Gloucestershire Hospitals NHS Foundation Trust

Inspection report

Alexandra House
Cheltenham General Hospital, Sandford Road
Cheltenham
GL53 7AN
Tel: 08454222222
www.gloshopsitals.nhs.uk

Date of inspection visit: 12-13 April 14-16 June 2022
Date of publication: N/A (DRAFT)

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

We carried out an unannounced inspection of Surgery services provided by the trust because we had concerns about the safety and quality of services. We inspected the Surgery core services at Gloucestershire Royal Hospital and Cheltenham General Hospital.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement. Use of Resources was not assessed during this inspection.

At our last comprehensive inspection of Gloucestershire Hospitals NHS Foundation Trust, published in 2019, we rated well-led and the trust as good overall.

Our ratings for both the core service inspections and the well led assessment deteriorated.

For Surgery at Gloucestershire Royal Hospital and Cheltenham General Hospital, we rated the services as inadequate for safe and well-led. We rated the key questions of effective and responsive as requires improvement and caring as good. The overall ratings for Surgery were inadequate.

Following the inspection, we issued a section 29a Warning Notice to the trust as we found significant improvement was required in areas of safety, leadership, risk management and governance for the surgery services.

We did not inspect a number of core services at the trust's locations. We continue monitoring the progress of improvements to services.

Our findings

- We rated well-led as requires improvement following the well-led assessment.
- We rated safe and responsive as requires improvement, effective and caring as good.
- In rating the trust, we took into account the current ratings of the services not inspected this time. We rated 10 of the trust's 16 services as good, two as outstanding, and two as inadequate.

Our rating of the trust went down. We rated them as requires improvement because:

- Leaders did not always use the organisations' values to improve the culture and services for patients. Not all leaders were visible and approachable for patients and staff and not all staff felt respected, supported and valued.
- The trust did not have an open culture where staff could raise concerns without fear. Leaders did not always promote equality and diversity in daily work, and some staff groups did not get provided opportunities for career development.
- Not all levels of governance and management functioned effectively and interacted with each other. There was a disconnect between some senior level leader's perception and the reality for the frontline staff. Staff did not always feel actively engaged in the planning and delivery of services and in shaping the culture.
- Learning following incidents was not always shared effectively to make improvements and change was not always sustained. Middle level managers and leaders did not all feel listened to or involved in improvement strategies.

However:

- Most leaders had the skills and abilities, experience and capacity to manage the trust. However, many were new to the organisation. Leaders were aware of the challenges the trust faced as a whole including the system and political context.
- The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. There were collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs.
- A review of the effectiveness of committee structure and governance was underway. Changes were being implemented to improve risk management and visibility from frontline services to the board. Senior leaders were clear about their roles and accountabilities.
- Leaders encouraged innovation and participation in research. Staff and leaders had a good understanding of quality improvement methods and the skills to use them.

How we carried out the inspection

We carried out an unannounced inspection of Surgery core services at the trust's locations of Gloucestershire Royal Hospital and Cheltenham General Hospital. During the on site inspection, we spoke with approximately 98 staff, seven patients and saw feedback from patient surveys. We reviewed 14 patient records. We conducted four interviews following the inspection. Twelve members of staff contacted the Care Quality Commission directly to share their views as they were not able to speak with us during the inspection.

The team that inspected the Surgery service comprised a CQC lead inspector, a CQC inspector, the CQC national professional advisor for surgery and three specialist advisors. The inspection team was overseen by Catherine Campbell, Head of Hospital Inspection.

Our findings

We also inspected the well-led key question for the trust overall. During the well-led assessment we undertook a number of interviews and staff focus groups including matrons, consultants, pharmacy staff, trust leadership team, governors and staff representative, executive and non-executive directors. Fifty members of staff contacted the CQC directly following the well-led inspection.

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

Outstanding practice

We found the following outstanding practice:

The trust's infection prevention and control team had a strong collaborative and system working approach, resulting in reducing incidence of surgical site infections and had won national level awards.

Areas for improvement

Following the inspection, we issued a section 29a Warning Notice to the trust as we found significant improvement was required in areas of safety, leadership, risk management and governance for Surgery services.

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

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with 16 legal requirements. This action related to 2 locations and at trust wide level.

Trust wide

- The trust must operate effective governance systems to ensure compliance with all relevant sections as set out in Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17(1).
- The trust must improve the culture and ensure all staff are actively encouraged to raise concerns and be involved in continually improving the quality of care. Regulation 17(2)(a).
- The trust must ensure that incident investigations and action plans are completed and shared with all teams in a timely way so actions can be taken swiftly to reduce risk. Regulation 17(2)(b).
- The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. Regulation 17(2)(e).
- The trust must ensure it promotes values and equality and diversity throughout the organisation. Regulation 17(2)(e).
- The trust must ensure action is taken regarding identified themes to resolve concerns. Regulation 17(2)(e).
- The trust must ensure all risks are escalated in a timely way. Regulation 17(2)(b).

Our findings

Surgery core service at Cheltenham General Hospital

- The service must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12(2)(c).
- The service must ensure staffing levels meet the needs of patients and national guidelines. Regulation 18(1).
- The service must ensure medical gases are stored safely. Regulation 12(2)(g).
- The service must ensure room temperatures where medicines are stored are monitored. Regulation 12(2)(g).
- The service must ensure physical devices are used appropriately to reduce the risk of deep vein thrombosis. Regulation 12(2)(g).
- The service must ensure patients receive treatment when they need it and do not experience delays which places them at risk of deterioration and harm. Regulation 12(2)(a).
- The service must ensure staff working in theatres and on wards are competent in their area of work and these competencies are regularly assessed. Regulation 12(2)(c).
- The service must ensure incident investigations are completed in a timely way, action is taken swiftly, and learning is shared. Regulation 17(2)(b)(e).

Surgery core service at Gloucestershire Royal Hospital

- The service must ensure staff complete their mandatory training and each module meets their compliance targets. Regulation 12(2)(c).
- The service must ensure staffing levels meet the needs of patients and national guidelines. Regulation 18(1).
- The service must ensure rescue medicines are appropriately authorised. Regulation 12 (2)(g).
- The service must ensure room temperatures where medicines are stored are monitored. Regulation 12(2)(g).
- The service must ensure physical devices are used appropriately to reduce the risk of deep vein thrombosis. Regulation 12(2)(g).
- The service must ensure patients receive treatment when they need it and do not experience delays which places them at risk of deterioration and harm. Regulation 12(2)(a).
- The service must ensure staff working in theatres and on wards are competent in their area of work and these competencies are regularly assessed. Regulation 12(2)(c).
- The service must ensure incident investigations are completed in a timely way, action is taken swiftly, and learning is shared. Regulation 17(2)(b)(e).

Action the trust SHOULD take to improve:

Trust wide

- The trust should consider how it improves communication and decision making between the executive team and frontline staff.

Surgery core service at Cheltenham General Hospital

- The service should ensure all staff follow infection control principles. Regulation 12(2)(h).

Our findings

- The service should ensure emergency equipment is checked in line with the trust policy and these checks are audited. Regulation 12(2)(e).
- The service should ensure pharmacy services are available to meet patient need. Regulation (12)(2)(g).
- The service should ensure staff appraisals are completed in line with trust targets Regulation (18)(2)(a).

Surgery core service at Gloucestershire Royal Hospital

- The service should ensure all staff follow infection control principles. Regulation 12(2)(h).
- The service should ensure emergency equipment is checked in line with the trust policy and these checks are audited. Regulation 12(2)(e).
- The service should ensure medical gas cylinders are transported safely around the hospital. Regulation (12)(2)(g).
- The service should ensure pharmacy services are available to meet patient need. Regulation (12)(2)(g).

Is this organisation well-led?

The overall well-led rating comes from the trust-wide well-led inspection. It takes into account leadership at service level and the most senior level. Our rating of well-led went down. We rated it as requires improvement.

Leadership

Most leaders had the skills and abilities, experience and capacity to manage the trust. However, many were new to the organisation. Leaders were aware of the challenges the trust faced as a whole including the system and political context. Not all leaders were visible and approachable for patients and staff. Middle level management and leaders did not all feel listened to or involved in improvement strategies.

Most leaders had the skills and abilities, experience and capacity to manage the trust. However, many were new to the organisation. The executive leadership team at the trust was made up of chief executive officer, medical director, director of quality and chief nurse, director of finance, chief operating officer, director for people and organisational development, chief digital and information officer and the director of strategy and transformation. There was also a chair and non-executive directors, each with a specific area of responsibility and a council of governors.

The executive leadership team was essentially a new team. There had been some recent changes to the executive team portfolio's and appointments. The chief executive officer (CEO) was on leave due to ill health and therefore the medical director was acting CEO. The deputy medical director was acting medical director, covering the responsible officer and Caldicott guardian roles. At the time of our inspection, they had been in interim roles for six weeks. The director for quality and chief nurse had recently been appointed in the role (had been an interim). The chair had been in their role since 2 May 2022. The chief operating officer and director of people were also relatively new in post.

The next level in the management structure was called the trust leadership team. This team included the leads of the four divisions; medicine, surgical, women and children and diagnostics and specialities. Each division had a chief of service, director of operations and director of quality and chief nurse.

Most leaders had the skills and abilities to run the service. We were provided with examples of where this was not the case and resulting human resources processes had occurred.

Our findings

Leaders were aware of the challenges the trust faced as a whole including the system and political context. They were also aware that they had aspects of poor culture in the organisation. See Culture section for more details.

Not all leaders were visible and approachable for patients and staff. The non-executive directors had recently begun to undertake hospital visits again after pausing physical attendance to clinical areas due to COVID-19 pandemic restrictions. From 1 January 2022 to 17 June 2022, a non-executive director had attended six visits to clinical areas. Staff told us that this did not necessarily involve spending time with front line staff and therefore, the non-executive directors would not always hear first-hand about the issues they were facing. The CEO was notably approachable with many staff describing when a direct approach had been taken. However, some leaders told us this had the potential to sidestep usual processes and management structures.

Middle level managers and leaders did not all feel listened to or involved in improvement strategies. During the inspection we were given many examples where senior staff had raised issues, concerns and offered constructive solutions. However, these were not always taken on board leaving some staff feeling demoralised. Staff described a disconnect from the ward to the board and felt they were unable to escalate ideas, concerns or issues. Front line teams did not always feel listened to nor feel involved in improvement and strategy. See Culture section for more details.

Vision and Strategy

Leaders did not always use the organisations' values to improve the culture and services for patients. The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy.

Leaders did not always use the organisations' values to improve the culture and services for patients. There was a general lack of discussion about the organisation's values. These were; Caring, Listening and Excelling. The values were referenced in the freedom to speak up review tool (December 2021), as being launched as part of the compassionate culture and leadership work, following extensive engagement with trust colleagues. There was also a rollout of a values and behaviours framework, incorporating the "civility saves lives" campaign. However, the values were not described in the trust's presentation to the well-led inspection team and were rarely referenced by the staff we interviewed. The director of people stated a reset of the values would take place at some point to improve the culture of the trust.

The trust had a vision for what it wanted to achieve and a strategy to turn it into action, developed with relevant stakeholders. The trust had strategic objectives that were set from 2019. These were outstanding care, compassionate workforce, quality improvement, care without boundaries, involved people, centres of excellence, financial balance, effective estate, digital future and driving research. They were currently three years into a five-year strategy. There was a board director whose role was to lead on strategy and transformation.

The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. During the inspection the trust shared their priorities for the future and they included: cultural development, supporting staff to recover, build individual and team resilience with a significant focus on retention of staff and recruitment, recovery of services and the reduction in backlogs and waiting times, developing a winter plan with system partners and implementing the clinical strategy 'fit for the future' programme.

The vision for the 'fit for future' programme was for a single, ground-breaking specialist hospital for Gloucestershire operating out of two campuses: Cheltenham General Hospital as a centre of excellence for planned care and oncology and Gloucestershire Royal Hospital as a centre of excellence for emergency care and paediatrics.

Our findings

Alongside the five-year strategy, the trust's ambition was to become a leader in sustainable healthcare, supporting the NHS long term plan to ensure they were as environmentally, economically and socially sustainable as possible. There were other separate but interlinked strategies including: scientific and allied health professions, digital, people and organisational development and research.

The board assurance framework had recently been reviewed and updated. This clearly described the risk to meeting the trust's strategic aims. See Management of risk, issues and performance section for more details.

Culture

Not all staff felt respected, supported and valued. Staff did not all feel positive and proud to work in the organisation. The trust did not have an open culture where staff could raise concerns without fear. Leaders did not always promote equality and diversity in daily work, and some staff groups did not get provided opportunities for career development. Not all staff received regular appraisal and career development conversations.

Not all staff felt respected, supported and valued. We found issues with the culture were palpable throughout the inspection. Staff at all levels told us there was an acceptance and tolerance of poor behaviours. Staff articulated and had observed rudeness and incivility throughout the organisation. The majority of leaders we spoke with during the inspection had also witnessed poor behaviours. These had taken place at all levels in the organisation and in general these had been tolerated and not tackled. For example, we observed that some individual senior leaders were repeatedly talked over by other colleagues during our focus groups. The culture issues had been recognised by the trust and the recently appointed director of people was clear about how to improve this.

The trust employed around 8,000 staff. Approximately half of the staff took part in the NHS staff survey. The staff survey results (2021) had deteriorated from previous year's results and the majority of the scores were worse than the average for acute trusts. There had been significant decreases in scores relating to staff engagement and morale.

Staff did not always resolve conflict quickly and constructively. We heard of multiple examples where staff disagreements continued unresolved and resentment had deepened. Some staff issues were quickly escalated into human resources processes.

There was a general absence of staff referencing the organisation's vision and values throughout the well-led inspection.

The trust did not have an open culture where staff could raise concerns without fear. There was a lack of trust, psychological safety and fear of speaking up. We heard that when staff did raise concerns they were not always supported or treated with respect. Some staff told us they had tried repeatedly to raise concerns and due to lack of or negative responses, eventually they had become disengaged with overall improvement strategies and focused instead on day-to-day service provision. In the staff survey, 56.1% of staff felt safe to speak up about anything that concerned them. This had decreased (was worse) than the previous survey result (62.9%) and was below the average for acute NHS trusts (60.7%).

Prior to the inspection, the interim CEO invited staff to contact the CQC and share their thoughts about the leadership of the trust. From 7 June 2022 to 7 July 2022, we received 50 accounts of feedback. The feedback was provided by many different staff groups at different levels and divisions, departments and sites throughout the organisation.

Our findings

- Many staff said they were worried about providing this feedback to us as they feared reprisal. Some therefore had provided the feedback anonymously.
- Out of 50 accounts of feedback, two were positive about the leadership of the trust.
- Most feedback included aspects of a poor culture including: bullying, incivility, lack of listening to frontline staff, poor leadership, lack of leader visibility, lack of trust in the freedom to speak up system, lack of action when concerns were raised, disconnect between leaders and frontline staff, blame culture, discrimination and applying positive 'spin' to situations that were negative.

The trust had freedom to speak up processes and guardians including an executive sponsor, non-executive and governor lead. Freedom to speak up is about encouraging a positive culture where people feel they can speak up and their voices will be heard, and their suggestions acted upon. During the inspection we heard staff were not all confident in the freedom to speak up process, there was a lack of trust in the confidentiality and some felt that issues in the organisation were not being tackled. However, trust leaders told us they had responded when concerns about freedom to speak up confidentiality were raised and had made changes in an attempt to address issues of colleague confidence.

A presentation updating the trust board about freedom to speak up status from October 2021 included the following themes:

- Unprofessional and unkind behaviours;
- Team culture concerns – behaviours being entrenched within teams;
- Black and Minority Ethnic colleagues experienced discrimination and not offered the same opportunities as white colleagues;
- People did not feel listened to or supported by managers;
- Concerns about fairness and confidentiality of processes.

The majority of issues raised to the guardians were regarding staff experience, rather than concerns about services for patients.

A review into the freedom to speak up process using an evaluation tool from December 2021, showed an assessment of full compliance with standards. There were some actions noted for improvement. These included further promotion of the role of the guardians and wider circulation of case studies, feeding of learning into programmes such as respectful resolution and to visit an acute trust (with high cultural index) for learning to influence the local plan. The freedom to speak up policy was being updated to include details of the wide range of support available for trust staff and we were provided with a copy of the final draft for approval May 2022.

Leaders did not always promote equality and diversity in daily work, and some staff groups did not get provided opportunities for career development. Not all staff with protected characteristics under the Equality Act, felt they were treated equitably, particularly regarding opportunities for career development.

The trust's performance against Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) experience indicators had deteriorated, all scores were lower for black, minority ethnic (BME) and disabled colleagues. BME staff were 1.56 times as likely to enter disciplinary processes, which was much higher than the national

average and higher than the regional average for the South West (1.17 times). The percentage of staff experienced bullying was high for BME staff (32.7% compared to an average in national WRES report of 28.9%). The percentage of BME staff saying that they have experienced discrimination at work had risen significantly from 18.7% to 23.6% and was much higher than the national average of 16.7%.

The WDES report showed the percentage where disability status of staff was unknown, was high at 40%, compared to average in national WDES report of 25.4%. The likelihood of disabled staff being appointed into roles was low. Non-disabled staff were 1.67 times as likely to be appointed from shortlisting, compared to national average of 1.11 times.

The trust had three staff equality networks: ethnic minority network, disabled network and LGBT+ (lesbian, gay, bisexual, transgender+) network. However, there was no-one available from the disabled or LGBT+ network during the inspection. The trust advised both networks were in the process of recruiting new chairs. The ethnic minority network were passionate about supporting black and minority ethnic colleagues. They held monthly meetings, but staff were not always released to attend.

An equality diversity and inclusion "one year on" report was presented to the trust board in July 2021. The report provided a progress update and action plan, as well as highlighting additional activities that had been achieved. The trust had commissioned a 'big conversation' with an external partner to help them to better understand the experience of colleagues from an ethnic minority, those with disabilities and those from the lesbian, gay, bisexual, transgender (LGBTQ+) community. The was shared with the trust board in 2021. There were many recommendations and these had been captured in an equality, diversity and inclusion action plan. While actions had been taken against the majority of recommendations, the effectiveness of these had not yet been established.

