6% of the total population, compared with 14.6% nationally. The BME staff group made up 8.6% of the trust's workforce and there was generally a good spread of BME staff across the staff bands. Of 2,418 applications for employment from BME staff, 26% were shortlisted. This was slightly lower than for white staff (33%).
- In the trust's 2016 workforce strategy two strategic aims had been included relating to race equality and diversity:
- Embed equality and diversity as part of the trust 'DNA', extending the opportunity to hear from staff about their real experience of working in the trust;
- Introduce and track performance against the Workforce Race Equality Standard (WRES), taking appropriate actions to improve performance;
- The trust had an equality and diversity steering group, had recently implemented equality and diversity e-learning for staff, and had launched a new equality, diversity and inclusion training module as part of their management essentials training programme.

- The composition of the trust board did not reflect the staff mix or local community mix, with all voting board members being from a white background.
- There was a commitment to establishing a BME staff network. However, this had been identified and discussed at numerous meetings for almost 12 months and was no further forward in development at the time of our inspection.

Fit and Proper Persons

- The trust had systems in place to ensure board members were fit and proper. However, these systems did not fully meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to Regulation 5: Fit and proper persons: directors. This regulation ensures directors of NHS providers are fit and proper to carry out this important role.
- The trust's recruitment and selection procedure (January 2017) included the need to undertake checks of senior appointments (including executive and director level positions) in order to comply with the Regulation, but did not provide detail about how this would be managed.
- The trust's list of posts requiring a DBS check stated the Chair, Chief Executive and board level directors did not require a DBS check. Without a DBS check, the trust does not fully comply with Schedule 4 Parts 1 and 2 of the Regulation to ensure appointees are fit and of good character.
- The board agreed to implement a system of checks to comply with the Regulation in February 2015. The board agreed and signed off the action plan, which included:
  - Commence a county-wide procurement exercise to identify an executive search partner for future appointments
  - Amend the template for director job descriptions and prospective employment contracts
  - Design a self-declaration form for prospective directors to complete at short listing stage
  - Design a summary form for presenting to the Chair and Chief Executive, itemising all checks made on the proposed appointee confirming compliance with the Regulation
  - Collation of a suite of values based questions for use by interview panels for director posts
  - Revision of director induction programme to ensure suitable content regarding the Regulation
  - Letter to be sent from the Chair and Chief Executive to directors confirming they meet the requirements of the Regulation and requesting self-certification

- We reviewed the personnel files of seven directors on the board, including the chair, chief executive, executive and non-executive directors. The files provided most, but not all, the evidence that relevant checks had been done. For example, one file did not have two references recorded; job descriptions and terms of employment did not all contain reference to the Regulation; six files did not contain Disclosure and Barring Service (DBS) checks.
- We informed the trust of our concerns and were told that where gaps in references and some DBS checks existed, it was an administrative error. Since the inspection we have received assurance that they had reviewed their policy on Disclosure and Barring Service checks to ensure these met the regulations, and that where required, actions had been undertaken to ensure compliance with this regulation.

Public engagement

- The trust public engagement model was set out in two key strategies; 'Improving patient and carer experience strategy 2015-17' and the now out of date 'Membership engagement strategy 2014-16'. The most up to date figures provided to us on membership showed there were around 20,890 members, of which 8,200 were staff and 12,780 were members of the public and patients.
- The Trust has 12 public Governors with two Governors representing each of the six public constituencies in Gloucestershire. There is also a Patient Governor representing Trust patients living outside of Gloucestershire.
- Governors and member representatives sat on some of the organisational committees, for example the cancer experience patient group, the VTE group, patient information advisory group and the learning disabilities user group.

Staff engagement

- In the NHS Staff Survey 2016, the trust performed better than other trusts in two questions, about the same as other trusts in 23 questions and worse than other trusts in seven questions.
- The questions for which the trust performed better than other trusts were:
  - Percentage of staff working extra hours (68% vs England average 72%)
  - Response rate (51% vs England average 41%)
- The questions for which the trust performed worse than other trusts were:
  - Recognition and value of staff by managers and the organization (3.96 vs England average 4.03)

Summary of findings

  - Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (4% vs England average 4%)
  - Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month (33% vs England average 31%)
  - Effective use of patient / service user feedback (3.54 vs England average 3.69)
  - Staff confidence and security in reporting unsafe clinical practice (3.52 vs England average 3.62)
  - Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell (66% vs England average 59%)
  - Percentage of staff able to contribute towards improvements at work (67% vs England average 70%)
- The engagement score for this trust was 3.71, which is about the about the same as other trusts
- Actions identified as a result of the survey included;
  - Rebranding and re-introduction of staff forums
  - Re-launch of 'walk abouts' at speciality and divisional level
  - Increase networking including exploration of safe use of social networking apps
- Whilst the staff side referred to positive relationships with senior management and improvements in communication, they described feeling less engaged as under the previous executive team, but realised this was likely as a result of the significant changes.