There was a draft equality and diversity plan for 2022-2024. The four priority areas were: attracting and recruiting a diverse and inclusive workforce; developing and retaining a diverse and inclusive workforce; embedding an inclusive and compassionate culture; and engaging and involving diverse voices in our workforce. Each priority area had headline actions and timescales.

Some leaders we spoke with were passionate about equality, diversity and inclusion. However, they acknowledged the trust needed to improve.

There were programmes to support career progression run at Integrated Care System level in Gloucestershire called Flourish that staff could access, targeted at those colleagues with protected characteristics including BME and with disabilities.

Not all staff received regular appraisal and career development conversations. The trustwide appraisal rate for April 2022 was 78%, which was lower than the standard target of 90%. The compliance rate had been below the target 12 months prior to the inspection, ranging from 78% to 85%.

Staff did not all feel positive and proud to work in the organisation. In the staff survey 2021, 53% of respondents would recommend the organisation as a place to work (worse than the average of 58% for acute NHS trusts). This was much worse than the previous year when 64% would recommend the organisation as a place to work.

We heard that many staff had left the organisation including those in management level posts. In April 2022, the total vacancy rate was 10.79%, this had been rising from April 2021 when it was 4.3%. When looking at staff groups: the vacancy rate for doctors in April 2022 was 7.91%, which also had been rising over the year, when in April 2021 it was 1.38%; whereas the vacancy rate for nurses in April 2022 was 14.34% compared to 7.24% in April 2021. A total of 1468 full

time equivalent staff had left the organisation in the year from April 2021. This included 20 full time equivalent consultants and 192 senior clinicians including nurses in band 6 and 7 roles (from permanent contracts). The trust had a workforce sustainability transformation programme which included transactional recruitment, electronic rostering and plans for a sustainable workforce. They continued to actively recruit to vacancies and acknowledged maintaining the workforce continued to be a challenge. Some staff told us there was not enough focus on retention of existing staff.

There were many workstreams and strategies in plan to tackle the culture and improve the experience of staff with protected characteristics under the Equality Act. However, this was being relooked at. For example, following the recent poor staff survey results the idea was to choose a small number of things that need to be done really well, rather than a large action plan. The phrase, 'inch wide, mile deep' was used to describe the tactic. There would also be a focus on improving response rates in readiness for the next survey, using the results in discussions and actioning quick wins.

The trust had an advice and support hub for staff. Since its launch in May 2019, there had been 18,656 contacts made.

The staff survey results had been discussed at the people and organisational development committee in April 2022 and 'encouraged a review into external organisations to gather and utilise best practice but were assured by the new approach being taken to respond to the results at corporate and divisional levels'. The poor staff survey result was noted as forming a context for the newly refreshed board assurance framework.

Governance

Not all levels of governance and management function effectively and interacted with each other. There was a disconnect between some senior level leader's perception and the reality for the frontline staff. A review of the effectiveness of committee structure and governance was underway. Senior leaders were clear about their roles and accountabilities.

Not all levels of governance and management functioned effectively and interacted with each other. The trust leadership team included the four divisional management teams. According to the committee and governance structure, they received information and papers from twelve group meetings. Whereas the trust board received five direct committees' papers: audit and assurance, estates and facilities, finance and digital, people and organisational development and quality and performance committee. This structure had been implemented in 2019 and throughout 2020. The aim of the structure was that the trust board would receive the same if not an enhanced level of assurance at board level. The structure also released the trust board to focus on strategic matters; while the responsibility of managing the day-to-day business was given to the trust leadership team. However, there was a strong theme of disconnect described by staff and leaders during the inspection. This disconnect included governance, which did not seem to be fully integrated to ensure that the trust board had oversight of what was happening at ward level. Many stated that the disconnect was happening at trust leadership team level. As a result there were missed opportunities to ensure that front line staff and middle leaders were involved in identifying issues and improvements.

A review of the effectiveness of committee structure and governance was underway. The trust secretary was new in post and was conducting the annual review of the effectiveness of the board committee structure and governance. This included reviewing the terms of reference for the committees. In order to improve the boards oversight, there had been the introduction of a key issues and assurance report to go the trust board following each committee meeting, to provide clear assurance on each item that was considered.

The review proposed changes were needed to strengthen governance arrangements. These changes were required to ensure: effective and timely decision-making; risk management from the frontline to the board; streamlining of meeting structures; and improve clarity and visibility of the business of divisions, committees and the board. The proposals

included: continuing the review to include the overall committee, delivery group and divisional meeting structure in order to streamline governance; improve information flow from divisional and operational groups to committees and to the board and implement an integrated performance report at board level in order to eliminate duplication of reports from committee to board.

Senior leaders were clear about their roles and accountabilities and had regular opportunities to meet to discuss the performance of services. However, there was a disconnect between some senior level leader's perception and reality for the frontline staff and services. Some leaders had a positive view on matters and issues despite the seriousness of situations at the trust. The most positive group we spoke with during the inspection, were the non-executive directors. However, they did not describe the extent of staff culture issues and overall were satisfied with the trust's performance. The non-executive's role is to help to ensure the trust is accountable to the people it serves by ensuring constructive and appropriate challenge is made to the trust board.

Management of risk, issues and performance

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. Leaders and teams used systems to manage performance. Changes were being implemented to improve risk management and visibility from frontline services to the board.

Leaders and teams used systems to manage performance. There were assurance systems, and performance issues were escalated through structures and processes. The organisation was key performance target driven. The trust was performing above the national average for all cancer waiting time standards.

Changes were being implemented to improve risk management and visibility from frontline services to the board.

The trust had reviewed its risk appetite in June 2021. The assessment showed a cautious approach to risk related to safety and the environment.

The board assurance framework (BAF) had recently been refreshed and was presented to the trust board in May 2022. It included risks against achieving the ten strategic objectives. The five strategic risks rated as high were:

1. Breach of CQC regulations or other quality related regulatory standards.
2. Failure to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve.
3. Failure to deliver financial balance.
4. Failure to develop our estate which will affect access to services and our environmental impact.
5. Inability to access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings.

The trust secretary was undertaking the annual terms of reference and a full committee structure review. This highlighted that the BAF was not regularly reviewed at all committees, including trust board. The BAF was recommended to be reviewed monthly as part of each committee meeting for assurance. The use of key issues and assurance reports were also being implemented to improve risk management and visibility from the frontline to the board.

Our findings

Potential risks were taken into account when planning services, for example there was a winter plan to prepare for seasonal fluctuations in demand.

Risks to quality of care and patient safety were explored and escalated. The trusts risk register was included in trust board papers and in June 2022 consisted of 29 risks. Of these 17 were rated as extreme risk and the others high risk. However, there were examples where risks were either not identified proactively or where escalation had not occurred until risk was raised during our inspections. For example, risk of harm due to delays in maternity triage.

Leaders' risk priorities aligned with the BAF and trust level risk register. However, at speciality and divisional level there were numerous risks register entries which could hinder risk management due to the volume. For example, the risk register for the surgical division had 117 risks: 45 were at surgical speciality level; 70 were at divisional level and two were on the trust risk register.

There was a systematic programme of clinical and internal audit to monitor quality, operational and financial processes. This was overseen via the audit and assurance committee. From 1 April 2021 to 31 March 2022, the trust had taken part in 50 national clinical audits and three national confidential enquiries.

Across the three years prior to our inspection the trust had seen an improvement and stabilisation in its financial position. The trust had financial undertakings in place since 2016 relating to financial sustainability. These were partially removed in 2018 and the remaining financial undertakings were lifted in 2021. The trust had achieved financial balance for two consecutive years.

The system forecast for 2021/22 was to breakeven but there was a risk of a £4m surplus, which they were working to mitigate. The trust and the wider system were described as working closely with the NHS England regional team in an open and transparent manner on financial matters.

The review of the committee structure proposed a repurpose of the existing finance and digital committee to increase its scope and refocus the agenda on strategic financial, digital, and estates issues, and align with approval of investments and business cases. The committee would become the finance and resources committee and would encompass oversight of Gloucestershire Managed Services and reduce meeting burdens by absorbing responsibilities of the estates and facilities committee. Gloucestershire Managed Services (GMS) was a wholly owned subsidiary company of the trust. GMS was established in April 2018 and responsibilities included managing the buildings, assets and facilities. The failure to develop the trust's estate currently rated as a high strategic risk on the BAF. This was due to £72m backlog in maintenance of which £41m was for critical infrastructure and capital spend constraints and reliance on national capital to fund significant estate developments.

Information Management

Digital improvements had been made since 2019. There were clear service performance measures, which were reported and monitored. There were arrangements to ensure the confidentiality of identifiable data, records and data management systems, and information governance breaches were reported. There were arrangements to ensure data or notifications were submitted to external bodies as required.

Digital improvements had been made since 2019. We were shown the progression the trust had made with digital improvements over the last few years. They acknowledged a delay in comparison with some organisations due to their historic financial situation. Some staff told us that progress had been very slow and this impacted on their day to day work. For example, at the time of the inspection outpatients were not part of the electronic patient record system and staff spoke of cumbersome workarounds and paper records had to be used. There were plans to go paperless in

outpatient settings later on in 2022 and an electronic prescribing and medicines administration project was in progress. Some staff also felt that IT solutions were available for certain issues, but they were not always able to get them. Examples of these issues included local risk register entries describing issues that were waiting years for IT solutions. The digital team prioritised improvements by the highest risk and those offering the most significant improvements. These formed the annual digital programme which would be approved through the trusts' governance structures.

There were clear service performance measures, which were reported and monitored. The trust board papers included performance on dashboards and score cards. These included variation results showing the trends in performance over time and assurance results showing whether a target was likely to be achieved, based on trends.

Data had been mapped to explore health inequalities for patients, in terms of overall health status, service utilisation, and outcomes. This showed inequalities existed across a number of characteristics including age, gender, ethnicity, geography, living situation, and socio-economic status. Plans to reduce inequalities by the trust however, were not included in the data presentation.

There were arrangements to ensure the information used to monitor quality and performance was accurate, timely and relevant. However, there had been some erroneous information presented in the recent trust board papers. This related to data regarding the incidence of patients who developed pressure ulcers. This error was noted, acknowledged and corrected.

There were arrangements to ensure data or notifications were submitted to external bodies as required.

There was a system to monitor and assess whether board directors were deemed to be of good character and were not unfit, meeting the fit and proper persons regulation requirements.

There were arrangements to ensure the confidentiality of identifiable data, records and data management systems, and information governance breaches were reported. A total of 436 information governance incidents were reviewed and investigated throughout the year and reported internally through the governance reporting structure. Six incidents were reported externally to the information commissioner's office during the 2021/22 reporting period. This compared to 10 reported in the previous period.

The trust had carried out a recent cyber internal audit and action plans were in progress with the majority of urgent projects complete.

Engagement

Staff did not always feel actively engaged in the planning and delivery of services and in shaping the culture. There were collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. Leaders engaged externally with patients, the public and local organisations to plan and manage and shape services.

Leaders engaged externally with patients, the public and local organisations to plan and shape services. Public and staff consultation had been extensive regarding the clinical strategy fit for the future. The vision for the fit for future programme was for a single specialist hospital for Gloucestershire operating out of two campuses: Cheltenham General Hospital as a centre of excellence for planned care and oncology and Gloucestershire Royal Hospital as a centre of excellence for emergency care and paediatrics.

Our findings

There were collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. There were strong external stakeholder engagement relationships, evidence of system working, with leadership roles to support this. For example, a system approach was essential to improving the flow of patients through the hospital, reduce ambulance delays and pressure on the urgent and emergency care pathway.

Staff did not always feel actively engaged in the planning and delivery of services and in shaping the culture. The staff survey results (2021) had deteriorated from previous years and there had been significant decreases in positive responses regarding staff engagement and morale. For example: 49% of staff agreed they were 'able to make improvements happen in my area of work', 53% would recommend the organisation as a place to work and 46% felt they were 'involved in deciding on changes introduced that affect my work'. These results had deteriorated from previous results and were all worse than the average for other acute NHS trusts. We met lots of committed and passionate staff and leaders who had a desire to make improvements. However, they did not all feel trusted and included as part of designing solutions. Some leaders described themselves as disengaged from senior level management at the trust due to feeling repeatedly not heard. A feeling of disconnect was described by most leaders during our inspection. The majority held view was that the barrier and cause of disconnect was at trust leadership team level.

Learning, continuous improvement and innovation

Leaders encouraged innovation and participation in research. Staff and leaders had a good understanding of quality improvement methods and the skills to use them. There were systems to support improvement and innovation work. However, this did not always lead to sustained improvements. Learning following incidents was not always shared effectively to make improvements.

Leaders encouraged innovation and participation in research. The trust had ambition to become a teaching hospital and had plans to become involved more in research. The research strategy outlined the stages and steps required for the trust to be known as a centre of excellence for both clinical and educational research and achieve University Hospital status. The trust learned from external reviews, and from internal processes such as mortality reviews and complaints. However, learning following incidents was not always shared effectively to make improvements.

The trust had reported a high number of never events. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. During the 2021/22 reporting period they had declared 11 events. This had been flagged as a concern by the regional and national quality teams at NHS England. There was a programme of planned improvement in order to improve safety and enhance staff engagement. However, not all senior staff were aware of all the never events that had taken place at the trust. Information was not always being shared widely or effectively to raise awareness and share transferable learning points. It was also often hard to find evidence of examples of tangible changes that had taken place to prevent further never events.

There was a process for monitoring action plans following serious incidents and complaints via the monthly safety and experience review group meetings. This group was responsible for monitoring the progress of and formally approving investigations, action plans and closure of action plans. However, we did not see clear learning outcomes as a result of this work. The meeting minutes included lots of comments about asking staff to attend to present investigations and action plans and there were delays noted with audits to check compliance with changes made to practice. The group reported to the Board and the quality and performance committee. The quality delivery group also received escalation from the group about any delayed actions.

Our findings

Staff and leaders had a good understanding of quality improvement methods and the skills to use them. There were systems to support improvement and innovation work. However, this did not always lead to sustained improvements. There had clearly been an investment in quality improvement (QI) methodology and extensive roll out of training to support this approach. The trust had developed the Gloucestershire Safety and Quality Improvement Academy to support use of quality improvement. They had 3,556 staff members either trained or in training. Two examples of completed QI projects included, improving postnatal bladder care and removal of gastric feeding tubes in outpatients for head and neck cancer patients.

The trust was passionate about QI. We heard the process and methodology had initially engaged teams however over time this petered out and little change had taken place as a result. We heard that when change did occur this did not always get sustained.

Following the never events, QI methodology was applied to look at processes and create improvement actions. At the never events meeting in February 2022, the group noted a concern that involvement in projects has tapered off and action was needed for those who had been named in projects to encourage attendance to the meetings. Sustainable change and the impact on the quality of care was not always being monitored. Therefore, it was often not clear what improvements or changes had been made as a result.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↓ Sep 2022	Good ➔➔ Sep 2022	Good ➔➔ Sep 2022	Requires Improvement ➔➔ Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Cheltenham General Hospital	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022
Gloucestershire Royal Hospital	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022
Stroud Maternity Hospital	Not rated	Not rated	Not rated	Not rated	Not rated	Good Jun 2015
Overall trust	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Cheltenham General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019
Critical care	Good Jun 2015	Outstanding Jun 2015	Outstanding Jun 2015	Good Jun 2015	Outstanding Jun 2015	Outstanding Jun 2015
End of life care	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017
Maternity and gynaecology	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Surgery	Inadequate ↓↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Inadequate ↓↓ Sep 2022	Inadequate ↓↓ Sep 2022
Urgent and emergency services	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019	Good Feb 2019
Outpatients	Good Feb 2019	Not rated	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019
Overall	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022

Rating for Gloucestershire Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Feb 2019	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019
Services for children & young people	Good Jul 2017	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Critical care	Good Jun 2015	Outstanding Jun 2015	Outstanding Jun 2015	Good Jun 2015	Outstanding Jun 2015	Outstanding Jun 2015
End of life care	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017	Good Jul 2017
Surgery	Inadequate ↓↓ Sep 2022	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Inadequate ↓↓ Sep 2022	Inadequate ↓↓ Sep 2022
Urgent and emergency services	Requires improvement Jun 2021	Good Feb 2019	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Requires improvement Jun 2021
Outpatients	Good Feb 2019	Not rated	Good Feb 2019	Requires improvement Feb 2019	Good Feb 2019	Good Feb 2019
Maternity	Inadequate Jul 2022	Not rated	Not rated	Not rated	Inadequate Jul 2022	Inadequate Jul 2022
Overall	Requires Improvement ↓ Sep 2022	Good →← Sep 2022	Good →← Sep 2022	Requires Improvement →← Sep 2022	Requires Improvement ↓ Sep 2022	Requires Improvement ↓ Sep 2022

Rating for Stroud Maternity Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity and gynaecology	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015	Good Jun 2015
Overall	Not rated	Not rated	Not rated	Not rated	Not rated	Good Jun 2015

Gloucestershire Royal Hospital

Great Western Road
Gloucester
GL1 3NN
Tel: 08454224721
www.gloshospitals.org.uk

Description of this hospital

Gloucestershire Hospitals NHS Foundation Trust provides surgical services to patients in the Gloucestershire area. Surgical care is provided at two hospital sites, Gloucestershire Royal Hospital and Cheltenham General Hospital. All surgical services across both sites are managed by one surgical division. Data was provided by the trust at divisional level and related to both locations. Therefore, information will be similar within both location reports. The surgical division consists of six service lines:

- Trauma and Orthopaedics; trauma, orthopaedics and orthotics.
- Head and Neck; oral maxillofacial, ears nose and throat, orthodontics, and audiology.
- Ophthalmology; ophthalmology, orthoptics, optometry, diabetic retinal screening and medical photography.
- General Surgery; urology, breast, vascular, upper gastrointestinal, colorectal, bariatric, urology and abdominal aortic aneurysm screening.
- Theatres; theatres and day surgery.
- Anaesthetics; anaesthetics, chronic and acute pain, pre-assessment, acute care response and critical care.

We carried out this unannounced inspection of surgery because of a high number of never events reported by the trust and information of concern we had received about the safety and quality of the service.

Our rating of this location went down. We rated it as inadequate because:

- Not all staff had training in key skills. Infection control was not always managed well. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The service did not always have enough staff to care for patients and keep them safe. Staff did not always assess risks to patients, nor act on them. Staff did not always manage medicines well. Care records were not always kept updated. The service managed safety incidents but did not always learn lessons.
- There was a mixed approach to monitoring the renewal of competencies with limited oversight of the competency of staff. Policies were not always reviewed. People could not always access the service when they needed it and waited too long for treatment.
- Leaders were not always visible to frontline staff. The service had set objectives for what it wanted to achieve in the 2021/22 financial year. However, there were no clear strategies as to how to turn these aims into action nor how progress would be monitored. Not all staff felt respected, supported and valued. Staff did not feel they could raise concerns in a safe way.

Our findings

However:

- Managers monitored the effectiveness of the service and mostly achieved good outcomes for patients. Staff advised patients on how to lead healthier lives and supported them to make decisions about their care. Most key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and provided emotional support to patients, families and carers.

Following the inspection, we issued a section 29a warning notice to the trust as we found significant improvement was required to surgical safety, leadership, risk management and governance.

Surgery

Inadequate ↓↓

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory Training

The service provided mandatory training but not all staff had updated it and leaders did not make sure everyone completed it. The training offered was comprehensive.

Mandatory training was offered but not all staff had completed it. Records showed overall compliance for all staff within the surgery division was 85%. Nursing staff compliance was 87%, medical staff compliance was 78% for consultant doctors. However, 55% of training grade doctors were compliant. This was not in line with the trust target of 90%.

Mandatory training subjects were comprehensive and included basic life support training, However, training compliance for this subject was 72% for all staff within the surgery division.

The electronic computer system which monitored training rates sent alerts to staff to remind them to complete mandatory training when modules were due. Mandatory training was monitored and discussed by each speciality during service line reviews. However, we saw no evidence as to how the service was going to improve compliance within service line review documents.

Managers told us during the COVID-19 pandemic mandatory training compliance had become difficult to ensure due to the reluctance for people to deliver and attend training face to face and the necessary reduction in numbers of people who could attend.

Safeguarding

Not all staff had received training on how to recognise and report abuse. However, staff understood how to protect patients from abuse and told us how they raised concerns.

Staff received training specific for their role on how to recognise and report abuse, however, not all staff had completed this. Data confirmed 97% of staff had completed level one safeguarding adults training, 90% level two safeguarding children training and 93% level one safeguarding children training. However, 83% had completed level two safeguarding adults training and 71% in level three safeguarding adults training. It was unclear if registered staff were included in the numbers of staff expected to complete level three safeguarding adults training in line with latest guidance Adult Safeguarding Roles and Competencies for Healthcare Staff.

Staff showed a good understanding of the trust's safeguarding policy and could give us examples of when they had reported a safeguarding concern.

The trust had a safeguarding adults hub where staff could gain advice or guidance on specific concerns and staff were aware of this hub. There was a trust wide safeguarding adults operational group and a specialist lead nurse in safeguarding adults.

Surgery

Cleanliness, infection control and hygiene

The service did not always control infection risk well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They mostly kept equipment and the premises visibly clean.

Ward areas were mostly visibly clean. The majority of areas were visibly clean; however, we saw visibly dirty plastic screens between patients and there was no evidence or assurance these had been cleaned adequately.

Some wards we visited were looking tired and in need of repair. For example, ward 2a within Gloucestershire Royal Hospital had broken plaster on the walls and broken floor tiles. This was a risk to infection control as it could hinder adequate cleaning.

Some wards we visited were cluttered and overcrowded with equipment due to inadequate storage space.

Staff did not follow some infection control principles. We saw an instance where a side room was not clearly labelled in line with infection control principles. A room where a patient had been diagnosed with an infectious illness had no clear signage on the doorway to identify there was an infection risk and to stop people from entering.

Disposable curtains with clear labelling were used within theatres. These labels showed when curtains should be changed. We saw the use of fabric curtains within wards between patient bed spaces. There was no indication as to when these curtains should be replaced. However, the trust have subsequently told us there was a replacement programme for fabric curtains.

Staff had access to personal protective equipment such as masks, face shields and gloves. There were sufficient quantities of antibacterial hand gels and washing facilities. The division monitored the availability of hand gel and reported 95% availability in March 2022. We observed staff were bare below the elbow in all areas we visited.

Equipment was not labelled to show when it was last cleaned. We did not see evidence that equipment was labelled to show when it was last cleaned. The trust told us they asked staff to clean equipment prior to use to ensure it was safe to use.

The service monitored hand hygiene audit compliance. Hand hygiene compliance was monitored as part of routine monthly audits. The audits showed compliance with hand hygiene audits was 91% within the surgery division from April 2021 to March 2022.

We requested evidence of environmental infection control audits from the trust but were only provided with hand hygiene audit compliance figures. The trust did not set a target for compliance with hand hygiene and instead promoted completion and compliance of the audit rather than the result.

We viewed standard operating procedures relating to environmental cleaning. For example, the environmental cleaning and preparation of theatre document related to all staff working in theatres throughout the service. It included suggested cleaning sequences. However, the document had no review date.

Staff used data to identify how well the service prevented infections. From November 2021 to April 2022 there were 51 hospital onset probable healthcare associated COVID-19 infections and 58 hospital onset definite healthcare associated

infections acquired on surgical wards. A hospital-onset probable healthcare-associated infection was defined as an infection where the first positive specimen was taken eight to 14 days after hospital admission with day of admission counted as day one. A hospital-onset definite healthcare-associated infection was defined as an infection where the first positive specimen was taken 15 or more days after hospital admission, with day of admission counted as day one.

The service monitored the incidence of infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. Diff), Methicillin Sensitive Staphylococcus Aureus (MSSA) and Escherichia Coli (E. Coli). From 1 October 2021 to 31 March 2022 there were seven hospital onset healthcare associated C.Diff infections and one MRSA infection reported on surgical wards.

Staff worked to prevent, identify and treat surgical site infections. Antibiotic use was monitored. The trust had access to antimicrobial stewards to monitor the use of antibiotics.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The service did not have suitable facilities to meet the needs of patients and their families. Areas within the hospital were being used outside of their intended purpose with a lack of mitigation, timely risk escalation and insufficient governance processes. Following the inspection, the service provided evidence that a number of operations avoided being cancelled by using facilities that were not designed to deliver ward based care. The trust told us the decision was made to prioritise procedures and understood patient experience was negatively affected as this environment was not designed to support this care.

There were no effective systems to identify when to open and close theatre recovery area and the surgical assessment unit for patients requiring ward-based care, in times of escalation. We reviewed the Patient Flow and Escalation policy, but this did not include the use of theatre recovery as a designated escalation area. Some patients were kept in recovery areas within the hospital for extended periods of time mainly due to a lack of beds within the rest of the hospital.

On the morning of the inspection we observed four patients had been cared for overnight in theatre recovery. We requested further data on how often patients were requiring overnight care in this area. We were provided with information which showed out of 151 days, there were 102 days in which patients stayed overnight. From December 2021 to May 2022, the longest stay of any patient in the theatre recovery being two nights. On one occasion, within that time frame, eight patients were being cared for overnight within the recovery area. Following the inspection, the trust told us from January to February 2022, the surgical division lost 60% of inpatient ward beds due to the volume of medical patients being cared for in surgical wards. This was related to the increase in need for medical inpatient beds as a result of the surge in the numbers of patients with COVID-19. During this time the surgical service continued to deliver elective operations for urgent procedures through the use of the theatre recovery areas to care for patients following their operations. The trust acknowledged the negative impact to patient experience during this time.

Staff had raised 252 incidents from November 2021 to April 2022 where patients had stayed overnight or where patients were discharged directly from recovery.

The recovery area was not suitable for patients to remain overnight as there was a lack of privacy and dignity. Toilet and washing facilities were not available within theatre recovery areas but were available on an adjacent unit. Staff accompanied patients to use these facilities to ensure they did not come to harm as a result of having to move between departments. The area had no visitor access, no natural light and no easy access to food or drink. Staff told us they were

trying their best within the circumstances but were upset as they were unable to give the rehabilitation that people required and provide a good patient experience. This impacted on staff morale and the flow of activity within theatres. The trust recognised the decision to use theatre recovery areas as inpatient wards had a negative impact on staff morale during this time and recognised the need for additional workforce.

The surgical assessment unit did not have sufficient space to accommodate the numbers of patients being seen. We observed patients waiting in landing areas by lifts outside the unit itself. This area was described as cold, cluttered and unwelcoming by patients. On the day of our inspection we saw one patient had been sat in a chair on the unit waiting for a bed to become available from 10.30am the day before.

In the surgical assessment unit patients occupying three beds had access to a call bell to raise an alarm in the event of a concern. However, not all patients in chairs had access to such alarms. Both male and female patients had access to one toilet. There was little privacy and dignity as chairs had a plastic screen separating them. As the surgical assessment unit accommodated both male and female patients daily and overnight there was a concern mixed sex breaches had not been considered nor reported.

On wards we heard of examples where patients were “boarding” (where an additional temporary bed space was created in a bay or in a ward corridor) but did not see examples of this at the time of the inspection. Most patients could reach call bells however, some patients within these additional beds had no access to a call bell, piped oxygen or suction. We were informed patients were risk assessed as suitable to being cared for in these areas and portable oxygen and suction was available. However, this practice appeared to have become “normalised” and not the exception, despite staff recognising the environment was not suitable for patients to remain for long periods.

Staff mostly carried out daily safety checks of specialist equipment. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure with tamper seals. Checks we reviewed were completed daily with the name of the staff member, date and their signature. However, we found some items to be past their expiration date so could not confirm how thorough these checks had been. On ward 2b we found saline solution which was out of date despite being documents being signed to say they had been checked the day before the inspection.

The service had enough suitable equipment to help staff safely care for patients. Staff did not report any shortages of equipment. Equipment used to safely lift patients had dates of the last and next service displayed and these were in date. Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not identify and act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients but did not always escalate them appropriately. The trust used the National Early Warning Score 2 (NEWS2) tool to identify deteriorating patients. However, we observed some patient care was not managed in accordance with guidance. We reviewed eight care records and found five did not have an escalation decision documented. We requested evidence of NEWS2 audits to ensure observations and escalation were audited against NICE clinical guidelines. However, the service provided a data report on the timeliness of observations rather than an audit. There was a risk, patients who become acutely unwell, would receive sub-optimal care.

Surgery

Staff did not always complete risk assessments for each patient on admission. An inpatient care report for the surgical division, showed poor compliance for the completion of risk assessments on admission. In March 2022 out of 1,393 patients, 561 (40.3%) did not have a nursing admission document completed within 24 hours of admission. Out of 596 patients, 219 (36.7%) did not have a falls risk assessment completed in full within 24 hours of admission. Out of 656 patients, 488 (74.4%) did not have a falls risk assessment completed within four hours of being transferred from another ward.

Staff did not always ensure patients received timely care to meet their needs and to maintain their safety. Patient observations were not always completed within specified timeframes. In March 2022, out of 31,222 patient observations (of at least four hours frequency), 6,492 (20.8%) were not completed within the specified timeframe. Out of 1,878 patient observations (of over 15 minutes and under four hours frequency), 976 (52%) observations were not completed within the specified timeframe.

In February 2022 the trust as a whole reported 87.1% of adult inpatients had received a venous thromboembolism (VTE) risk assessment which was lower than the trust target of 95%. We requested figures specifically for the surgical division, but these were not provided.

We saw deep vein thrombosis (DVT) risk assessments were documented on most medicine charts we viewed, and medicines were prescribed when required. However, we noted physical devices to reduce DVT risk were not prescribed or monitored in the relevant section of the medicine chart. We saw charts were blank where these items should have been recorded. This had been identified as an issue by the trust during a review of the processes to reduce the risk of DVT.

Staff knew about but did not always manage specific risk issues. Staff received training in sepsis recognition and management when first employed by the service. A sepsis care bundle was in use on surgical wards to support staff.

The trust did not provide sepsis performance data specifically for the surgical division. The trust as a whole was not meeting targets for sepsis identification and treatment. In April 2021 the trust reported 70% of emergency patients with severe sepsis were given antibiotics within one hour of diagnosis. This was below the target of 90%.

Staff undertook the World Health Organisation (WHO) ‘5 steps to safer surgery’ checklist in theatres and undertook audits to measure compliance. We saw staff consistently undertaking all five steps of the checklist during the inspection. The service used a healthcare information system to monitor completion of the checklist. This information system did not link with the other systems used by the trust and therefore staff had to duplicate the inputting of information.

In March 2022 27,525 patients had undergone surgery where checklists were needed. These were within general theatres at Cheltenham General Hospital (CGH), elective orthopaedics CGH, ophthalmology CGH and all theatres in Gloucestershire Royal Hospital, Head & Neck, Trauma and Orthopaedics, General surgery, Emergency and Obstetrics. Out of these patients one WHO checklist was not completed where a procedure had been undertaken.

In addition, spot check audits were completed in theatres to ensure compliance with the checklist. We viewed data from audits undertaken at Gloucestershire Royal Hospital dated September and October, but no year provided. The audit showed 100% of procedures included the completion of the WHO safety checklist. There was evidence of actions being taken where there were issues that could affect safety. For example, the ordering of name badges as not everyone was wearing one at the time of the audit.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). The psychiatric liaison team was available 24 hours a day.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included necessary key information to keep patients safe. There were arrangements for handovers to ensure important information was shared. Ward rounds were completed each day by a consultant. Staff completed safety briefs where all patients were discussed to ensure important messages were shared including risks, infection control issues and any other concerns.

Theatres undertook a "team ten" meeting each morning. This was attended by theatre staff and used to communicate important information for the day ahead. We attended a "team ten" meeting at Gloucestershire Royal Hospital and observed this was well attended by a range of staff. The meeting was well led and covered a range of topics such as safety messages, staffing, equipment and bed space.

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction.

The service did not always have enough nursing and support staff to keep patients safe. In January 2022 the trust as a whole had a 14.46% vacancy rate for registered nursing staff. This was much higher and therefore worse than the trust 5% target.

The service had high vacancy rates. In March 2022 the highest vacancy rate within the surgical division was within the upper and lower gastrointestinal service line, with a 23.09% vacancy rate for nursing staff. Trauma and orthopaedics had a nursing staff vacancy rate of 19.14% and theatres had a nursing staff vacancy rate of 8.22%.

The service had high turnover rates. In March 2022 the trauma and orthopaedics service line the turnover rate was 12.78%. Within theatres the turnover rate for nursing staff was 9.65%

Clinical nurse managers reviewed and adjusted staffing levels using a risk-based approach through the use of a nationally recognised safe care tool. Clinical nurse managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance and use of the speciality specific tools. The trust used safer staffing guidance to ensure there were enough staff on each shift. We heard from staff that they were regularly asked to move into areas where staff were needed, and managers moved staff to ensure there were limited gaps in staffing levels.

Staffing levels were discussed at site management meetings which were held throughout the day each day. The trust risk register noted as a low risk that patients could come to harm due to inadequate staffing.

Staff told us they felt there was not enough staff to care for patients safely. They felt any impact on patients was minimal because they worked hard to ensure patients' needs were met and they felt cared for. Staff told us that the impact of that extra workload was seen in staff morale. Staff felt recruitment and retention of staff had not been addressed. Divisional leaders acknowledged staffing was a national issue.

Surgery

Managers used bank and agency staff regularly but requested, where possible, staff already familiar with the service. They made sure bank and agency staff had an induction and understood the service. Records showed high levels of bank staff were used within the surgical service.

Within Gloucestershire Royal Hospital the areas where the most bank or agency staff were used were within the surgical assessment unit and emergency theatres. From October 2021 to April 2022 258 shifts on the surgical assessment unit and 297 shifts within emergency theatres were covered by bank or agency staff. We were told the same bank staff were used regularly so they were familiar with the service and they received an induction to the area they were working.

Medical staffing

The service did not always have enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. The service had high vacancy rates for medical staff. In March 2022 the highest vacancy rate within the surgical division was reported in the trauma and orthopaedics service line with a 12.92% vacancy rate for medical staff. The general surgery, upper and lower gastrointestinal service line had a 9.01% vacancy rate for medical staff. This was higher and therefore worse than the target of 5%.

In March 2022 the highest turnover rate for medical staff was within the head and neck service line of 14.08%.

Managers could access locums when they needed additional medical staff. We saw evidence the trust used locum medical staff where needed.

The service had a consultant on call during evenings and weekends. Anaesthetic medical cover was available 24 hours a day, 7 days a week at Gloucestershire Royal Hospital.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear but not always up to date. They were stored securely and mostly available to staff providing care.

Patient notes were not always complete, and not all staff could access them easily. Staff told us it could be difficult to get information due to records being contained within a mixture of paper and electronic records. Theatre staff did not use the electronic record system which meant workarounds were needed which increased duplication.

We saw examples where records such as risk assessments were incomplete, and data provided by the trust supported this evidence.

Records were stored securely. We saw records were kept securely within lockable drawers.

Medicines

The service did not always follow systems and processes to prescribe, administer, record and store medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff did not always complete medicines records accurately and keep them up to date. We saw prescriptions for emergency medicines were pre-printed on medicines charts. However, we saw clinicians were not authorising this prescription for patients who may require this. There was a risk emergency medicines would not be administered in a timely manner.

Staff did not always store and manage all medicines and prescribing documents safely. The trolley used to transfer medical gas cylinders from the hospital gas store was not designed for medical gas cylinders. The temperature of medicines requiring refrigeration was monitored, however, room temperatures where medicines were stored were not monitored. There was a risk medicines stored at room temperature were not appropriately managed.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff visited the ward from Monday to Friday. However, at weekends the pharmacy team only briefly visited the wards. A member of staff raised concerns that at weekends the pharmacy closed, before they had reviewed all their patients and amended relevant prescriptions.