Innovation, improvement and sustainability

- There was strong sense of drive to improve services, most notably in urgent and emergency care and end of life. However. some concerns which we identified at our last inspection had not been addressed with sufficient pace.
- The safety and quality improvement academy was integral to driving forward a continuous culture of improvement. Staff were encouraged to undertake quality improvement projects at all levels.
- As part of the sustainability and transformation program, the trust were reviewing services across the county.

Overview of ratings

Our ratings for Gloucestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Requires improvement	Good	N/A	Requires improvement	N/A	N/A
Maternity and gynaecology	Requires improvement	N/A	N/A	N/A	N/A	N/A
Services for children and young people	Good	N/A	N/A	N/A	N/A	N/A
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Requires improvement	N/A	N/A	Requires improvement	N/A	N/A

Our ratings for Cheltenham General Hospital

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

Overview of ratings

Our ratings for Gloucestershire Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	N/A	N/A	N/A	N/A	N/A	N/A

Outstanding practice and areas for improvement

Outstanding practice

- The diagnostic imaging department sent radiographers onto wards to liaise with staff to identify inpatients who were waiting for scans, in order to help speed up treatment and ultimately discharge.
- The therapies department had placed occupational therapists and physiotherapists on wards over Christmas to support and speed up patient discharges during a period of high pressure.
- The inpatient specialist palliative care team had won an annual staff award the trust - patient's choice award 2016. This was from patients and others who recognised the NHS staff who had made a difference to their lives.
- The consultant in the specialist palliative care team was part of a multi-disciplinary team who had won the national Linda McEnhill award 2016. The award was recognition by the Palliative Care of People with Learning Disabilities professional network of excellence in end of life care for individuals with learning disabilities. Work included improving how different teams worked better together.
- The development of a training package for midwives to enable them to administer flu vaccinations to at risk women had meant that a high number of women who would otherwise have not had the flu vaccine had received it.
- Direct access to electronic information held by community services, including GPs. This meant that hospital staff could access up-to-date information about patients, for example, details of their current medicine.
- The emergency department had recently developed a team known as the Gloucestershire elderly emergency care (GEEC), championed by an ED consultant. The aim was to raise awareness of the issues faced by frail elderly patients in the emergency department and to identify areas where the experience of this patient group could be improved.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

- Review processes to monitor the acuity of patients to ensure safe staffing levels.
- Ensure wards are compliant with legislation regarding the Control of Substances Hazardous to Health (COSSH).
- Review processes for ensuring effective cleaning of ward areas and equipment and patient waiting areas.
- Review the governance and effectiveness of care and treatment through national audits.
- Ensure patient records are kept securely at all times.
- Ensure equipment is replaced to ensure safe diagnosis and treatment.
- Ensure the medical day unit is suitable for the delivery of care and protects patients dignity and confidentiality.
- Ensure all staff are trained and understand their responsibilities in a resuscitation situation.
- Ensure resuscitation equipment is readily available and accessible to staff.
- Ensure steps are taken to reduce the current typing backlog in some specialities.
- Ensure specialities have oversight of all of their waiting lists.
- Ensure that all information related to patients' mental capacity and consent for 'Do Not Attempt Cardio-Pulmonary Resuscitation' (DNA CPR) is available in patient records.
- Ensure trust staff comply with all the requirements of the Mental Capacity Act (2005).
- Ensure the emergency department is consistently staffed to planned levels to deliver safe, effective and responsive care.
- Review support staff functions to ensure the emergency department is adequately supported.

Outstanding practice and areas for improvement

- Ensure that all staff are up-to-date with mandatory training and receive yearly appraisals in line with trust policy.
- Ensure patients arriving in the emergency department receive a prompt face-to-face assessment by a suitably qualified clinician.
- Improve record keeping so that patients' records provide a contemporaneous account of assessment, care and treatment.
- Ensure patients in the emergency department receive prompt and regular observations and that early warning scores are calculated, recorded and acted upon.
- Ensure the mental health assessment room in the emergency department meets safety standards recommended by the Royal College of Psychiatrists.
- Ensure that a suitable space is identified for the assessment and observation of patients presenting at the emergency department with mental health problems.
- When using Kemerton and Chedworth Suite for inpatients, provision must be made for the cleaning of the units at weekends and to provide patients with clean water jugs and drinks.
- Ensure emergency resuscitation trolleys are checked and have guidelines attached according to best practice guidance and in line with trust policy.
- Ensure the safe management of medicines at all times, including storage, use and disposal and the checking and signed for controlled drugs.
- Ensure all drug storage refrigerator temperatures are checked and the results recorded daily. Additionally if the temperatures fall outside of the accepted range action is taken and that action recorded.
- Ensure patient group directives are up to date and consistent in their information.
- Ensure women attending the triage unit within the maternity service are seen within 15 minutes of arrival.
- Ensure machines used for near patient testing of patient's blood sugar, are calibrated daily and this is recorded or ensure all staff are trained in how to use the new machine so the old machines can be removed.
- Ensure steps are taken to reduce the current typing backlog in some specialities