Staff learned from safety alerts and incidents to improve practice.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. The service used an electronic record system to report incidents. Incidents were escalated depending on the level of harm that had occurred. The trust risk team supported staff in the investigation of serious incidents. Managers received notifications from this team if investigations were not completed in line with performance targets. However, staff told us they did not always get feedback on incidents and did not feel listened to when they raised concerns. Information about incidents was not shared with others to promote learning, including those that had the potential for harm.

Investigation reports showed that patients were invited to contribute to the investigation, were supported and apologised to.

The trust reported, in their April 2021 board papers, they had the highest number of never events within England. In documents produced following the inspection we saw from April 2021 to March 2022 the trust had the highest reported number of never events within the South of England with only three organisations reporting a higher number within England as a whole. The trust had reported seven never events from March 2021 to February 2022. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. All seven of these events related to surgery or surgical specialities. Incident themes included care to the wrong part of the body, or a wrong fixing used.

A quality improvement initiative had been set up to make improvements in care as a result of never events. The divisional director of quality and nursing worked with the trust wide safety team to arrange never events working

groups. We saw a change had been made to a process where teams were expected to stop before anaesthetic was given. A box had been introduced which slowed the process down to allow those involved in procedures to ensure the correct part of the body was being cared for. However, we saw no other improvements and therefore were not clear how effective actions had been and were concerned over the pace of the work.

Meeting minutes which stated there had been a concern over staff not attending meetings and not being engaged in the process and many working group meetings were postponed due to a lack of time and operational pressures.

The never event progress tracker showed updates were not being regularly provided on action. The tracker was not red, amber, green rated so it was difficult to determine what progress had been made within each project.

Managers did not always share learning about never events with their staff and across the trust. Not all staff within the surgery division were aware of the never events that had taken place and could not tell us of improvements that had been made as a result of learning.

Not all staff understood the duty of candour, but they told us they would be open and transparent and gave patients and families a full explanation if things went wrong. Staff we spoke with were not clear on the duty of candour and what this would mean for them.

Staff mostly received feedback from investigation of incidents, internal to the service. Staff told us feedback was given to them from incidents when they occurred in their ward or area of work, however, this often had to be requested. Managers told us incidents were discussed at team briefings, however, staff spoke about their frustration at the feeling no action was being taken as a result of incidents. Some staff said they felt there was little point in raising concerns as things did not change as a result.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, policies were not regularly reviewed.

Staff followed policies to plan and deliver care according to best practice and national guidance. Staff told us policies were easy to find. The surgical service provided care and treatment based on national guidance. This included National Institute for Health and Care Excellence (NICE), Royal College of Surgeons and the Association for Perioperative Practice (AfPP) guidance.

The surgical service had developed Local Safety Standards for Invasive Procedures (LocSSIPs) based on National Safety Standards for Invasive Procedures (NatSSIPs). However, we found procedures were not reviewed within their review date. We viewed 15 standard operating procedures relating to surgery services and found 14 to be missing a review date or overdue for review.

Surgery

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed staff discussing the psychological and emotional needs of patients during handovers and within the theatre environment.

Nutrition and hydration

Staff mostly gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasted before surgery. However, patients told us there could be long waits without food in areas such as theatre recovery and the surgical assessment unit.

Staff mostly made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used special hydration and feeding techniques when necessary and specific menus were available to provide for patients' religious and cultural preferences. However, we heard of patients in the surgical assessment and recovery units at Gloucestershire Royal Hospital waiting long periods of time for food and drink as these areas were not equipped to care for patients for the length of time they stayed there.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff accurately completed patients' fluid and nutrition charts where needed. There was evidence the malnutrition universal screening tool (MUST) was being used to assess nutritional needs. The records we reviewed showed, where appropriate to be used, these were completed accurately with MUST scores documented.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff monitored patients waiting to have surgery and reviewed the need for being nil by mouth if operating lists changed.

Pain relief

Staff assessed and monitored patients to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs. Staff supported those who could not communicate verbally through the use of suitable assessment tools.

Staff prescribed, administered and recorded pain relief accurately. Prescription charts showed pain relief was prescribed, administered and recorded accurately.

Patients did not always receive pain relief soon after requesting it. We were not told of any difficulties with receiving pain relief from patients during the inspection. However, feedback from patient surveys suggested pain relief was not always provided as quickly as patients would wish. Being in pain was a common theme of feedback through the friends and family survey.

Patient outcomes

Staff monitored the effectiveness of care and treatment and mostly achieved good outcomes for patients.

The service participated in relevant national clinical audits and outcomes for patients were positive and met expectations, such as national standards.

Surgery

The service participated in the 2019-2020 National Bowel Cancer Audit. The trust reported the number of unplanned readmissions to hospital within 30 days of treatment were in line with the national average. Unplanned returns to theatre within 30 days was in line with the national average.

Mortality rates after 90 days of treatment was in line with the national average. Mortality rates after 2 years of treatment was in line with the national average.

However, the trust reported 40.9% of patients undergoing rectal cancer treatment had unclosed ileostomies within 18 months of treatment as 40.9%. This led to the trust being a negative outlier in comparison with other trusts nationally. An ileostomy is where the small bowel (small intestine) is diverted through an opening in the tummy (abdomen). The service told us cases had been reviewed and the Quality Delivery Group within the trust had identified errors in the data which was reported. At the time of the inspection the trust was awaiting confirmation as to whether updated figures would influence the negative outlier finding.

In the 2019-2020 National Emergency Laparotomy Audit Gloucestershire Royal Hospital was in line or better than the national average for all but one key performance indicator for the 346 cases completed.

The trust carried out Patient Reported Outcomes Measures Surveys (PROMS). Patients were asked whether they felt better or worse after receiving specific operations. These included knee and hip replacements. From April 2020 to March 2021 there was a 90.7% participation rate which was better than the England average of 65.2%. Figures for hip and knee replacements showed the trust was in line with the national average in these measures.

The service had a higher than expected risk of readmission for both elective and non-elective care than the England average. For the time period August 2020 to July 2021 trauma and orthopaedic patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England average.

Competent staff

Managers mostly appraised staff's work performance and held supervision meetings with them to provide support and development. The service made sure staff were competent for their roles however, there was inconsistency over the monitoring of competencies.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave new staff an induction tailored to their role before they started work. Staff reported they received an induction process to help orientate them to their place of work. A piece of work had commenced within one service line to use a specific induction booklet for staff.

Managers mostly supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers appraised staff work performance on most wards and theatres we visited. Evidence showed staff had received appraisals or meetings were arranged for staff appraisals. However, appraisal compliance was falling short of trust targets.

Surgery

Overall, within the surgery division there was a 78% appraisal compliance rate. This was below the trust target of 90%. Seventy-nine percent of nursing staff within the surgical division had completed their annual appraisal. Ninety-one percent of consultants had received an appraisal but only 70% of allied health professionals had received one. We were told appraisal completion had been impacted by the COVID-19 pandemic and the stop on all non-essential meetings. The service was hopeful this would improve.

Clinical educators supported the learning and development needs of staff. Clinical educators were available within the surgery division. However, their time had been taken up by undertaking clinical work, especially during the COVID-19 pandemic and this had impacted upon their ability to provide training and support to staff. Funding for educator posts was also due to be reviewed at the time of the inspection so staff were not sure if the role would be able to continue.

Managers did not make sure staff attended team meetings. Team meetings had been affected by the COVID-19 pandemic and were not taking place during that time. Staff reported this had a negative impact upon team building and cohesion.

Managers did not always make sure staff received specialist training for their role. There was limited evidence of competency frameworks to monitor, record or assess the skills of staff. We were told numerous competencies were in place however, there was a mixed response from staff as to when competencies needed to be assessed and reviewed. There was also a concern staff moving between wards did not have the specific competencies for the care they were expected to provide.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed meetings where members of the multidisciplinary team worked well together for the benefit of patients. These meetings were calm and organised and included discussion of items all staff needed to know.

Staff referred patients for mental health assessments when they showed signs of mental ill health including depression. Staff had access to the psychiatric liaison team 24 hours a day and would contact them if there were concerns regarding the mental health of a patient.

Seven-day services

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

Consultants led daily ward rounds on surgical wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, there was a shortage in the number of radiographers available. There was currently one radiographer allocated to orthopaedic theatres. We were told patients were sometimes left waiting for a radiographer despite lists being monitored to avoid clashes. No radiographer was in attendance at the “team ten” meeting we observed at Gloucestershire Royal Hospital theatres.

The pain team were available Monday to Friday. Anaesthetic medical cover was available at Gloucestershire Royal Hospital 24 hours a day, seven days a week.

The dementia and learning disability liaison nurses were available Monday to Friday, 9am to 5pm. The psychiatric liaison team was available 24 hours a day.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Leaflets were available to patients on wards. We saw displays and posters promoting healthier lifestyles on a number of wards we visited. For example, support to stop smoking and the importance of a good diet.

Staff assessed each patient's health and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We were provided with data to show the numbers of staff who had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). However, these figures did not contain the percentage of staff who had completed training, so we were unable to say if all staff were up to date with this training.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff told us they were able to ask for support around deprivation of liberty safeguards and the Mental Health and Mental Capacity Acts from leaders and also from the trust safeguarding adult hub.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. The trust had introduced new mental capacity assessment documentation. In January 2022 a new DoLS documentation audit had commenced. This was supported by the trust safeguarding adult hub, trust dementia care admiral nurse and trust learning disability liaison nurse team.

Managers monitored the use of Deprivation of Liberty Safeguards and were making improvements to make sure staff knew how to complete them. A bi-monthly report on DoLS activity was undertaken by the trust safeguarding adult hub. From January to March 2022 42 applications for the authorisation of deprivation of liberty safeguards were made within the surgical division. The report acknowledged it was highly likely that actual application need was significantly higher than was recognised or achieved within practice.

The trust safeguarding adult hub had completed an audit of capacity assessment documentation and deprivation of liberty safeguards (DoLS) needs assessment documentation at the end of 2021 and beginning of 2022. Fifteen records were audited across both the medical and surgical divisions within the trust. The audit found 10 out of 15 records documented the assessment of capacity to consent to current care and treatment arrangements. In 11 out of 15 records showed a DoLS application was made where considered appropriate. However, not every patient with a DoLS application had a documented assessment of decision specific capacity recorded.

Surgery

The audit also noted care teams were likely to request a member of the medical team to complete the capacity assessment which could cause delays. Development points were noted on the audit, but no action plans were provided by the service to understand how improvements would be made.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions between staff and patients to be positive, encouraging and kind. Patients on wards told us staff used curtains to respect their privacy especially when they were completing ward rounds although it was still possible to hear conversations at times.

Patients said staff treated them well and with kindness. One patient told us they "could not fault the staff" who they found to be "attentive". Another told us their care had been "fabulous". Patients told us they were treated well, and staff were doing the best they could in difficult circumstances. Another patient told us "we are in difficult times" and staff were "making the most" with what they had.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients. We observed interactions between staff and patients which demonstrated an understanding of the anxiety people faced when undergoing surgery. We saw staff communicate clearly to patients who were concerned and explained procedures to them in a clear way.

Staff understood and respected the personal, and social needs of patients and how they may relate to care needs. We were told patients who identified as gender neutral or transgender were given a choice over which ward, they would prefer to stay on. Staff were respectful of people's needs in this respect.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal and social needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff speaking with patients in a supportive and helpful manner. Staff told us despite being under pressure they tried to do the best they could for patients in difficult circumstances.

Staff appreciated the distress having surgery could cause and were conscious to provide as much advice and assistance as they could.

Surgery

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients told us it was difficult having only one visitor at a time due to visiting restrictions. Staff were conscious of this and supported individuals to contact those close to them. We observed an interaction on one ward where an individual had returned from an operation. Staff had made contact with the individual's family in a timely way and explained the outcome of the procedure. This appeared to reassure the patient.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure patients and those close to them understood their care and treatment. One patient told us staff were open to answering any questions they had, and doctors especially had communicated clearly to them in a way they could understand. However, feedback from some patients highlighted that communication could be improved in terms of why they were waiting and when they were likely to receive treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The staff within the theatre recovery unit at Gloucestershire Royal Hospital had completed a "patient feedback snapshot audit" throughout February 2022. This was undertaken as staff recognised patients were being cared for over long periods of time in an unsuitable environment.

Staff wanted a better understanding of the patient experience within these areas and supported patients to give feedback. Twenty-six out of 65 patients who had been provided with an overnight recovery bed due to a lack of surgical bed responded to the survey.

Patients were asked "what has your experience been like in recovery and how has that made you feel", "what patient services are missing in recovery" and "what could be improved"? The feedback described staff as "excellent and professional", "helpful, kind and attentive" and "compassionate". However. patients also reported concerns over the lack of privacy in these areas, an inability to have visitors and a lack of toilet facilities.

Patients reported nurses were "very kind and lovely", "brilliant" and "excellent" however, they also reported that the environment was "frightening", "cold" and "listening to doctors discussing what they had been doing in the operating theatre was very scary".

Patients mostly gave positive feedback about the service. The surgical division gathered feedback from patients and their families through the use of the friends and family test. We were provided with an overview of this feedback from February 2022. The surgical division asked patients "overall, how was your experience of our service". The feedback captured responses from 2,962 patients. 74.5% of patients reported their experience was very good and 16.7% responded that their experience was good. Positive themes from the feedback included "compassionate staff", "friendliness" and "emotional and physical support" being given. However, patients reported being unhappy at waiting times, being in pain too long and gaps in communication.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Surgery

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The trust was involved in consultations with the wider health and social care system within Gloucestershire. The "Fit for the Future" programme was part of the "One Gloucestershire" vision. The vision included the medium- and long-term future of specialist hospital services across both the Cheltenham General and Gloucestershire Royal Hospital sites. This related specifically to surgical services as it included plans for elective and emergency surgery and where they would take place.

The service did not report breaches for mixed sex accommodation. For the period April 2021 to March 2022 the trust as a whole reported one mixed sex accommodation breach in August 2021. We saw evidence that within theatre recovery units and the surgical assessment unit there was no facility to provide separate areas for male and female patients. Patients were regularly remaining overnight in these areas.

Incident reports demonstrated in within Gloucestershire Royal Hospital theatre recovery there were 102 days out of 151 days where patients stayed overnight.

We were provided with a draft standard operating procedure for the admission of patients to theatre recovery areas when ward-based care could not be provided. The document did not include consideration of mixed sex accommodation of patients who stayed overnight. There was therefore a concern that not all mixed sex breaches had been identified and reported in line with trust policy.

Only one bathroom was provided in the surgical assessment unit which accommodated both male and female patients. Again, this was not reported as a breach of mixed sex accommodation policy when patients stayed overnight.

Since the inspection the trust told us historically, mixed sex accommodation breaches had been deemed non-reportable when the trust escalation status was at level three or four. Breaches had been not reported for an extended period as the trust escalation status had remained at those levels. The trust told us they had altered the reporting framework to give oversight of breaches at all times, regardless of escalation status. We were told all breaches, categorised in accordance with national guidelines, would be authorised by the Chief Nurse or Deputy Chief Nurse. Following the inspection, we saw trust board papers which reflected mixed sex breaches were being reported. Figures rose from two to 22 breaches in April 2022.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. However, due to pressures on the service and environment reasonable adjustments were not always able to be made for patients living with dementia or a learning disability.

Wards were not designed to meet the needs of patients living with dementia or a learning disability. Some surgical wards we visited were cluttered and not designed to accommodate patients living with dementia or a learning disability. However, we did see evidence of individual staff creating display boards to support people to familiarise themselves with the hospital. For example, we saw displays which had pictures of staff uniforms so people could identify the uniforms of different grades of staff.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw the 'This is me' tool being used for patients living with a learning disability on wards.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us there was access to interpreting services for patients whose first language was not English. We saw evidence of the trust monitoring the need for interpreting services and ensuring they had sufficient availability.

The service had information leaflets in languages spoken by patients and local community. The service had access to a range of information leaflets for patients to read about a variety of conditions and support services. However, there was no easy way to access these leaflets in a range of different languages. This included through the hospital website.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff told us they could use communication boards and other aids to support people to communicate.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Patients could not always access services when needed and did not receive treatment within agreed timeframes and national targets. However, managers monitored waiting times. In line with national trends following the COVID-19 pandemic, the trust's elective waiting list had increased and was around 13% higher in December 2021 than in July 2020.

The standard was for no patient to wait longer than 52 weeks for treatment. In March 2021 there were around 3,500 patients waiting more than 52 weeks for treatment. However, this had fallen to 1,900 in December 2021. The number of patients waiting more than 52 weeks for treatment had continued to fall in January 2022. Therefore, the trust was making improvements in the numbers of patients waiting for treatment over long periods of time.

The trust had not been able to meet the 92% target for patients receiving treatment within 18 weeks from referral; though performance had been gradually improving over time. In the 2021/22 period referral to treatment ongoing pathways under 18 weeks was reported as 72.33% which was below and therefore worse than the national standard of 92%.

The trauma and orthopaedics service line reported 54.22% of patients received treatment within 18 weeks of referral in January 2022 which was much worse than the 92% standard.

The service had not minimised the number of surgical patients on non-surgical wards. Numbers of patients being cared for with surgical needs on non-surgical wards were monitored by the trust. When this happened, the service referred to these patients as being within "outlying" wards. We requested data from the service on the number of "outlying" surgical patients on non-surgical wards but were only provided details on the number of medical patients "outlying" on surgical wards. In January 2022 the daily average number of medical patients in surgical beds was 90, in February 2022 the daily average was 94 medical patients in surgical beds. Staff told us this had a negative impact upon staff and patients as they were not able to provide specialist care for patients who were being cared for away from the surgical speciality they needed.

There was frustration amongst staff due to a lack of flow within the hospital as a whole. There had been increased demand on emergency departments and the medical divisions which impacted upon surgery as surgical bed spaces were used to care for medical patients. Staff told us they felt elective patients were often waiting for long periods of time due to inefficiencies within the flow of the hospital.

Surgery

Managers had arrangements for surgical staff to review any surgical patients on non-surgical wards. Consultants knew where patients were located within the hospital and made arrangements to review these patients on a daily basis. However, surgical beds were being used for medical patients which led to surgical patients "outlying" in medical beds and specialties not related to their condition. Staff told us ward rounds were not efficient enough and took long periods of time which impacted on the time they had with patients. Consultants reported feeling they were on "safari" having to search for patients within the hospital which was inefficient and created additional stress.

When patients had their operations cancelled at the last minute, managers did not make sure they were all rearranged as soon as possible and within national targets and guidance. Data showed that cancelled patients were not always offered another date within 28 days. From April 2021 to March 2022, 790 operations were cancelled 107 of these operations were classed as urgent. Eighty-two percent of patients were readmitted within the target of 28 days. This was below and therefore worse than the national standard of 95%. The trust board report highlighted the re-booking of patients as a challenge and noted staff sickness and bed capacity to be the reason for the difficulty.

Managers worked to ensure theatres were being utilised efficiently. The service reported a theatre utilisation rate of 87% which was better than the standard of 85%. The service planned to use an NHS Improvement model described as a "6-4-2" process where surgical staff agreed their annual leave six weeks in advance, agreed surgical lists four weeks in advance, and checked plans two weeks ahead. However, we were told meetings related to theatre efficiency had not been held for some time. Staff reported being frustrated with changes to operating lists, however, we were told there was currently a lack commitment to the model. The trust told us the divisional director of operations had led engagement sessions in January and February 2022, with operational managers and nursing representatives to discuss bed allocations per specialist to reduce list changes.

The theatre utilisation working group had been postponed during the COVID-19 pandemic but recommenced in February 2022 to ensure theatres were being used efficiently. A new general manager for theatres had recently been appointed. They continued to support this group. Plans were being made for the general manager to speak with each speciality director to understand the demand and capacity in each service line and how theatres could support each speciality.

Managers monitored waiting times and made sure patients could access cancer treatment services when needed and received treatment within agreed timeframes and national targets. The service was proud of its ability to maintain standards in relation to cancer treatment waiting times throughout the COVID-19 pandemic when this had been affected at a national level.

The trust was above and therefore better than the national average for all cancer waiting time standards. There was an increase in suspected cancer referrals. In 2020-21 there were 22,029 referrals compared with 26,581 referrals in 2021-22. The trust saw 24,673 patients out of 26,581 patients within 14 days of their referral. This represented 92.8% of patients. The trust treated 97% of new patients with a cancer diagnosis within the 31-day standard. This was better than the standard of 96%.

Managers and staff worked to make sure patients did not stay longer than they needed to. The length of stay for surgical patients was better than the England average of 5.06 days. From January 2021 to March 2022 there were 53,888 surgical admissions. During this time the average length of stay for inpatient elective surgical patients was 2.6 days which was better than the national average. For inpatient non-elective patients, the length of stay was 4.2 days which was better than the national average.

Managers and staff started planning each patient's discharge as early as possible. We saw evidence discharge was discussed when patients were admitted. However, we saw evidence of times where patients were discharged from recovery units due to a lack of bed space within the hospital. Patients were often cared for overnight in recovery when a bed could not be provided on a surgical ward. This impacted upon individual rehabilitation programmes and provided a poor experience for patients as they were being cared for in areas not intended for inpatient stays.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. However, not all complaints were responded to in line with trust targets and staff were not able to tell us how complaints had been used to improve services.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with felt confident they would be able to raise a concern if they needed to. One patient told us they would use the internet to determine how to complain if necessary.

The service displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us they felt confident in being able to deal with complaints and would try to resolve them at the time of being raised or passed on if necessary.

We reviewed the guidance for lead investigators whose responsibility it was to respond to complaints. This was likely to be the clinical or nursing lead. This included finding out if the actions of the staff were appropriate and if not, what action should have been taken at the time and will be taken to reduce the risk of and/or prevent a recurrence of the issue that gave rise to the complaint.

The trust had piloted an early dispute resolution process at the time of the inspection. We were provided with details of this. The process included, where appropriate, the offer of a meeting with the divisional director of quality and nursing. It was expected this would be used for complaints where the issue was poor patient experience or staff attitude.

Managers investigated complaints and identified themes. The trust adopted a new process to respond to complaints in February 2022. Each speciality leadership team formulated complaint responses with senior directors signing off serious complaints.

The service monitored the numbers of complaints and analysed these on a quarterly basis. This information was shared with the surgical quality board.

The trauma and orthopaedics service line received the highest number of complaints within the surgery division in October 2021 and January 2022. An improvement plan was to be reported by the service line at the next service line review. However, we did not see evidence of this plan.

Themes from complaints included attitude of staff, waiting times, care issues and communication.

Patients received feedback from managers after the investigation into their complaint. Patients were involved in the investigation of complaints. In March 2022, 60% of standard complaints were closed within the trust target of 35 days. Eighty percent of serious complaints were closed within the trust target of 65 days.

Surgery

Managers told us they shared feedback from complaints with staff. However, staff could not give specific examples of how patient feedback had been used to improve daily practice.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders mostly had the skills and ability to run the service. Leaders did not fully understand and manage the priorities and issues the service faced. Staff did not feel all leaders were visible and approachable in the service for patients and staff. Not all staff felt supported to develop their skills and take on more senior roles.

The surgical division was led by a chief of service, a divisional director of quality and nursing and an operations manager as well as deputies for each role. This leadership style was referred to as a triumvirate. The triumvirate was supported by each speciality team which included a speciality director, a matron and a general manager.

Staff expressed negative views regarding visibility of leaders, how approachable trust executives were, and the transparency of processes followed by divisional leaders. Theatre and recovery staff told us they had never seen a member of the trust executive team in the department. Staff said they considered local leadership and management teams to be accessible, responsive and supportive. Divisional leaders provided evidence of a timetable of visits made by the executive team. They had visited theatres and surgical assessment areas and the divisional triumvirate completed walkabouts within departments. However, most staff said they rarely saw senior staff above matron level.

Matron and manager level staff were described as being drained due to a lack of support and confusing demands from divisional leaders. During the inspection there were many leaders we spoke with who had recently been appointed or were stepping into new roles as individuals had left the service.

Leaders did not manage the priorities in a way which reduced pressure and assisted staff treating patients within theatres, recovery areas or wards. We were told of examples where staff were pressured to achieve targets or standards without support from those above.

Staff had raised concerns regarding staffing, low morale and did not feel they were listened to. The chief of service was aware of issues affecting the service and had a desire to make improvements. However, it was unclear how action would be taken to address this across all specialities. A theatre transformation senior matron had been employed to support theatre workforce, culture, patient safety, leadership and development.

Staff felt certain roles were undervalued such as healthcare assistants. Due to the complexities of the role within surgery some felt unrewarded for the skill level needed. We saw documents which suggested some roles should be graded more highly and this was escalated. However, staff told us there had been a limited response from leaders as to what changes would be made.

Most staff told us they were supported to develop within their roles and had opportunities to discuss development. However, not all staff received regular appraisal and career development conversations.

Surgery

Vision and Strategy

The service had set objectives for what it wanted to achieve in the 2021-22 financial year however, there was no clear strategy to turn it into action.

The trust had strategic objectives that were set from 2019. The objectives were: outstanding care, compassionate workforce, quality improvement, care without boundaries, involved people, centres of excellence, financial balance, effective estate, digital future and driving research. At the time of the inspection the trust was three years into a five-year strategy.

The service had set objectives for what it wanted to achieve as a surgical division in the 2021/22 financial year. The objectives were based on five year plans developed by each service line. However, there were no clear strategies as to how to turn these aims into action nor how progress would be monitored.

Divisional leaders had undertaken an away day to discuss an internal review of governance processes which had taken place in 2021. We were provided with evidence that ambitions were recorded, for example to "take a strategic view of what the division as a whole needed to achieve". However, the evidence we were provided with gave no indication as to what action would be taken to achieve this and how those actions would be monitored.

Staff were not clear as to why decisions about services were made and felt they had little opportunity to affect change. Staff were unhappy at the numerous movements of wards throughout the trust and felt there was no overarching plan or rationale behind these moves. These moves were described as unsettling staff and patients and caused confusion.

Staff we spoke with were not aware of the trust values.

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care but were not always able to deliver the level of care they needed. Not all staff felt the service had an open culture where staff could raise concerns without fear.

Poor morale and perceived bullying, incivility and concerns around retribution were highlighted during the inspection. Members of staff who spoke with us identified a concern around speaking up for fear of reprisal.

Staff told us there was a "top down" approach to management which felt punitive if performance targets were not reached. However, it was felt there was little support offered to manage performance and to influence factors that were not within their control. Leaders told us the executive team were informed of escalation through executive reviews, divisional board and risk management group meetings.

Staff felt pressured into ensuring targets were met without an understanding by leaders as to why quality was being affected. Staff told us emails and escalation about care, the environment and patient experience were not responded to by leaders.

Staff were described as demoralised and felt there was an acceptance of low standards in order to meet targets. Divisional leaders told us they felt they had tackled poor behaviours and incivility directly and encouraged staff to report incidents formally. However, staff felt individuals demonstrating poor behaviour were not challenged. We heard of examples where incivility and unacceptable behaviour were accepted.

Surgery

Managers described their staff as being tired and "broken" with constant change adding to the pressure. The lost social aspect of face to face meetings was highlighted as a concern as most meetings were virtual and led to a lack of team building and a sense of community. Following the inspection, the division recommenced face to face divisional board meetings from June 2022 and service line reviews from July 2022.

There was a lack of trust amongst staff and fear of speaking up. We heard when staff did raise concerns they were not always supported or treated with respect. Some staff told us they had tried repeatedly to raise concerns and due to lack of or negative responses, eventually they had become disengaged and focused instead on day-to-day service provision.

Following our inspection, 12 members of staff contacted us, some anonymously, to discuss concerns. We were told there was an over focus by management when things went wrong and a lack of celebrating staff when things went right. Direct managers were not given support by those above them including feedback which led to them feeling a lack of confidence that they were being listened to. However, the surgery division took part in the "Going the Extra Mile" (GEM) awards. Individual team members could nominate their colleagues for these awards. We saw evidence of awards being given in 2021 for staff going above and beyond in their roles. We saw where whole teams had been nominated for GEM awards for the care they had provided. An electronic newsletter for the surgery division highlighted thank you letters from patients and where gratitude for care had been given.

Governance

Leaders did not operate effective governance processes. There were governance processes, but these were not effective in gaining full assurance, improving or developing the service. Managers were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Not all levels of governance and management functioned effectively.

In May 2021 the surgery service had undergone an internal review of its governance arrangements. This review found concerns over the lack of clear guidance around divisional governance including trust expectations on meeting terms of reference, frequency of meetings and escalation of concerns. As a result of this review a reconfiguration of governance took place within the surgical division in June 2021. The divisional leadership team worked with service line teams and refined the terms of reference, agenda and report formats for service line reviews and surgical quality board which then informed the divisional board.

Governance processes consisted of a trust executive review which was informed by the surgery divisional board. This board received information from the surgical quality board and each service line reported on a monthly basis.

At the time of the inspection each speciality undertook a monthly service line review. This meeting involved discussing safety, quality measures, performance, workforce, finances and service development. We reviewed these service line reviews and found incomplete documents. Some templates had not been completed in full and consisted of prepopulated sentences which had not been updated with the information requested. There was no evidence provided of the depth of the discussion or scrutiny within the review. Documents we viewed lacked enough detail to show what action was being taken in relation to areas of poor performance and whether there was any support or challenge provided.

Governance processes for the monitoring of procedures and policies were not effective. We found standard operating procedures for theatre care and treatment were out of date or overdue review. There were seven reported never events

from March 2021 to February 2022 relating to surgery or surgical specialties. We requested and received 15 standard operating procedures relating to theatre practice. Out of 15 documents we reviewed 14 were overdue for review or did not have a review date stated, this included the local anaesthetic 'stop before you block' process which was relevant to two of the never events which had occurred.

Staff told us of perceived ineffective arrangements for monitoring, managing and reporting on quality and performance. Due to lack of administrative support and duplication in systems we were told staff did not feel data could be relied upon. This had been escalated to information teams within the trust.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify effective actions to reduce their impact. Staff reported a lack of oversight and collaborative working from trust wide leadership.

The system to manage, identify, document and understand risk did not capture all clinical and patient risks. We reviewed the risk register for the surgical division. On the 7 February 2022, there were 117 surgical risks on the risk register; compared to 112 risks in the previous reporting period. Of these risks, 45 were at speciality level, 70 were at divisional level and two were on the trust risk register.

The service did not take timely action to mitigate risks to patients receiving ward-based care in theatre recovery areas. At the time of inspection there was an entry on the surgical divisional risk register relating to the risk to quality of care of patients remaining in theatre recovery areas when they required ward-based care. This risk was first entered on the risk register in 2018. There were no open actions documented for the ongoing mitigation of risk or evidence of escalation. The service did not provide us with an audit history of this risk register entry.

Following the inspection, the risk had been escalated and accepted onto the trust risk register which was presented to the trust board on 12 May 2022. There was a concern that risk was not being managed effectively and in a timely manner.

The service did not take timely action to mitigate risks to patients in certain areas within the hospital. The surgical assessment unit (SAU) did not have sufficient capacity to accommodate the volume of patients it was caring for, nor did its facilities meet the needs of the patients using the service. Patients were "boarded" within the SAU and within the corridor spaces outside of the unit. On 14 April 2022 we saw one patient cared for in a chair who had been waiting for a bed since 10.30am the previous day (13 April 2022). Not all patients had access to a call bell. Both male and female patients had access to one toilet. At the time of inspection and confirmed during an interview with the surgical directorate risk representatives, the issue did not feature on any risk register.

Leaders did not have oversight of whether staff followed processes to assess and monitor patients and to take action if their condition deteriorated. We found evidence that NEWS2 scores were not being escalated in a timely way which could impact on patient safety. There was no audit of NEWS2 documentation at the time of the inspection.

Staff told us despite raising and escalating concerns it was felt that action was not taken to mitigate risks. They did not feel like partners in the management of risk and were unsure of what risks were currently on the risk register.

Surgery

Information Management

The service collected data but did not always analyse and act on it to make improvements. Staff could not always find the data they needed, in easily accessible formats, to understand performance, and make improvements. The information systems were not always integrated. Data was submitted to external organisations as required.

The service submitted data to external bodies as required. These included national audits such as the National Bowel Cancer audit and the National Emergency Laparotomy Audit. This meant the service was able to benchmark performance against national outcomes. However, there was limited evidence managers and staff used results of national audits to improve patient outcomes. We requested evidence from the service on how they used audit findings to make improvements, including action plans but were not provided with this information.

The service used a healthcare information system to monitor compliance such as the World Health Organisation surgical safety checklist. This information system was not integrated with other systems used by the trust and therefore staff had to duplicate the inputting of information.

Theatres were not using electronic patient record systems at the time of the inspection. Therefore, workarounds were being used to ensure information was passed on and managed safely.

There was no dedicated deprivation of liberty safeguarding (DoLS) document within the electronic patient record to record patient DoLS activity. This information was therefore not easily visible to clinical teams. There was a risk DoLS application history would become lost within documentation. This issue had been escalated to the trust safeguarding adult lead.

During the inspection process the service was not able to provide a number of pieces of evidence requested. Staff told us there was a concern information was not being managed effectively and that staff could not access information easily and efficiently.

Engagement

Leaders engaged with staff and patients to plan and manage services. Staff did not always feel included or engaged with decisions made by senior leadership.

Leaders engaged externally with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. There had been extensive public consultation regarding the fit for the future programme involving both Cheltenham General Hospital and Gloucestershire Royal Hospital.

Communication and engagement with staff needed to improve. Staff told us they did not feel actively engaged in the planning and delivery of services and did not feel included with decisions that were being made.

A staff survey was completed in 2021. Results showed there had been a deterioration from previous years. The areas where results had deteriorated the most were within the questions; “my manager encourages me at work”, “there are enough staff at this organisation for me to do my job properly”, “I would recommend my organisation as a place to work” and “if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”.

Staff told us they felt disengaged from senior level management due to feeling repeatedly like they had not been heard. Managers did not feel they had feedback, and this had caused a disconnect between wards and the board.

Team meetings had been affected by the COVID-19 pandemic and were not taking place during that time. Many meetings had not returned to being face to face. Staff reported this had a negative impact on team building and cohesion. We saw evidence of local initiatives to increase staff engagement. This included a "staff shout out" document which was designed to be used to give staff key messages and highlight good practice within theatres.

The service collected data from patient surveys, and Friends and Family Tests (FFT) to help improve service provision. We saw patient surveys were used to gather information from patients in specific areas such as recovery units. Friends and Family Test results were monitored as a division. The results showed 74.5% of patients reported their experience was very good and 16.7% responded that their experience was good. We saw actions had been agreed as a result of feedback from the patient survey including pathway journey posters and exploration of alternative approaches to gaining feedback from patients with cognitive impairments.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services, however due to operational pressures this had not been a priority for staff within the service. Leaders had a good understanding of quality improvement methods; however, we saw little evidence of sustained change and improvement. Leaders were proud of the use of new technology within the service.

Staff were committed to continually learning and improving services however, due to operational pressures this had not been a priority for staff within the service. We met a number of committed and passionate staff and managers who desired to make improvements for patients and staff.

The service was passionate about quality improvement but there was little evidence of sustained change taking place as a result of initiatives. The service provided a list of quality improvement projects which had been started throughout 2021 however, there was no ability to track the progress of these projects and no outcomes noted to demonstrate the improvement that had been made.

The trust was approaching the review of never events through a quality improvement methodology. There had been investment in quality improvement methodology training to support this approach. A gold quality improvement trained individual was attached to each working group. However, the work was not being undertaken at pace and was not leading to the prevention of never events. We were provided with the never event tracker, but this did not show clear progress had been made and several working groups had stalled due to a lack of engagement.