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment 15 – (1) (a) All premises and equipment used by the service provider must be clean. The fabric of the building did not always ensure efficient cleaning could be carried out. The premises used for the delivery of services in ophthalmology outpatients were visibly unclean, with dirty fans in use in clinical procedure rooms. Staff did not always comply with legislation regarding the Control of Substances Hazardous to Health (COSHH). When Kemerton and Chedworth Suite were opened at weekends, there was no provision for cleaning of the unit 15 – (1) (c) All premises and equipment used by the service provider must be suitable for the purpose for which they are used The medical day unit comprised of mixed sex bays were cramped. Patients had very little space between chairs, several patients had visitors with them and this made the bay even more cramped and did not ensure patient's dignity or confidentiality The mental health assessment room did not comply with safety standards recommended by the Royal College of Psychiatrists

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
	(1) (d)(e) All premises and equipment used by the service provider must be properly used and maintained. There were new machines for checking of patients' blood sugar however, not all staff had had training so the old machines were also still in use. Staff did not always calibrate these daily in line with manufacturer's guidance.
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17 (2) (a) There must be systems and process in place to monitor and improve the quality of and safety of services. The processes and systems used to monitor and process the number of outstanding clinic letters were not effective, and several specialities had significant backlogs of typing. There was no oversight of competency for the use of syringe drivers. The medical service did not consistently review the effectiveness of care and treatment through participation in national audits. 17 (2) (b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; The processes and systems in place to identify and assess risks to the health and safety of people who used the services were not effective. The lack of oversight of the backlog of pending and follow up waiting lists placed patients at risk of harm due to increased delays in treatment and assessment.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 safe care and treatment 12 (2) (c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely; The systems and processes in place to protect patients from harm in emergency situations were not effective. Staff were unsure of their responsibilities in a resuscitation situation and did not feel sufficiently trained or confident to undertake immediate emergency care, and resuscitation equipment was not readily available, or easily located in all clinical departments.
	The processes and systems used to monitor and process the number of outstanding clinic letters were not effective, and several specialities had significant backlogs of typing. 17 (2) (c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; People who used the services were not protected from the risk associated with unauthorised access to confidential patient records. Patient records were not securely kept at all times. Documentation relating to patients' mental capacity and consent was not always complete or immediately obvious in 'do not attempt cardio-pulmonary resuscitation' (DNA CPR) records.

This section is primarily information for the provider

Requirement notices

Not all staff were up to date with mandatory training.

Risks to patients were not always mitigated because staff did not follow plans and pathways. Patient observations were not consistently undertaken with the required frequency in the emergency department to ensure that any deterioration in a patient's condition was identified. Risk assessments in respect of skin integrity and nutrition and hydration were not consistently undertaken.

Patients arriving in the emergency department did not always receive prompt, face to face initial assessment by a clinician.

The emergency department did not have a suitable space for the assessment and observation of patients who presented with mental health needs, as recommended by the Royal College of Psychiatrists.

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

This section is primarily information for the provider

Requirement notices

Records of resuscitation discussions with patients and their next of kin, or of why decisions to withhold resuscitation attempts were not discussed or were not documented.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 Staffing. (1) Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this part. (2) Persons employed by the service provider in the provision of a regulated activity must— (a) receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform, (c) where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator, be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role. There were not always sufficient numbers of suitably qualified, skilled and experienced nursing staff in the emergency department. There were insufficient numbers of senior medical staff employed at night in the emergency department to ensure patients received timely diagnosis and treatment.

This section is primarily information for the provider

Requirement notices

Support staffing in the emergency department was inadequate, which meant clinical staff were frequently required to undertake administrative, cleaning and portering tasks.

Nursing staffing levels were below establishment and wards relied on bank and agency to cover shifts every day.

The trust did not use a recognised tool to assess the acuity of patients daily and ensure safe staffing levels were in place on each shift and particularly at night.