Staff and leaders were enthusiastic and proud of their use of robotics within surgery for gastrointestinal, urological and colorectal procedures. Gloucestershire Royal Hospital was one of the first NHS hospitals in England to use mobile surgical robots for operations on the stomach and gallbladder. We saw evidence other hospitals throughout the UK had shown interest in watching live procedures being undertaken. The robots were benefiting patients by being more accurate and precise than the human hand and procedures were less likely to result in complications.

Cheltenham General Hospital

Sandford Road
Cheltenham
GL53 7AN
Tel: 08454224721
www.gloshospitals.nhs.uk

Description of this hospital

Gloucestershire Hospitals NHS Foundation Trust provides surgical services to patients in the Gloucestershire area. Surgical care is provided at two hospital sites, Gloucestershire Royal Hospital and Cheltenham General Hospital. All surgical services across both sites are managed by one surgical division. Data was provided by the trust at divisional level and related to both locations. Therefore, information will be similar within both location reports. The surgical division consists of six service lines:

- Trauma and Orthopaedics; trauma, orthopaedics and orthotics.
- Head and Neck; oral maxillofacial, ears nose and throat, orthodontics, and audiology.
- Ophthalmology; ophthalmology, orthoptics, optometry, diabetic retinal screening and medical photography.
- General Surgery; urology, breast, vascular, upper gastrointestinal, colorectal, bariatric, urology and abdominal aortic aneurysm screening.
- Theatres; theatres and day surgery.
- Anaesthetics; anaesthetics, chronic and acute pain, pre-assessment, acute care response and critical care.

We carried out this unannounced inspection of surgery because of a high number of never events reported by the trust and information of concern we had received about the safety and quality of the service.

Our rating of this location went down. We rated it as inadequate because:

- Not all staff had training in key skills. Infection control was not always managed well. The design, maintenance and use of facilities, premises and equipment did not always keep people safe. The service did not always have enough staff to care for patients and keep them safe. Staff did not always assess risks to patients, nor act on them. Staff did not always manage medicines well. Care records were not always kept updated. The service managed safety incidents but did not always learn lessons.
- There was a mixed approach to monitoring the renewal of competencies with limited oversight of the competency of staff. Policies were not always reviewed. People could not always access the service when they needed it and waited too long for treatment.
- Leaders were not always visible to frontline staff. The service had set objectives for what it wanted to achieve in the 2021/22 financial year. However, there were no clear strategies as to how to turn these aims into action nor how progress would be monitored. Not all staff felt respected, supported and valued. Staff did not feel they could raise concerns in a safe way.

Our findings

However:

- Managers monitored the effectiveness of the service and mostly achieved good outcomes for patients. Staff advised patients on how to lead healthier lives and supported them to make decisions about their care. Most key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and provided emotional support to patients, families and carers.

Following the inspection, we issued a section 29a warning notice to the trust as we found significant improvement was required to surgical safety, leadership, risk management and governance.

Surgery

Inadequate ↓↓

Is the service safe?

Inadequate ↓↓

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training but not all staff had updated it and leaders did not make sure everyone completed it. The training offered was comprehensive.

Mandatory training was offered but not all staff had completed it. Records showed overall compliance for all staff within the surgery division was 85%. Nursing staff compliance was 87%, medical staff compliance was 78% for consultant doctors. However, 55% of training grade doctors were compliant. This was not in line with the trust target of 90%.

Mandatory training subjects were comprehensive and included basic life support training, However, training compliance for this subject was 72% for all staff within the surgery division.

The electronic computer system which monitored training rates sent alerts to staff to remind them to complete mandatory training when modules were due. Mandatory training was monitored and discussed by each speciality during service line reviews. However, we saw no evidence as to how the service was going to improve compliance within service line review documents.

Managers told us during the COVID-19 pandemic mandatory training compliance had become difficult to ensure due to the reluctance for people to deliver and attend training face to face and the necessary reduction in numbers of people who could attend.

Safeguarding

Not all staff had received training on how to recognise and report abuse. However, staff understood how to protect patients from abuse and told us how they raised concerns.

Staff received training specific for their role on how to recognise and report abuse, however, not all staff had completed this. Data confirmed 97% of staff had completed level one safeguarding adults training, 90% level two safeguarding children training and 93% level one safeguarding children training. However, 83% had completed level two safeguarding adults training and 71% in level three safeguarding adults training. It was unclear if registered staff were included in the numbers of staff expected to complete level three safeguarding adults training in line with latest guidance Adult Safeguarding Roles and Competencies for Healthcare Staff.

Staff showed a good understanding of the trust's safeguarding policy and could give us examples of when they had reported a safeguarding concern.

The trust had a safeguarding adults hub where staff could gain advice or guidance on specific concerns and staff were aware of this hub. There was a trust wide safeguarding adults operational group and a specialist lead nurse in safeguarding adults.

Surgery

Cleanliness, infection control and hygiene

The service did not always control infection risk well. Staff used some control measures to protect patients, themselves and others from infection. They mostly kept equipment and the premises visibly clean. The service used systems to identify and prevent surgical site infections.

Ward areas were mostly visibly clean. The majority of areas were visibly clean; however, we saw visibly dirty plastic screens between patients and there was no evidence or assurance these had been cleaned adequately.

Some wards we visited were looking tired and in need of repair. For example, on a ward at Cheltenham Hospital we observed broken ceiling tiles in a clean utility room which allowed in dust and dirt.

Some wards we visited were cluttered and overcrowded with equipment due to inadequate storage space.

Disposable curtains with clear labelling were used within theatres. These labels showed when curtains should be changed. We saw the use of fabric curtains within wards between patient bed spaces. There was no indication as to when these curtains should be replaced. However, the trust have subsequently told us there was a replacement programme for fabric curtains.

Staff had access to personal protective equipment such as masks, face shields and gloves. There were sufficient quantities of antibacterial hand gels and washing facilities. The division monitored the availability of hand gel and reported 95% availability in March 2022. We observed staff were bare below the elbow in all areas we visited.

Equipment was not labelled to show when it was last cleaned. We did not see evidence that equipment was labelled to show when it was last cleaned. The trust told us they asked staff to clean equipment prior to use to ensure it was safe to use.

The service monitored hand hygiene audit compliance. Hand hygiene compliance was monitored as part of routine monthly audits. The audits showed compliance with hand hygiene audits was 91% within the surgery division from April 2021 to March 2022.

We requested evidence of environmental infection control audits from the trust but were only provided with hand hygiene audit compliance figures. The trust did not set a target for compliance with hand hygiene and instead promoted completion and compliance of the audit rather than the result.

We viewed standard operating procedures relating to environmental cleaning. For example, the environmental cleaning and preparation of theatre document related to all staff who worked in theatres throughout the service. It included suggested cleaning sequences. However, the document had no review date.

Staff used data to identify how well the service prevented infections. The service monitored the incidence of healthcare associated infections. From November 2021 to April 2022 there were 51 hospital onset probable healthcare associated COVID-19 infections and 58 hospital onset definite healthcare associated infections acquired on surgical wards. A hospital-onset probable healthcare-associated infection was defined as an infection where the first positive specimen was taken eight to 14 days after hospital admission with day of admission counted as day one. A hospital-onset definite healthcare-associated infection was defined as an infection where the first positive specimen was taken 15 or more days after hospital admission, with day of admission counted as day one.

Surgery

The service monitored the incidence of infections such as Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium Difficile (C. Diff), Methicillin Sensitive Staphylococcus Aureus (MSSA) and Escherichia Coli (E. Coli). From 1 October 2021 to 31 March 2022 there were seven hospital onset healthcare associated C.Diff infections and one MRSA infection reported on surgical wards.

Staff worked to prevent, identify and treat surgical site infections. Antibiotic use was monitored. The trust had access to antimicrobial stewards to monitor the use of antibiotics.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The service did not have suitable facilities to meet the needs of patients and their families. Areas within the hospital were being used outside of their intended purpose with a lack of mitigation, timely risk escalation and insufficient governance processes. Following the inspection, the service provided evidence that a number of operations avoided being cancelled by using facilities that were not designed to deliver ward based care. The trust told us the decision was made to prioritise procedures and understood patient experience was negatively affected as this environment was not designed to support this care.

There were no effective systems to identify when to open and close theatre recovery areas for patients requiring ward based care, in times of escalation. Some patients were kept in recovery areas within the hospital for extended periods of time mainly due to a lack of beds within the rest of the hospital. We reviewed the Patient Flow and Escalation policy, but this did not include the use of theatre recovery as a designated escalation area.

During the inspection we were told patients had been regularly cared for overnight in theatre recovery areas. We requested further data on how often patients required overnight care in this area. We were provided with information which showed out of 151 days, there were 102 days in which patients stayed overnight on recovery units. From December 2021 to May 2022, the longest stay of any patient in the theatre recovery area was two nights. Following the inspection, the trust told us from January to February 2022, the surgical division lost 60% of inpatient ward beds due to the volume of medical patients being cared for in surgical wards. This was related to the increase in need for medical inpatient beds as a result of the surge in the numbers of patients with COVID-19. During this time the surgical service continued to deliver elective operations for urgent procedures through the use of the theatre recovery areas to care for patients following their operations. The trust acknowledged the negative impact to patient experience during this time.

Staff had raised 252 incidents from November 2021 to April 2022 where patients had stayed overnight or where patients were discharged directly from recovery.

The recovery area was not suitable for patients to remain overnight as there was a lack of privacy and dignity. The area had no toilet or washing facilities, no visitor access, no natural light and no easy access to food or drink. Staff told us they tried their best within the circumstances but were upset as they were unable to give the rehabilitation that people required and provide a good patient experience. This impacted on staff morale and the flow of activity within theatres. The trust recognised the decision to use theatre recovery areas as inpatient wards had a negative impact on staff morale during this time and recognised the need for additional workforce.

On wards we heard of examples where patients were “boarding” (where an additional temporary bed space was created in a bay or in a ward corridor) but did not see examples of this at the time of the inspection. Most patients could reach

call bells however, some patients within these additional beds had no access to a call bell, piped oxygen or suction. We were informed patients were risk assessed as suitable for being cared for in these areas and portable oxygen and suction was available. However, this practice appeared to have become "normalised" and not the exception, despite staff recognising the environment was not suitable for patients to remain for long periods.

Staff mostly carried out daily safety checks of specialist equipment. All wards and departments we visited had emergency resuscitation trolleys available. These were locked and secure with tamper seals. Checks we reviewed were completed daily with the name of the staff member, date and their signature. However, we found gaps within daily checks. On Avening ward there were gaps in the daily checks of emergency equipment. We noted gaps in checks on the 19,20,26,27 March and the 3, 4, 10 April 2022.

The service had enough suitable equipment to help staff safely care for patients. Staff did not report any shortages of equipment. Equipment used to safely lift patients had dates of the last and next service displayed and these were in date. Staff disposed of clinical waste safely. Staff used separate and designated waste bins for general and clinical waste disposal.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient to remove or minimise risks. Staff did not identify and act upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients but did not escalate appropriately. The trust used the National Early Warning Score 2 (NEWS2) tool to identify deteriorating patients. However, we observed some patient care was not managed in accordance with guidance. We reviewed eight care records and found five did not have an escalation decision documented. We requested evidence of NEWS2 audits to ensure observations and escalation were audited against National Institute for Clinical Excellence guidelines. However, the service provided a data report on the timeliness of observations rather than an audit. There was a risk, patients who became acutely unwell, would receive sub-optimal care.

Staff did not complete risk assessments for each patient on admission. An inpatient care report for the surgical division, showed poor compliance for the completion of risk assessments on admission. In March 2022 out of 1,393 patients, 561 (40.3%) did not have a nursing admission document completed within 24 hours of admission. Out of 596 patients, 219 (36.7%) did not have a falls risk assessment completed in full within 24 hours of admission. Out of 656 patients, 488 (74.4%) did not have a falls risk assessment completed within four hours of being transferred from another ward.

Staff did not ensure patients received timely care to meet their needs and to maintain their safety. Patient observations were not always completed within specified timeframes. In March 2022, out of 31,222 patient observations (of at least four hours frequency), 6,492 (20.8%) were not completed within the specified timeframe. Out of 1,878 patient observations (of over 15 minutes and under four hours frequency), 976 (52%) observations were not completed within the specified timeframe.

In February 2022 the trust as a whole reported 87.1% of adult inpatients had received a venous thromboembolism (VTE) risk assessment which was lower than the trust target of 95%. We requested figures specifically for the surgical division, but these were not provided.

Surgery

We saw deep vein thrombosis (DVT) risk assessments were documented on most medicine charts we viewed and medicines were prescribed when required. However, we noted physical devices to reduce DVT risk were not prescribed or monitored in the relevant section of the medicine chart. We saw charts were blank where these items should have been recorded. This had been identified as an issue by the trust during a review of the processes to reduce the risk of DVT.

Staff knew about but did not always manage specific risk issues. Staff received training in sepsis recognition and management when first employed by the service. A sepsis care bundle was in use on surgical wards to support staff.

The trust did not provide sepsis performance data specifically for the surgical division. The trust as a whole was not meeting targets for sepsis identification and treatment. In April 2021 the trust reported 70% of emergency patients with severe sepsis were given antibiotics within one hour of diagnosis. This was below the target of 90%.

Staff undertook the World Health Organisation (WHO) '5 steps to safer surgery' checklist in theatres and undertook audits to measure compliance. We saw staff consistently undertaking all five steps of the checklist during the inspection. The service used a healthcare information system to monitor completion of the checklist. This information system did not link with the other systems used by the trust and therefore staff had to duplicate the inputting of information.

In March 2022 27,525 patients had undergone surgery where checklists were needed. These were within general theatres at Cheltenham General Hospital (CGH), elective orthopaedics CGH, ophthalmology CGH and all theatres in Gloucestershire Royal Hospital, Head & Neck, Trauma and Orthopaedics, General surgery, Emergency and Obstetrics. Out of these patients one WHO checklist was not completed where a procedure had been undertaken.

In addition, spot check audits were completed in theatres to ensure compliance with the checklist. We reviewed the results of five spot check audits undertaken at Cheltenham General Hospital. No date was attached to the audit we viewed. This audit showed 50% compliance with the surgeon audibly acknowledging the count of swabs, sharps and instruments. There were no effective actions noted to improve this. However, 100% of procedures audited included the completion of the WHO safety checklist.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). The psychiatric liaison team was available 24 hours a day.

Staff shared key information to keep patients safe when handing over their care to others. Shift changes and handovers included necessary key information to keep patients safe. There were arrangements for handovers to ensure important information was shared. Ward rounds were completed each day by a consultant. Staff completed safety briefs where all patients were discussed to ensure important messages were shared including risks, infection control issues and any other concerns.

Theatres undertook a "team ten" meeting each morning. This was attended by theatre staff and used to communicate important information for the day ahead. This meeting covered a range of topics such as safety messages, staffing, equipment and bed space.

Nurse staffing

The service did not always have enough nursing and support staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff an induction.

Surgery

The service did not always have enough nursing and support staff to keep patients safe. In January 2022 the trust as a whole had a 14.46% vacancy rate for registered nursing staff. This was much higher and therefore worse than the trust's 5% target.

The service had high vacancy rates. In March 2022 the highest vacancy rate within the surgical division was within the general surgery, upper and lower gastrointestinal service line with a 23.09% vacancy rate for nursing staff. Trauma and orthopaedics had a nursing staff vacancy rate of 19.14% and theatres had a nursing staff vacancy rate of 8.22%.

The service had high turnover rates. In March 2022 the trauma and orthopaedics service line had the highest turnover rate of 12.78%. Within theatres the turnover rate for nursing staff was 9.65%.

Clinical nurse managers reviewed and adjusted staffing levels using a risk-based approach through the use of a nationally recognised safe care tool. Clinical nurse managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance and use of the speciality specific tools. The trust used safer staffing guidance to ensure there were enough staff on each shift. We heard from staff that they were regularly asked to move into areas where staff were needed, and managers moved staff to ensure there were limited gaps in staffing levels.

Staffing levels were discussed at site management meetings which were held throughout the day each day. The trust risk register noted as a low risk that patients could come to harm due to inadequate staffing.

Staff told us they felt there was not enough staff to care for patients safely. They felt any impact on patients was minimal because they worked hard to ensure patients' needs were met and they felt cared for. Staff told us the impact of that extra workload was seen in staff morale. Staff felt recruitment and retention of staff had not been addressed. Divisional leaders acknowledged staffing was a national issue.

Managers used bank and agency staff regularly but requested, where possible, staff already familiar with the service. They made sure bank and agency staff had an induction and understood the service. Records which showed high levels of bank staff were used within the surgical service. Within Cheltenham General Hospital the areas with the most bank or agency staff used were Prescott and Bibury wards. From October 2021 to April 2022 219 shifts on Prescott ward and 183 shifts on Bibury ward were covered by bank or agency staff. We were told the same bank staff were used regularly so they were familiar with the service and they received an induction to the area they were working.

Medical Staffing

The service did not always have enough medical staff to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. The service had high vacancy rates for medical staff. In March 2022 the highest vacancy rate within the surgical division was reported in the trauma and orthopaedics service line with a 12.92% vacancy rate for medical staff. The general surgery, upper and lower gastrointestinal service line had a 9.01% vacancy rate for medical staff. This was higher and therefore worse than the target of 5%.

In March 2022 the highest turnover rate for medical staff was within the head and neck service line of 14.08%.

Surgery

Managers could access locums when they needed additional medical staff. We saw evidence the trust used locum medical staff where needed.

The service had a consultant on call during evenings and weekends. Anaesthetic medical cover was available at Cheltenham General Hospital until 10pm. After 10pm the service was covered by a consultant who could be called upon but was not resident on site.

Records

Staff did not always keep detailed records of patients' care and treatment. Records were clear but not always up to date. They were stored securely and mostly available to staff providing care.

Patient notes were not always complete, and not all staff could access them easily. Staff told us it could be difficult to get information due to records being contained within a mixture of paper and electronic records. Theatre staff did not use the electronic patient record system which meant workarounds were needed which increased duplication.

We saw examples where records such as risk assessments were incomplete, and data provided by the trust supported this evidence.

Records were stored securely. We saw records were kept securely within lockable drawers.

Medicines

The service did not always follow systems and processes to prescribe, administer, record and store medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date.

Staff did not always store and manage medicines and prescribing documents safely. Concerns were identified with the hospital medical gas store. For example, medical gas cylinders were stored on trolleys not designed for medical gas cylinders and safety chains were not always used. The medical gas store lacked safety signs. The temperature of medicines requiring refrigeration was monitored, however, room temperatures where medicines were stored were not. Therefore, there was a risk medicines stored at room temperature may not be appropriately managed.

Staff did not always follow national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff visited the ward from Monday to Friday. However, at weekends the pharmacy team only briefly visited the wards. Ward staff we spoke with were not aware of a critical medicines list at the hospital. Critical medicines are medicines that if omitted or delayed can result inpatient harm. Non-medical prescribers within the clinical pharmacy services worked in pre-operative assessment. Their role included prescribing patients' regular and pre-operation medicines.

Wards used "to take out" packs when discharging patients, the clinical pharmacy service only reviewed discharge summaries that required medicines to be dispensed from the pharmacy. Therefore, there was a risk not all discharge summaries were consistent with the medicines prescribed on the in-patient chart.

Surgery

Incidents

The service did not always manage patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents but did not always share lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients information and suitable support.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. The service used an electronic record system to report incidents. Incidents were escalated depending on the level of harm that had occurred. The trust risk team supported staff in the investigation of serious incidents. Managers received notifications from this team if investigations were not completed in line with performance targets. However, staff told us they did not always get feedback on incidents and did not feel listened to when they raised concerns. Information about incidents was not shared with others to promote learning, including those that had the potential for harm.

Investigation reports showed that patients were invited to contribute to the investigation, were supported and apologised to.

The trust reported, in their April 2021 board papers, they had the highest number of never events within England. In documents produced following the inspection we saw from April 2021 to March 2022 the trust had the highest reported number of never events within the South of England with only three organisations reporting a higher number within England as a whole. The trust had reported seven never events from March 2021 to February 2022. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event. All seven of these events related to surgery or surgical specialities. Incident themes included care to the wrong part of the body, or a wrong fixing used.

A quality improvement initiative had been set up to make improvements in care as a result of never events. The divisional director of quality and nursing worked with the trust wide safety team to arrange never events working groups. We saw a change had been made to a process where teams were expected to stop before anaesthetic was given. A box had been introduced which slowed the process down to allow those involved in procedures to ensure the correct part of the body was being cared for. However, we saw no other improvements and therefore were not clear how effective actions had been and were concerned over the pace of the work.

Meeting minutes stated there had been a concern over staff not attending meetings and not being engaged in the process and many working group meetings were postponed due to a lack of time and operational pressures.

The never event progress tracker showed updates were not being regularly provided on action. The tracker was not red, amber, green rated so it was difficult to determine what progress had been made within each project.

Managers did not always share learning about never events with their staff and across the trust. Not all staff within the surgery division were aware of the never events that had taken place and could not tell us of improvements that had been made as a result of learning.

Not all staff understood the duty of candour, but they told us they would be open and transparent and gave patients and families a full explanation if things went wrong. Staff we spoke with were not clear on the duty of candour and what this would mean for them.

Surgery

Staff mostly received feedback from investigation of incidents, internal to the service. Staff told us feedback was given to them from incidents when they occurred in their ward or area of work, however, this often had to be requested. Managers told us incidents were discussed at team briefings, however, staff spoke about their frustration at the feeling no action was being taken as a result of incidents. Some staff said they felt there was little point in raising concerns as things did not change as a result.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. However, policies were not regularly reviewed.

Staff followed policies to plan and deliver care according to best practice and national guidance. Staff told us policies were easy to find. The surgical service provided care and treatment based on national guidance. This included National Institute for Health and Care Excellence (NICE), Royal College of Surgeons and the Association for Perioperative Practice (AfPP) guidance.

The surgical service had developed Local Safety Standards for Invasive Procedures (LocSSIPs) based on National Safety Standards for Invasive Procedures (NatSSIPs). However, we found policies were not reviewed within their review date. We viewed 15 standard operating procedures relating to surgery services and found nine to be out of review date and four without a review date.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. We observed staff discussing the psychological and emotional needs of patients during handovers and within the theatre environment.

Nutrition and hydration

Staff mostly gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasted before surgery. However, patients told us there could be long waits without food in areas such as theatre recovery.

Staff mostly made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. Staff used special hydration and feeding techniques when necessary and specific menus were available to provide for patients' religious and cultural preferences. However, we heard of patients in recovery units at Cheltenham General Hospital waiting long periods of time for food and drink as these areas were not equipped to care for patients for the length of time they stayed there.

Surgery

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff accurately completed patients' fluid and nutrition charts where needed. There was evidence the malnutrition universal screening tool (MUST) was being used to assess nutritional needs. The records we reviewed showed, where appropriate to be used, these were completed accurately with MUST scores documented.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff monitored patients waiting to have surgery and reviewed the need for being nil by mouth if operating lists changed.

Pain relief

Staff assessed and monitored patients to see if they were in pain, and mostly gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs. Staff supported those who could not communicate verbally through the use of suitable assessment tools.

Staff prescribed, administered and recorded pain relief accurately. Prescription charts showed pain relief was prescribed, administered and recorded accurately.

Patients did not always receive pain relief soon after requesting it. We were not told of any difficulties with receiving pain relief from patients during the inspection. However, feedback from patient surveys suggested pain relief was not always provided as quickly as patients would wish. Being in pain was a common theme of feedback through the friends and family survey.

Patient outcomes

Staff monitored the effectiveness of care and treatment and mostly achieved good outcomes for patients.

The service participated in relevant national clinical audits and outcomes for patients were positive and met expectations, such as national standards.

The service participated in the 2019-2020 National Bowel Cancer Audit. The trust reported the number of unplanned readmissions to hospital within 30 days of treatment were in line with the national average. Unplanned returns to theatre within 30 days was in line with the national average.

Mortality rates after 90 days of treatment was in line with the national average. Mortality rates after 2 years of treatment was in line with the national average.

However, the trust reported 40.9% of patients undergoing rectal cancer treatment had unclosed ileostomies within 18 months of treatment as 40.9%. This led to the trust being a negative outlier in comparison with other trusts nationally. An ileostomy is where the small bowel (small intestine) is diverted through an opening in the tummy (abdomen). The service told us cases had been reviewed and the Quality Delivery Group within the trust had identified errors in the data which was reported. At the time of the inspection the trust was awaiting confirmation as to whether updated figures would influence the negative outlier finding.

In the 2019-2020 National Emergency Laparotomy Audit Cheltenham General Hospital was in line or better than the national average for the 47 cases completed.

Surgery

The trust carried out Patient Reported Outcomes Measures Surveys (PROMS). Patients were asked whether they felt better or worse after receiving specific operations. These included knee and hip replacements. From April 2020 to March 2021 there was a 90.7% participation rate which was better than the England average of 65.2%. Figures for hip and knee replacements showed the trust was in line with the national average in these measures.

The service had a higher than expected risk of readmission for both elective and non-elective care than the England average. For the time period August 2020 to July 2021 trauma and orthopaedic patients at the trust had a higher than expected risk of readmission for both elective and non-elective admissions when compared to the England average.

Competent staff

Managers mostly appraised staff's work performance and held supervision meetings with them to provide support and development. The service made sure staff were competent for their roles however, there was inconsistency over the monitoring of competencies.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave new staff an induction tailored to their role before they started work. Staff reported they received an induction process to help orientate them to their place of work. A piece of work had commenced within one service line to use a specific induction booklet for staff.

Managers mostly supported staff to develop through yearly, constructive appraisals of their work. Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers appraised staff work performance on most wards and theatres we visited. Evidence showed staff had received appraisals or meetings were arranged for staff appraisals. However, appraisal compliance was falling short of trust targets.

Overall, within the surgery division there was a 78% appraisal compliance rate. This was below the trust target of 90%. Seventy-nine percent of nursing staff within the surgical division had completed their annual appraisal. Ninety-one percent of consultants had received an appraisal but only 70% of allied health professionals had received one. We were told appraisal completion had been impacted by the COVID-19 pandemic and the stop on all non-essential meetings. The service was hopeful this would improve.

Clinical educators supported the learning and development needs of staff. Clinical educators were available within the surgery division. However, their time had been taken up by undertaking clinical work, especially during the COVID-19 pandemic and this had impacted upon their ability to provide training and support to staff. Funding for educator posts was also due to be reviewed at the time of the inspection so staff were not sure if the role would be able to continue.

Managers did not make sure staff attended team meetings. Team meetings had been affected by the COVID-19 pandemic and were not taking place during that time. Staff reported this had a negative impact upon team building and cohesion.

Managers did not always make sure staff received specialist training for their role. There was limited evidence of competency frameworks to monitor, record or assess the skills of staff. We were told numerous competencies were in place however, there was a mixed response from staff as to when competencies needed to be assessed and reviewed. There was also a concern staff moving between wards did not have the specific competencies for the care they were expected to provide.

Surgery

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We observed meetings where members of the multidisciplinary team worked together for the benefit of patients. These meetings were calm and organised and included discussion of items all staff needed to know.

Staff referred patients for mental health assessments when they showed signs of mental ill health including depression. Staff had access to the psychiatric liaison team 24 hours a day and would contact them if there were concerns regarding the mental health of a patient.

Seven-day services

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

Consultants led daily ward rounds on surgical wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. However, there was a shortage in the number of radiographers available. We were told patients were sometimes left waiting for a radiographer despite lists being monitored to avoid clashes.

The pain team were available Monday to Friday. Anaesthetic medical cover was available at Cheltenham General Hospital through the resident on call anaesthetic rota which operated until 10pm. After this time an anaesthetic on call service converted to the consultant rota.

The dementia and learning disability liaison nurses were available Monday to Friday, 9am to 5pm. The psychiatric liaison team was available 24 hours a day.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Leaflets were available to patients on wards. We saw displays and posters promoting healthier lifestyles on a number of wards we visited. For example, support to stop smoking and the importance of a good diet.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Surgery

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. We were provided with data to show the numbers of staff who had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS). However, these figures did not contain the percentage of staff who had completed training, so we were unable to say if all staff were up to date with this training.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff told us they were able to ask for support around deprivation of liberty safeguards and the Mental Health and Mental Capacity Acts from leaders and also from the trust safeguarding adult hub.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation. The trust had introduced new mental capacity assessment documentation. In January 2022 a new DoLS documentation audit had commenced. This was supported by the trust safeguarding adult hub, trust dementia care admiral nurse and trust learning disability liaison nurse team.

Managers monitored the use of Deprivation of Liberty Safeguards and were making improvements to make sure staff knew how to complete them. A bi-monthly report of DoLS activity was undertaken by the trust safeguarding adult hub. From January to March 2022 42 applications for the authorisation of deprivation of liberty safeguards were made within the surgical division. The report acknowledged it was highly likely that actual application need was significantly higher than was recognised or achieved within practice.

The trust safeguarding adult hub had completed an audit of capacity assessment documentation and deprivation of liberty safeguards (DoLS) needs assessment documentation at the end of 2021 and beginning of 2022. Fifteen records were audited across both the medical and surgical divisions within the trust. The audit found 10 out of 15 records documented the assessment of capacity to consent to current care and treatment arrangements. In 11 out of 15 records showed a DoLS application was made where considered appropriate. However, not every patient with a DoLS application had a documented assessment of decision specific capacity recorded.

The audit also noted care teams were likely to request a member of the medical team to complete the capacity assessment which could cause delays. Development points were noted on the audit, but no action plans were provided by the service to understand how improvements would be made.

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Compassionate care

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

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed interactions between staff and patients to be positive, encouraging and kind. Patients on wards told us staff used curtains to respect their privacy especially when they were completing ward rounds although it was still possible to hear conversations at times.

Surgery

Patients said staff treated them well and with kindness. One patient told us they "could not fault the staff" who they found to be "attentive". Another told us their care had been "fabulous". Patients told us they were treated well, and staff were doing the best they could in difficult circumstances. Another patient told us "we are in difficult times" and staff were "making the most" with what they had.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for patients. We observed interactions between staff and patients which demonstrated an understanding of the anxiety people faced when undergoing surgery. We saw staff communicate clearly to patients who were concerned and explained procedures to them in a clear way.

Staff understood and respected the personal, and social needs of patients and how they may relate to care needs. We were told patients who identified as gender neutral or transgender were given a choice over which ward they would prefer to stay on. Staff were respectful of people's needs in this respect.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal and social needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. We observed staff speaking with patients in a supportive and helpful manner. Staff told us despite being under pressure they tried to do the best they could for patients in difficult circumstances.

Staff appreciated the distress having surgery could cause and were conscious to provide as much advice and assistance as they could.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients told us it was difficult having only one visitor at a time due to visiting restrictions. Staff were conscious of this and supported individuals to contact those close to them. We heard of examples where staff had made contact with an individual's family in a timely way and explained the outcome of a procedure.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff mostly made sure patients and those close to them understood their care and treatment. One patient told us staff were open to answering any questions they had, and doctors especially had communicated clearly to them in a way they could understand. However, feedback from some patients highlighted that communication could be improved in terms of why they were waiting and when they were likely to receive treatment.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients mostly gave positive feedback about the service. The surgical division gathered feedback from patients and their families through the use of the friends and family test. We were provided with an overview of this feedback from February 2022. The surgical division asked patients "overall, how was your experience of our service". The feedback

captured responses from 2,962 patients. 74.5% of patients reported their experience was very good and 16.7% responded that their experience was good. Positive themes from the feedback included “compassionate staff”, “friendliness” and “emotional and physical support” being given. However, patients reported being unhappy at waiting times, being in pain too long and gaps in communication.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. The trust was involved in consultations with the wider health and social care system within Gloucestershire. The “Fit for the Future” programme was part of the “One Gloucestershire” vision. The vision included the medium and long term future of specialist hospital services across both the Cheltenham General and Gloucestershire Royal Hospital sites. This related specifically to surgical services as it included plans for elective and emergency surgery and where they would take place.

The service did not report breaches for mixed sex accommodation. For the period April 2021 to March 2022 the trust as a whole reported one mixed sex accommodation breach in August 2021. We saw evidence that within theatre recovery units there was no facility to provide separate areas for male and female patients. Patients were regularly remaining overnight in these areas.

Incident reports demonstrated in Cheltenham General Hospital theatre recovery there were 46 out of 120 days where patients stayed overnight.

We were provided with a draft standard operating procedure for the admission of patients to theatre recovery areas when ward-based care could not be provided due to a lack of beds. The document did not include consideration of mixed sex accommodation of patients who stayed overnight. There was, therefore, a concern that not all mixed sex breaches had been identified and reported in line with trust policy.

Since the inspection the trust told us historically, mixed sex accommodation breaches had been deemed non-reportable when the trust escalation status was at level three or four. Breaches had been not reported for an extended period as the trust escalation status had remained at those levels. The trust told us they had altered the reporting framework to give oversight of breaches at all times, regardless of escalation status. We were told all breaches, categorised in accordance with national guidelines, would be authorised by the Chief Nurse or Deputy Chief Nurse. Following the inspection, we saw trust board papers which reflected mixed sex breaches were being reported. Figures rose from two to 22 breaches in April 2022.

Surgery

Meeting people's individual needs

Due to pressures on the service and environment reasonable adjustments were not always able to be made for patients living with dementia or a learning disability. However, the service worked to take into account of patients' individual needs and preferences.

Wards were not designed to meet the needs of patients living with dementia or a learning disability. Some surgical wards we visited were cluttered and not designed to accommodate patients living with dementia or a learning disability.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. We saw the 'This is me' tool being used for patients living with a learning disability on wards within Cheltenham General Hospital.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us there was access to interpreting services for patients whose first language was not English. We saw evidence the trust monitored the need for interpreting services and ensured they had sufficient availability.

The service had information leaflets in languages spoken by patients and local community. The service had access to a range of information leaflets for patients to read about a variety of conditions and support services. However, there was no easy way to access these leaflets in a range of different languages. This included through the hospital website.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff told us they could use communication boards and other aids to support people to communicate.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards.

Patients could not always access services when needed and did not receive treatment within agreed timeframes and national standards. However, managers monitored waiting times. In line with national trends following the COVID-19 pandemic, the trust's elective waiting list had increased and was around 13% higher in December 2021 than in July 2020.

The standard was for no patient to wait longer than 52 weeks for treatment. In March 2021 there were around 3,500 patients waiting more than 52 weeks for treatment. However, this had fallen to 1,900 in December 2021. The number of patients waiting more than 52 weeks for treatment had continued to fall in January 2022. Therefore, the trust was making improvements in the numbers of patients waiting for treatment over long periods of time.

The trust had not been able to meet the 92% standard for patients receiving treatment within 18 weeks from referral; though performance had been gradually improving over time. In the 2021/22 period referral to treatment ongoing pathways under 18 weeks was reported as 72.33% which was below and therefore worse than the national standard of 92%.

The trauma and orthopaedics service line reported 54.22% of patients received treatment within 18 weeks of referral in January 2022 which was much worse than the 92% standard.

Surgery

The service had not minimised the number of surgical patients on non-surgical wards. Numbers of patients being cared for with surgical needs on non-surgical wards were monitored by the trust. When this happened, the service referred to these patients as being within "outlying" wards. We requested data from the service on the number of "outlying" surgical patients on non-surgical wards but were only provided details on the number of medical patients "outlying" on surgical wards. In January 2022 the daily average number of medical patients in surgical beds was 90, in February 2022 the daily average was 94 medical patients in surgical beds. Staff told us this had a negative impact upon staff and patients as they were not able to provide specialist care for patients who were being cared for away from the surgical speciality they needed.

There was frustration amongst staff due to a lack of patient flow within the hospital as a whole. There had been increased demand on emergency departments and the medical divisions which impacted upon surgery as surgical bed spaces were used to care for medical patients. Staff told us they felt elective patients were often waiting for long periods of time due to inefficiencies within the flow of the hospital.

Managers had arrangements for surgical staff to review any surgical patients on non-surgical wards. Consultants knew where patients were located within the hospital and made arrangements to review these patients on a daily basis. However, surgical beds were being used for medical patients which led to surgical patients "outlying" in medical beds and specialties not related to their condition. Staff told us ward rounds were not efficient enough and took long periods of time which impacted on the time they had with patients.

When patients had their operations cancelled at the last minute, managers did not make sure they were all rearranged as soon as possible and within national targets and guidance. Data showed that cancelled patients were not always offered another date within 28 days. From April 2021 to March 2022, 790 operations were cancelled 107 of these operations were classed as urgent. Eighty-two percent of patients were readmitted within the target of 28 days. This was below and therefore worse than the national standard of 95%. The trust board report highlighted the re-booking of patients as a challenge and noted staff sickness and bed capacity to be the reason for the difficulty.

Managers worked to ensure theatres were being utilised efficiently. The service reported a theatre utilisation rate of 87% which was better than the standard of 85%. The service planned to use an NHS Improvement model described as a "6-4-2" process where surgical staff agreed their annual leave six weeks in advance, agreed surgical lists four weeks in advance, and checked plans two weeks ahead. However, we were told meetings related to theatre efficiency had not been held for some time. Staff reported being frustrated with changes to operating lists, however, we were told, there was a perceived lack of commitment to the model. The trust told us the divisional director of operations had led engagement sessions in January and February 2022, with operational managers and nursing representatives to discuss bed allocations per specialist to reduce list changes.

The theatre utilisation working group had been postponed during the COVID-19 pandemic but recommenced in February 2022 to ensure theatres were being used efficiently. A new general manager for theatres had recently been appointed. They continued to support this group. Plans were being made for the general manager to speak with each speciality director to understand the demand and capacity in each service line and how theatres could support each speciality.

Managers monitored waiting times and made sure patients could access cancer treatment services when needed and received treatment within agreed timeframes and national targets. The service was proud of its ability to maintain standards in relation to cancer treatment waiting times throughout the COVID-19 pandemic when this had been affected at a national level.

Surgery

The trust was above and therefore better than the national average for all cancer waiting time standards. There was an increase in suspected cancer referrals. In 2020-21 there were 22,029 referrals compared with 26,581 referrals in 2021-22. The trust saw 24,673 patients out of 26,581 patients within 14 days of their referral. This represented 92.8% of patients. The trust treated 97% of new patients with a cancer diagnosis within the 31-day standard. This was better than the target of 96%.

Managers and staff worked to make sure patients did not stay longer than they needed to. The length of stay for surgical patients was better than the England average of 5.06 days. From January 2021 to March 2022 there were 53,888 surgical admissions. During this time the average length of stay for inpatient elective surgical patients was 2.6 days which was better than the national average. For inpatient non-elective patients, the length of stay was 4.2 days which was better than the national average.

Managers and staff started planning each patient's discharge as early as possible. We saw evidence discharge was discussed when patients were admitted. However, we saw evidence of times where patients were discharged from recovery units due to a lack of bed space within the hospital. Patients were often cared for overnight in recovery when a bed could not be provided on a surgical ward. This impacted upon individual rehabilitation programmes and provided a poor experience for patients as they were being cared for in areas not intended for inpatient stays.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them. However, not all complaints were responded to in line with trust targets and staff were not able to tell us how complaints had been used to improve services.

Patients, relatives and carers knew how to complain or raise concerns. Patients we spoke with felt confident they would be able to raise a concern if they needed to. One patient told us they would use the internet to determine how to complain if necessary.

The service displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Staff told us they felt confident in being able to deal with complaints and would try to resolve them at the time of being raised or passed on if necessary.

We reviewed the guidance for lead investigators whose responsibility it was to respond to complaints. This was likely to be the clinical or nursing lead. This included finding out if the actions of the staff were appropriate and if not, what action should have been taken at the time and will be taken to reduce the risk of and/or prevent a recurrence of the issue that gave rise to the complaint.

The trust had piloted an early dispute resolution process at the time of the inspection. We were provided with details of this. The process included, where appropriate, the offer of a meeting with the divisional director of quality and nursing. It was expected this would be used for complaints where the issue was poor patient experience or staff attitude.

Managers investigated complaints and identified themes. The trust adopted a new process to respond to complaints in February 2022. Each speciality leadership team formulated complaint responses with senior directors signing off serious complaints.

The service monitored the numbers of complaints and analysed these on a quarterly basis. This information was shared with the surgical quality board.

Surgery

The trauma and orthopaedics service line received the highest number of complaints within the surgery division in October 2021 and January 2022. An improvement plan was to be reported by the service line at the next service line review. However, we did not see evidence of this plan.

Themes from complaints included attitude of staff, waiting times, care issues and communication.

Patients received feedback from managers after the investigation into their complaint. Patients were involved in the investigation of complaints. In March 2022, 60% of standard complaints were closed within the trust target of 35 days. Eighty percent of serious complaints were closed within the trust target of 65 days.

Managers told us they shared feedback from complaints with staff. However, staff could not give specific examples of how patient feedback had been used to improve daily practice.

Is the service well-led?

Inadequate ↓↓

Our rating of well-led went down. We rated it as inadequate.

Leadership

Leaders mostly had the skills and ability to run the service. Leaders did not fully understand and manage the priorities and issues the service faced. Staff did not feel all leaders were visible and approachable in the service for patients and staff. Not all staff felt supported to develop their skills and take on more senior roles.

The surgical division was led by a chief of service, a divisional director of quality and nursing and an operations manager as well as deputies for each role. This leadership style was referred to as a triumvirate. The triumvirate was supported by each speciality team which included a speciality director, a matron and a general manager.

Staff expressed negative views regarding visibility of leaders, how approachable trust executives were, and the transparency of processes followed by divisional leaders. Theatre and recovery staff told us they had never seen a member of the trust executive team in the department. Staff said they considered local leadership and management teams to be accessible, responsive and supportive. Divisional leaders provided evidence of a timetable of visits made by the executive team. They had visited theatres and surgical assessment areas and the divisional triumvirate completed walkabouts within departments. However, most staff said they rarely saw senior staff above matron level.

Matron and manager level staff were described as being drained due to a lack of support and confusing demands from divisional leaders. During the inspection there were many leaders we spoke with who had recently been appointed or were stepping into new roles as individuals had left the service.

Leaders did not manage the priorities in a way which reduced pressure and assisted staff treating patients within theatres, recovery areas or wards. We were told of examples where staff were pressured to achieve targets or standards without support from those above.

Surgery

Staff had raised concerns regarding staffing, low morale and did not feel they were listened to. The chief of service was aware of issues affecting the service and had a desire to make improvements. However, it was unclear how action would be taken to address this across all specialities. A theatre transformation senior matron had been employed to support theatre workforce, culture, patient safety, leadership and development.

Staff felt certain roles were undervalued such as healthcare assistants. Due to the complexities of the role within surgery some felt unrewarded for the skill level needed. We saw documents which suggested some roles should be graded more highly and this was escalated. However, staff told us there had been a limited response from leaders as to what changes would be made.

Most staff told us they were supported to develop within their roles and had opportunities to discuss development. However, not all staff received regular appraisal and career development conversations.

Vision and Strategy

The service had set objectives for what it wanted to achieve in the 2021-22 financial year however, there was no clear strategy to turn it into action.

The trust had strategic objectives that were set from 2019. The objectives were: outstanding care, compassionate workforce, quality improvement, care without boundaries, involved people, centres of excellence, financial balance, effective estate, digital future and driving research. At the time of the inspection the trust was three years into a five-year strategy.

The service had set objectives for what it wanted to achieve as a surgical division in the 2021/22 financial year. The objectives were based on five year plans developed by each service line. However, there were no clear strategies as to how to turn these aims into action nor how progress would be monitored.

Divisional leaders had undertaken an away day to discuss an internal review of governance processes which had taken place in 2021. We were provided with evidence that ambitions were recorded, for example to “take a strategic view of what the division as a whole needed to achieve”. However, the evidence we were provided with gave no indication as to what action would be taken to achieve this and how those actions would be monitored.

Staff were not clear as to why decisions about services were made and felt they had little opportunity to affect change. Staff were unhappy at the numerous movements of wards throughout the trust and felt there was no overarching plan or rationale behind these moves. These moves were described as unsettling staff and patients and caused confusion.

Staff we spoke with were not aware of the trust values.

Culture

Not all staff felt respected, supported and valued. Staff were focused on the needs of patients receiving care but were not always able to deliver the level of care they needed. Not all staff felt the service had an open culture where staff could raise concerns without fear.

Poor morale and perceived bullying, incivility and concerns around retribution were highlighted during the inspection. Members of staff who spoke with us identified a concern around speaking up for fear of reprisal.

Surgery

Staff told us there was a "top down" approach to management which felt punitive if performance targets were not reached. However, it was felt there was little support offered to manage performance and to influence factors that were not within their control. Leaders told us the executive team were informed of escalation through executive reviews, divisional board and risk management group meetings.

Staff felt pressured into ensuring targets were met without an understanding by leaders as to why quality was being affected. Staff told us emails and escalation about care, the environment and patient experience were not responded to by leaders.

Staff were described as demoralised and felt there was an acceptance of low standards in order to meet targets. Divisional leaders told us they felt they had tackled poor behaviours and incivility directly and encouraged staff to report incidents formally. However, staff felt individuals demonstrating poor behaviour were not challenged. We heard of examples where incivility and unacceptable behaviour were accepted.

Managers described their staff as being tired and "broken" with constant change adding to the pressure. The lost social aspect of face to face meetings was highlighted as a concern as most meetings were virtual and led to a lack of team building and a sense of community. Following the inspection, the division recommenced face to face divisional board meetings from June 2022 and service line reviews from July 2022.

There was a lack of trust amongst staff and fear of speaking up. We heard when staff did raise concerns they were not always supported or treated with respect. Some staff told us they had tried repeatedly to raise concerns and due to lack of or negative responses, eventually they had become disengaged and focused instead on day-to-day service provision.

Following our inspection, 12 members of staff contacted us, some anonymously, to discuss concerns. We were told there was an over focus by management when things went wrong and a lack of celebrating staff when things went right. Direct managers were not given support by those above them including feedback which led to them feeling a lack of confidence that they were being listened to. However, the surgery division took part in the "Going the Extra Mile" (GEM) awards. Individual team members could nominate their colleagues for these awards. We saw evidence of awards being given in 2021 for staff going above and beyond in their roles. We saw where whole teams had been nominated for GEM awards for the care they had provided. An electronic newsletter for the surgery division highlighted thank you letters from patients and where gratitude for care had been given.

Governance

Leaders did not operate effective governance processes. There were governance processes, but these were not effective in gaining full assurance, improving or developing the service. Managers were clear about their roles and accountabilities and had opportunities to meet, discuss and learn from the performance of the service. Not all levels of governance and management functioned effectively.

In May 2021 the surgery service had undergone an internal review of its governance arrangements. This review found concerns over the lack of clear guidance around divisional governance including trust expectations on meeting terms of reference, frequency of meetings and escalation of concerns. As a result of this review a reconfiguration of governance took place within the surgical division in June 2021. The divisional leadership team worked with service line teams and refined the terms of reference, agenda and report formats for service line reviews and surgical quality board which then informed the divisional board.

Governance processes consisted of the trust executive review which was informed by the surgery divisional board. This board received information from the surgical quality board and each service line reported on a monthly basis.

Surgery

At the time of the inspection each speciality undertook a monthly service line review. This meeting involved discussing safety, quality measures, performance, workforce, finances and service development. We reviewed these service line reviews and found incomplete documents. Some templates had not been completed in full and consisted of prepopulated sentences which had not been updated with the information requested. There was no evidence provided of the depth of the discussion or scrutiny within the review. Documents we viewed lacked enough detail to show what action was being taken in relation to areas of poor performance and whether there was any support or challenge provided.

Governance processes for the monitoring of procedures and policies were not effective. We found standard operating procedures for theatre care and treatment were out of date or overdue review. There were seven reported never events from March 2021 to February 2022 relating to surgery or surgical specialities. We requested and received 15 standard operating procedures relating to theatre practice. Out of 15 documents we reviewed 14 were overdue for review or did not have a review date stated, this included the local anaesthetic 'stop before you block' process which was relevant to two of the never events which had occurred.

Staff told us of perceived ineffective arrangements for monitoring, managing and reporting on quality and performance. Due to lack of administrative support and duplication in systems we were told staff did not feel data could be relied upon. This had been escalated to information teams within the trust.

Management of risk, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and issues and identify effective actions to reduce their impact. Staff reported a lack of oversight and collaborative working from trust wide leadership.

The system to manage, identify, document and understand risk did not capture all clinical and patient risks. We reviewed the risk register for the surgical division. On the 7 February 2022, there were 117 surgical risks on the risk register; compared to 112 risks in the previous reporting period. Of these risks, 45 were at speciality level, 70 were at divisional level and two were on the trust risk register.

The service did not take timely action to mitigate risks to patients receiving ward-based care in theatre recovery areas. At the time of inspection there was an entry on the surgical divisional risk register relating to the risk to quality of care of patients remaining in theatre recovery areas when they required ward-based care. This risk was first entered on the risk register in 2018. There were no open actions documented for the ongoing mitigation of risk or evidence of escalation. The service did not provide us with an audit history of this risk register entry.

Following the inspection, the risk had been escalated and accepted onto the trust risk register which was presented to the trust board on 12 May 2022. There was a concern that risk was not being managed effectively and in a timely manner.

Leaders did not have oversight of whether staff followed processes to assess and monitor patients and to take action if their condition deteriorated. We found evidence that NEWS2 scores were not escalated in a timely way which could impact on patient safety. There was no audit of NEWS2 documentation at the time of the inspection.

Staff told us, despite raising and escalating concerns, it was felt action was not taken to mitigate risks. They did not feel like partners in the management of risk and were unsure of what risks were currently on the risk register.

Surgery

Information Management

The service collected data but did not always analyse and act on it to make improvements. Staff could not always find the data they needed, in easily accessible formats, to understand performance, and make improvements. The information systems were not always integrated. Data was submitted to external organisations as required.

The service submitted data to external bodies as required. These included national audits such as the National Bowel Cancer audit and the National Emergency Laparotomy Audit. This meant the service was able to benchmark performance against national outcomes. However, there was limited evidence managers and staff used results of national audits to improve patient outcomes. We requested evidence as to how the service used audit findings to make improvements, including action plans but were not provided with this information.

The service used a healthcare information system to monitor compliance such as the World Health Organisation surgical safety checklist. This information system was not integrated with other systems used by the trust and therefore staff had to duplicate the inputting of information.

Theatres were not using electronic patient record systems at the time of the inspection. Therefore, workarounds were being used to ensure information was passed on and managed safely.

There was no dedicated deprivation of liberty safeguarding (DoLS) document within the electronic patient record to record patient DoLS activity. This information was therefore not easily visible to clinical teams. There was a risk DoLS application history would become lost within documentation. This issue had been escalated to the trust safeguarding adult lead.

During the inspection process the service was not able to provide a number of pieces of evidence requested. Staff told us there was a concern information was not being managed effectively and that staff could not access information easily and efficiently.

Engagement

Leaders engaged with staff and patients to plan and manage services. Staff did not always feel included or engaged with decisions made by senior leadership.

Leaders engaged externally with patients, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. There had been extensive public consultation regarding the fit for the future programme involving both Cheltenham General Hospital and Gloucestershire Royal Hospital.

Communication and engagement with staff needed to improve. Staff told us they did not feel actively engaged in the planning and delivery of services and did not feel included with decisions that were being made.

A staff survey was completed in 2021. Results showed there had been a deterioration from previous years. The areas where results had deteriorated the most were within the questions; “my manager encourages me at work”, “there are enough staff at this organisation for me to do my job properly”, “I would recommend my organisation as a place to work” and “if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”.

Staff told us they felt disengaged from senior level management due to feeling repeatedly like they had not been heard. Managers did not feel they had feedback, and this had caused a disconnect between wards and the board.

Team meetings had been affected by the COVID-19 pandemic and were not taking place during that time. Many meetings had not returned to being face to face. Staff reported this had a negative impact on team building and cohesion. We saw evidence of local initiatives to increase staff engagement. This included a "staff shout out" document which was designed to be used to give staff key messages and highlight good practice within theatres.

The service collected data from patient surveys, and Friends and Family Tests (FFT) to help improve service provision. We saw patient surveys were used to gather information from patients in specific areas such as recovery units. Friends and Family Test results were monitored as a division. The results showed 74.5% of patients reported their experience was very good and 16.7% responded that their experience was good. We saw actions had been agreed as a result of feedback from the patient survey including pathway journey posters and exploration of alternative approaches to gaining feedback from patients with cognitive impairments.

Learning, continuous improvement and innovation

Staff were committed to continually learning and improving services, however due to operational pressures this had not been a priority for staff within the service. Leaders had a good understanding of quality improvement methods; however, we saw little evidence of sustained change and improvement. However, leaders were proud of the use of new technology within the service.

Staff were committed to continually learning and improving services however, due to operational pressures this had not been a priority for staff within the service. We met a number of committed and passionate staff and managers who desired to make improvements for patients and staff.

The service was passionate about quality improvement but there was little evidence of sustained change taking place as a result. The service provided a list of quality improvement projects which had been started throughout 2021 however, there was no ability to track the progress of these projects and no outcomes noted to demonstrate the improvement that had been made.

The trust was approaching the review of never events through a quality improvement methodology. There had been investment in quality improvement methodology training to support this approach. A gold quality improvement trained individual was attached to each working group. However, the work was not being undertaken at pace and was not leading to the prevention of never events. We were provided with a never events tracker, this did not show clear progress had been made and several working groups had stalled due to a lack of engagement.

Staff and leaders were enthusiastic and proud of their use of robotics within surgery for gastrointestinal, urological and colorectal procedures. The trust was one of the first NHS trusts in England to use mobile surgical robots for operations on the stomach and gallbladder. We saw evidence other hospitals throughout the UK had shown interest in watching live procedures being undertaken. The robots were benefiting patients by being more accurate and precise than the human hand and procedures were less likely to result in complications.